Taking Action

All counselor actions with clients who are suicidal should be guided by and in concert with established program policies and procedures. These policies, while unique to each program, will, for the most part, have consistent points across a variety of agencies.

Some of the common points might be:

- That clients with suicidal thoughts and behaviors will not automatically be excluded from treatment for acknowledging their suicidal thoughts or behaviors.
- That all efforts will be made to help these clients stay in substance abuse treatment as long as their safety can be maintained.
- That all clients entering the program will be screened for suicidality.
- That potential warning signs that emerge during the course of treatment will be followed up.
- That all counselors will be trained in identifying and responding to suicidal thoughts and behaviors of clients in the program.
- That the program will strive to ensure that clients receive the best care available for their suicidal thoughts and behaviors, whether that care is pro• vided in the program or by referral.

There should be a "check off" procedure so counselors are not left on their own to make care decisions for clients at acute risk. Some of the levels of care that might be considered include:

- Observation.
- Contact with the client's family and/or significant others.
- Arrangements for disposal of suicide weapons in the possession of the client.
- Referral for assessment or for more intense care
- Referral for hospitalization as required for safety.

The 24•Hour Suicide Assessment Tool (see figure 3) is an example of a tool for rating a client's current suici• dal thoughts and behaviors. It rates the areas of sui• cidal ideation, behavior, general mood, and cogni• tion/perception. Although this tool is more appropri• ate for an inpatient psychiatric setting, it can be adapted to a variety of substance abuse treatment settings—especially therapeutic communities, detoxi• fication centers, and residential rehabilitation envi• ronments. Such a tool can be used to help guide staff to seek more intensive levels of mental health care. It should be noted that this instrument was developed by a community agency for residential treatment set• tings. The tool has not undergone extensive field testing.

Figure 3. 24•Hour Suicide Assessment Tool

Assessment Category	No Monitoring	Suicide Alert—Watch (Minimum 15 min.)	Level II—Observation (Minimum 15 min.)	Level I—Precaution (Constant Observation—1:1)
• Suicidal ideation • Thoughts • Plans • Method	• Verbalizes no current ideation • None to occasional suicidal thoughts with no plan	• Verbalizes current suicidal ideation • Frequent suicidal ideation • Has no plan or vague plan • Method unavailable or nonlethal	• Verbalizes current suicidal ideation • Frequent suicidal ideation • Has specific plan • Method unavailable or available and non•lethal	• Verbalizes current suicidal ideation • Frequent suicidal ideation • Specific plan and available method • Attempt within last 24 hours
Behavior cues • Impulse control • Behavioral activity • Preparation for death (suicide note, giving away belongings)	• Adequate impulse control • Consistent in behav•ior patterns	• Inconsistent impulse control • Some changes in usual behavior pat•terns	• Unpredictable at times or inconsistent impulse control • Distinct changes in behavior patterns	• Impulsive and unpre•dictable behavior • Sudden or abrupt change in behavior • Marked increase or decrease in behavior • Death preparation
Mood or affect • Predominant mood or affect • Mood stability • Tolerance of feelings	• Signs of mild depression • Indicators of hopefulness • Mood stable • Feelings tolerable	• Signs of moderate depression • Indicators of helplessness • Some mood fluctuations • Some anxiety, agitation•Feelings periodically distressing	• Signs of moderate depression • Indicators of helplessness and hopelessness • Labile mood • Moderate anxiety • Increased affective distress	• Severe depression • Indicators of help•lessness and hope•lessness • Calm resolution • Severe anxiety • Unbearable psycho•logical pain
Cognition/ Perception	• Problem solving intact • Accurate perception of reality	• Limited problem solving • Inconsistent or nar•rowed perception	• Poor problem solving • Impaired reality testing	• Unable to problem solve • Psychotic with com•mand hallucinations • Sees no alternative to suicide

1. The nurse will complete the Suicide Assessment Tool (SAT) when the client is admitted.
2. Results of the SAT will be communicated to the physician within 4 hours on determination of the level of suicide precaution warranted.
3. The nurse will complete a new SAT at least every 24 hours for all suicide alerts.
   - Suicide Alert—Watch: The nurse will document in progress notes once per shift the condition of the client. Designated staff will do safety checks a minimum of every 15 minutes.
   - Level II—Observation: The nurse will document in progress notes the condition of the client a minimum of every 4 hours. Designated staff will do safety checks a minimum of every 15 minutes.
   - Level I—Precaution (constant observation, 1:1): The nurse will document in progress notes the client's condition a minimum of every 2 hours. Designated staff assigned for constant observation.
4. The attending physician will review the results of the SAT level of monitoring determined every 24 hours.
5. The physician will order to continue or discontinue the monitoring precaution either in writing or verbally.

_____ _____
Nurse Signature Date

_____ _____
Physician Signature Review Date

_____ _____
Client Name Unit

Treatment programs should have a policy on referrals for clients who are suicidal or those needing other specialized services. An example is provided in sample policy 4 (p. 122). The specifics of such a policy will depend on State laws and regulations.

Documenting the clinical actions taken with clients who are suicidal is critical, so counselors need to be given the time to complete this important task. Forms for use in these situations should be developed to ensure that all necessary information is obtained (additional information on documentation can be found in Part 1, chapter 1).

Counselors should also be able to look to you for guidance and support with clients who are suicidal but resist treatment. Senior clinical staff, clinical supervisors, and administrators should be prepared to work with the counselor (and the client if necessary) to resolve some of the resistance and help the client accept appropriate treatment. Several of the vignettes in Part 1, chapter 2 illustrate counselors working with resistant clients. The collaboration of senior clinical staff and clinical supervisors with counselors in these client situations enables counselors to develop their clinical skills with clients who are showing resistance and improve services to clients with a variety of needs.

As the program becomes more experienced in working with clients with suicidal thoughts and behaviors, it can be expected that a more consistent repertoire of responses to suicidality will evolve. This does not mean that responses to clients will become stereotyped, but rather that experience will create more options and greater versatility in care.

Extending the Action and Following Up

It is important for counselors and program administrators to understand that program responsibilities do not end with a client's referral to another agency. Both the counselor and administrators continue to have a responsibility to ensure that the client follows through on the referral, that the referring agency accepts the client for treatment, and that treatment is actually implemented. You also have an ethical responsibility to ensure that the client's substance abuse treatment needs do not get lost in the process of referral. Such monitoring requires oversight by the substance abuse program with specific staff (perhaps clinical supervisors) to ensure this continuum of treatment.

Administrators can assign clinical supervisors the job of making sure that the tasks involved in extending care beyond the immediate actions are carried out. These tasks include:

- Following up on referrals.
- Case management as required, monitoring that clients are following a treatment plan established by the counselor and the clinical supervisor or by the treatment team.
- Checking in with the client and significant others (if warranted) to ensure that care is progressing.
- Continued observation and monitoring for suicidal thoughts and behaviors that may re•emerge after the initial crisis has passed.

An organized system of followup by the supervisor, such as a checklist of clients with suicidal ideation or behavior may be required. Clinical supervision training may need to emphasize the need for such followup.

Finally, the program needs to have a standardized system of documenting followup. Often, programs are not as consistent with documentation of followup actions as they are with documentation of clinical interventions undertaken by the counseling staff. Most charting in client records is oriented to responses to specific client behaviors or problems rather than to follow up on those behaviors or problems. As a result, program policy needs to describe how the followup documentation should occur and who in the program is responsible for the documentation. Furthermore, a senior•level staff member should review the documentation for oversight and quality assurance purposes.

Sample Policy 4

Topic: Criteria for and transfer to psychiatric facility

Policy Statement: Clients meeting the criteria for transfer to a psychiatric facility will be transferred either voluntarily or involuntarily.

Criteria for Transfer

Occasionally, clients of our treatment program have co•occurring psychiatric symptoms or conditions in addition to their substance use disorder. There are occasions when clients who experience significant psychiatric symptoms may require transfer to a psychiatric facility for evaluation or treatment.

Criteria for transfer include:

1. A clear and present danger to themselves or to others in the form of suicidality, homicidality, or the intent to harm another
2. Significant psychotic behavior
3. Overt aggressive behavior endangering self or others

Process for Hospital Admission

Voluntary Admission

1. The patient is willing to sign voluntarily for admission to psychiatric facility.
2. The unit and/or on•call clinical supervisor, along with counseling staff, will determine the appropriate facility and arrange for discharge from the agency and transportation to the facility.

Involuntary Commitment

Counseling staff working with a client who is suicidal or otherwise dangerous to him• or herself or others will review the client's condition with the clinical coordinator or the Executive Director and then contact the on-call clinical supervisor who will initiate the following process. Medical staff will consult with the medical director or on•call physician prior to initiating this process.

1. Contact the County Crisis Intervention Unit at [phone number] and inform them that we would like to admit the patient as an involuntary hospital admission. A delegate will be assigned to assist with the involuntary process, to interview the client, and to authorize the warrant for transportation.
2. The staff member who witnessed the suicidal behavior or heard the suicidal statements should be present to offer that information to the delegate when they arrive.
3. After the delegate arrives and it is determined that the patient will need admission to a psychiatric facility, the delegate will contact an ambulance for transportation of the patient and when appropriate, will assist them in making those arrangements.
4. If the patient is physically unmanageable or dangerous, the police will be contacted to ensure the safety of the client and to assist in the process.

Before all admissions to a psychiatric facility, the following must be completed:

1. Have available client demographics, including insurance information, and clinical information.
2. Notify parents of an adolescent or the emergency contact for an adult that a transfer to a psychiatric facility is occurring.