Chapter 2

Building a Suicide Prevention-and Intervention-Capable Agency

Introduction

The previous chapter presented an orientation for administrators about how suicide affects a substance abuse treatment program. It focused on several conceptual issues, including why a program administrator should be concerned with suicide, levels of agency preparedness to address suicide, and the legal and ethical considerations of working with clients in substance abuse treatment who have suicidal thoughts and behaviors.

This chapter presents four programming and implementation issues of primary concern to administrators and provides the tools you will need to:

- Help an agency become suicide prevention and intervention capable.
- Help a program develop and improve staff capabilities in working with suicidal clients.
- Help an agency develop and enhance its response system to suicide crises.
- Build administrative support for all components of GATE (**G**athering information, **A**ccessing supervision, **T**aking action, and **E**xtending the action).

Community-based substance abuse treatment programs come in a wide variety of sizes and orientations, with major differences in staff and other features. Given their size, staffing, orientation, and other features, not all substance abuse treatment programs will be able to provide all of the necessary services to all clients with suicidal thoughts and behaviors. In addition, some high-risk clients may be inappropriate for a given agency.

To further complicate matters, clients come into substance abuse treatment with a variety of needs and levels of risk. In the past, many agencies simply declined to treat anyone who might be a suicidal risk. However, such an option no longer exists, and such a general declaration now seems irresponsible and possibly programmatically unethical. With this in mind, substance abuse treatment programs now have to decide:

- Which clients who are suicidal they can adequately serve.
- Which clients will need to be linked with an agency that can better meet their needs.

Substance abuse treatment programs also need to strive to improve their services to a point where clients with elevated risk may be accommodated and treated (Level 2). Such an orientation is within the realm of most programs today. Such a shift does, however, require your knowledgeable commitment along with a plan for design, implementation, and evaluation of services and training of clinical supervisors, substance abuse counselors, and other treatment staff.

As noted before, the accrued benefits of becoming a Level 2 substance abuse treatment program are:

- Clients can remain in substance abuse treatment even though co-occurring problems like suicidality are present. Staying in treatment for substance use disorders may be critical for the client's recovery and rehabilitation.
- The Level 2 substance abuse program can be responsive to a variety of crisis states related to suicide that might otherwise disrupt functioning for the client who is suicidal, other clients, and program staff.
- The responsiveness of the program to issues of suicidality may increase the capacity of the program to respond to other client crises that present in the treatment program.
- Being a Level 2 substance abuse treatment program means staff have additional skills and diversity that can benefit the overall treatment program.
- Being Level 2 allows the program to treat clients who have specific co-occurring mental disorders who would otherwise have to be referred, thereby

potentially increasing program effectiveness and building financial benefits to the program.

- Most important, being a Level 2 program helps identify clients with suicidal thoughts and behaviors who would otherwise be undetected. Being a Level 2 program, in fact, has the potential to save lives.

This TIP recognizes that not all programs can treat clients with elevated risk of suicide. A Level 2 program has specially trained staff, being able to address and monitor suicidality onsite for many clients rather than through referral, and being prepared to coordinate treatment for a variety of co-occurring disorders often implicated in suicide risk (e.g., depression, borderline personality disorder, PTSD, anxiety disorders). Some programs are too small to have this capacity, others too specialized (such as many halfway houses). For these programs, being Level 1, and having working relationships with other agencies in the community for consultation, supervision, and referral may be sufficient.

Being a Level 2 program begins with your recognition of the need and value of addressing suicidal thoughts and behaviors in the program in a comprehensive way. This process requires three basic steps.

1. Organizational assessment
2. Organizational planning
   - Organizing a team or workgroup to address planning
   - Deciding on specific targets for change
   - Determining how and when to begin implementation
3. Program implementation
   - Adapting existing policies and programs
   - Implementing and integrating new programmatic elements

A valuable resource for administrators working in substance abuse treatment settings is *The Change Book* (Addiction Technology Transfer Center, 2004), which describes the organizational change process used in this TIP. In addition, you may want to review *Implementation Research: A Synthesis of the Literature* (Fixsen, Naoom, Friedman, Blase, & Wallace, 2005) for more information on the scientific basis for various implementation practices.

Organizational Assessment

Historically, organizational change in substance abuse treatment settings has tended to occur as a result of pressure from the outside: mandates from funding resources, rules and regulations from State agencies, or standards from accrediting bodies. But more and more, as programs and management become increasingly skilled and sophisticated, the perception of organizational assessment and change as an ongoing, internal, data-based, quality improvement-focused process has evolved. Research (e.g., Ogbonna & Harris, 1998; Schneider, 2002) supports that successful interventions and positive evolution of organizations depend not only on the quality of the intervention, but also on the organizational culture.

Gathering Data on the Effects of Suicidality on the Program

To get a snapshot of your organization's current ability to address suicidal thoughts and behaviors, you will need to consider your responses to the questions below.

Clients with suicidal thoughts and behaviors:

- How are clients with suicidal thoughts and behaviors currently identified in the treatment population? Does the program only identify clients who are in an obvious, self-disclosed suicidal crisis? Are screening questions for suicide routinely asked in clinical interviews? If not, a study of current clients might be considered in which the five screening questions recommended in this TIP (see Part 1, chapter 1, p. 17) are asked of all clients.
- What might you do to identify those clients whose suicidality is "under the program radar"? Are counselors aware of risk factors and warning signs of suicidality that might encourage them to explore suicidality in more detail with high-risk clients?
- How do suicidal thoughts and behaviors among clients in your program affect treatment in your program? Do clients with suicidal thoughts and behaviors have their treatment interrupted by referral to other programs? Do staff routinely dismiss suicidality as merely representing a defense against doing the work of recovery? Do clients experience their suicidality as a disruption to their

substance abuse treatment? Do clients experience their disclosure of suicidal thoughts and behaviors and subsequent referral to another program for treatment as “punishment” for their disclosure?
- What is the impact of client suicidality on the performance of treatment staff? Do staff feel prepared to screen and respond to clients with suicidal thoughts and behaviors? Are staff prepared to manage individuals who are suicidal not only for the clients’ own safety, but also in ways that minimize any impact on other clients? Do staff feel prepared to address this issue in their day-to-day practice?

The current organizational response to clients with suicidal thoughts and behaviors:
- What is the current organizational response to clients who are suicidal? Are there clear policy and procedure statements for managing clients with identified suicidal thoughts and behaviors?
- Do staff consistently document current and past suicidal thoughts and behaviors of clients?
- Do treatment records indicate that most clients with suicidal thoughts and behaviors are referred for specialized consultations when needed for services or treatment planning?
- Are the client’s suicidal thoughts and behaviors and the organization’s response (including consultations) integrated as a clinical issue into the treatment plan?
- What is the typical treatment response to clients who are experiencing a suicidal crisis? Are they able to maintain their substance abuse treatment while their suicidality needs are addressed?
- How would clinical staff (including clinical supervisors) define the optimal response to the variety of treatment issues raised by clients who are suicidal?

The impact of suicidal clients on program staffing:
- If the program is to become Level 2, how will that change affect staffing patterns, clinical practices, and staff morale?
- Are staff fearful of working with clients who are suicidal because of legal and malpractice consequences?
- Do staff believe that they have sufficient skills and knowledge to screen for suicidality and talk comfortably about suicidality with clients? Do they know about treatment resources for suicidality? Can training and clinical support in the form of supervision and consultation be developed and/or enhanced to help clinical staff feel more positive about the change?
- Is there a mechanism within the program to offer debriefing and professional support to counselors after serious adverse events (e.g., suicide attempt at the facility, suicide attempt by a client that led to significant injury regardless of where the attempt occurred, suicide death)?
- Is the staff resistant to this organizational change? If so, will it be helpful to have this information up front so that staff needs can be addressed and accommodated?

The organizational culture, including attitudes about suicide:
- Is suicide treated as a serious problem in the agency?
- Do staff at any level of the organization have negative attitudes toward suicide? If so, can administrators expect resistance to the effort to become a Level 2 program?
- Will attitudes such as “people who are suicidal do not belong in substance abuse treatment” or “working with people who are suicidal is dangerous and a real source of legal liability” or “clients who are suicidal will disrupt treatment for everyone else in the program” be barriers to effective change? Does the organizational change process need to be prepared to confront these attitudes?
- Does the organization have good relationships with mental health agencies, hospitals, and other places where clients with suicidal thoughts and behaviors can be referred?
- Is it feasible to include staff from all levels of the organization in the change process to promote ownership of the changes by all staff?

A good source of information on addressing suicidal thoughts and behaviors is to consider what other programs in your area are already doing and the efforts they made to arrive at their current level of competence in meeting the needs of clients who are suicidal. The goal of organizational change is not to duplicate services or to create overlapping, competitive environments. At the same time, each program should be able to offer services to its client population without automatically referring clients out who present with complicating difficulties (passing the buck).

Additionally, the experience of other programs in your area in organizational change regarding suicidality may provide valuable information in planning your own change process.

Other good resources for strengthening the capacity of a substance abuse treatment program to be Level 2 include Shea (2002) and Jobes (2006). The Suicide Prevention Resource Center (http://www.sprc.org) can provide helpful guidelines to assist substance abuse programs in becoming Level 2.

As these kinds of data are being gathered, the information has to be organized, placed in the context of the organizational goals to address suicidality, and integrated into steps in the planning process. Generally, data will come in various forms: some solid numbers, some impressions, some as summaries of the reactions of a variety of staff. It must be noted that data-gathering is not a static, one-time process but an evolving effort that needs to be part of the total, ongoing change effort. A method for documenting the implementation of policies toward becoming Level 2 and of assessing adherence to policies should be implemented.

PART 2

Organizational Planning for Becoming a Level 2 Program

Once data have been collected and the problem has been defined and described, the next step is to *organize a team or work group* to address the issue of planning the change. TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008), describes the process of team development that can be applied to organizational planning for addressing suicidality:

1. Identify one person to lead the effort. This person must have the backing of senior administration and the respect of clinical staff.
2. Obtain the commitment of the chief executive officer of the agency to articulate the vision for implementation throughout the agency, with all stakeholders, and to the public.
3. Convene an implementation work group consisting of key leaders from different stakeholder groups: consumer leaders, family leaders, team leaders, clinical leaders, and program and administrative leaders. Some stakeholders will serve as ongoing members of the work group while information from others may be solicited through focus groups.
4. Identify the program oversight committee to which the work group will report. For example, if your agency has a quality improvement committee, the work group may report its findings, recommendations, strategic plans, and modifications to that committee. This is one way to initiate and sustain implementation of program changes.

Some issues specific to suicide should be included in the planning process. For instance, depending on your program's current level of competence in suicidality, local mental health providers who have specialized knowledge and skills in addressing suicidal thoughts and behaviors should be invited into the planning process. Their knowledge of the needs of individuals with suicidal thoughts and behaviors and their awareness of community resources might prove helpful. If you anticipate that the management of clients' suicidal thoughts and behaviors will involve referral to other agencies, those agencies might need to be involved in the program planning stages.

The organizational work group should be able to *arrive at specific targets for change.* Some examples of targets for clients with suicidal thoughts and behaviors might include:

- Screening all new clients for suicidal thoughts and behaviors.
- Increasing the number of clients who are able to stay active in substance abuse treatment while their suicidal thoughts and/or behaviors are monitored and addressed entirely within the program or conjointly by another agency that is taking the lead in addressing suicidality.
- Increasing the skills of frontline substance abuse counselors in working with GATE: their comfort and skill levels in screening for suicidality and talking with clients about their suicidal thoughts and behaviors, their willingness to seek supervision or consultation on suicide-related issues, their ability to effectively make appropriate referrals to other resources for suicidal clients and to follow up with clients who have been referred.
- Increasing the capacity of clinical supervisors in the program to address the supervision needs of frontline counselors regarding suicide.
- Improving the connection between policies and procedures in the program and the actual needs of frontline counselors and clients.

The third step in organizational planning is *deciding how and when to start the implementation process.* Most programs find it more productive to make organizational changes in incremental steps, observing and evaluating the changes as they occur, rather than in one large leap. Larger changes tend to be more difficult to integrate into the existing system, and it is harder to correct the missteps that inevitably occur in the process. The timing of implementation is also important. Basically, should initiate change when the organizational system is most likely to be able to integrate the changes without distracting from the program's mission. Making too many changes too quickly can disrupt normal functioning and hinder the integration of new efforts. Ill-timed change can create more resistance than would have otherwise occurred. The implementation should have a system to monitor milestones so as to ensure sustainability.

Program Implementation

Adapting Existing Policies and Programs

It is quite possible that your program already has a variety of policy statements and programmatic elements that relate to client suicidality. For instance, your program probably has a policy about how to handle weapons that are brought onsite, what actions are to be taken when weapons are discovered, and who is to be notified. You also probably have policy statements that indicate what actions are to be taken when a client acknowledges active suicidal thoughts, intent, or behavior. You have policies concerning who can be contacted in client emergencies and when police or other first responders can be notified.

You already have program policy and programmatic elements that, while not being specific to suicidal clients, may be directly translatable to suicidal crises and to care for clients who acknowledge suicidal thoughts and behaviors. For instance, you probably have policies related to the care of clients with co-occurring disorders, such as a "no wrong door" policy, or programmatic elements such as one or more clinicians who are specially trained in working with clients with co-occurring disorders.

Implementing new policies and programmatic elements, therefore, is more often a case of adapting existing policies and procedures to meet the needs of clients with suicidal thoughts and behaviors. The organizational planning group mentioned earlier could review current program policies and procedures to see how they need to be adapted and revised. The work group might also be charged with examining how issues of client suicidality can be integrated into current policies for co-occurring disorders, crisis management in the program, contact with family and significant others in emergencies, and making referrals to other, specialized resources.

Implementing and Integrating New Programmatic Elements

It may be the case, however, that new policies and programmatic elements need to be incorporated into

Sample Policy 1
Topic: Clinical staff training and competence
Policy Statement: All clinical staff will receive training in suicidality and its impact on substance abuse treatment and can demonstrate basic competence in screening clients with substance use disorders for suicidal thoughts and behaviors.
Procedures: 1. All clinical and support staff will participate in a 1-day training session covering suicidality and its impact on substance abuse treatment retention and outcomes, attitudes toward clients with suicidal thoughts and behaviors, and intervention resources for clients who are suicidal. 2. The clinical supervisor of new employees will provide site-specific information on the procedures for screening and referring individuals who are experiencing suicidal thoughts and behaviors. 3. Clinical competence checklists completed at hire and annually thereafter will ensure that all clinical staff members have a basic knowledge of the benefits of addressing suicidal symptoms, understanding protocols for detecting client suicidality, and awareness of appropriate referral procedures.

Sample Policy 2

Topic: Screening and referral of clients with substance use disorders and suicidal thoughts and behaviors

Policy Statement: All clients will be screened for suicidality and will be monitored and/or referred as needed.

Procedures:

1. During the intake process, all clients will be screened for suicidal thoughts and behaviors using a standard protocol in which all counselors are trained.
2. Individuals demonstrating suicidal thoughts and behaviors will, after appropriate clinical supervision or consultation, be referred for assessment by a qualified mental health professional (QMHP) as needed.
3. All screening results, consultation sessions with the clinical supervisor, and referrals (and ongoing communications) to a QMHP will be documented in the client's record.
4. The counselor providing services to clients with suicidal thoughts and behaviors will provide the client with an emergency contact list that includes agency personnel, emergency mental health providers, and a suicide hotline. The client can refer to this list if his or her symptoms worsen outside business hours or when substance abuse counselors are not available.

Sample Policy 3

Topic: Individual client observation in a residential facility

Policy Statement: Special procedures will be instituted for clients in crisis who require hourly monitoring.

Provisions will be made for observation and/or a treatment area for clients who are displaying a level of emotional or psychological crisis and may need to be separated from their treatment unit for a period of time up to 48 hours. Each transfer or observation must result in a psychological or psychiatric consult. An observation checklist will be completed every hour during a client's stay in observation. This is not designed to assess for suicidality, but to identify symptoms that may require additional professional re-assessment.

Intent:

This policy is *not* designed to replace the policy for suicidal patients. This facility is not dually licensed as a psychiatric or mental health facility; therefore patients who have been assessed as being capable of carrying out suicidal or homicidal ideation or intent will be transferred to an acute stabilization unit.

It is the intent of this policy to address the needs of crisis stabilization that do not meet the criteria for hospitalization or involuntary admission to an acute care hospital. Clients will receive the appropriate level of ongoing observation and treatment for their individual needs, such as the patient who is evaluated as not being a threat to himself or others yet manifests a level of emotional or psychological crisis. This process will allow clients to have a quiet space to focus on their immediate stabilization and ensure that the treatment unit is not harmed by these crisis situations.

Procedure:

1. The client's counselor, unit Clinical Coordinator, and/or the Executive Director are responsible for the initial assessment and ongoing decision for observation of all clients, whether this occurs on the treatment unit or in the Medical Unit.
2. During client crisis, a psychologist, psychiatrist, Masters-level counselor or a nurse will perform assessment and re-assessment.

3 The Medical Unit, staffed with nurses and support staff is the first choice for crisis stabilization up to 48 hours. Clients in the Medical Unit or observation area will remain on the census of their treatment unit.

- The Coordinator or Director of the treatment unit will call the charge nurse of the Medical Unit to make the initial request for observation.
- The charge nurse will make every attempt to accommodate the request to observe the patient if there is a bed available and the acuity of the rest of the clients allows staff to observe. (Other staff members may be used if staffing is an issue.) The admissions schedule for the unit will be evaluated to assess bed availability.

- On approval, the client treatment unit staff will transport the client to the Medical Unit and provide a staff member to remain on the unit for the duration of the observation and assist either the Medical Unit staff or observe the client, depending on the needs of the Medical Unit and the client. The staff member may be requested by the nurse to be present on the Medical Unit a number of hours or for the entire shift.
- It is preferred that the staff member accompanying the client has rapport with the client or clinical credentials to assist the client in stabilization.

4. If the Medical Unit is unable to accept the client for observation, the following options exist. The Director or on-call coordinator will make the determination as to the next best option based on the individual case.
   - The coordinator may use other units or programs in the agency. It is recommended that the client be moved from his or her treatment unit to a safe and available dormitory area. The door alarms on either side of the area should be set in order to monitor the client's whereabouts during observation.
   - Other available areas should be safe, with priorities for units with lower census, first floor rooms, gender-separate areas, quiet and comfortable, and those that do not interfere with the programs.
   - To best use available staff in monitoring the client on an individual basis, staff should preferably be of the same sex and have some existing rapport with the patient.
   - Staff should be equipped with a communication device and have surrounding staff aware of the location of the observation as well as the need to relieve or assist the observer if needed. Hourly communication is required.
   - Staff observing the patient are to be trained in both de-escalation of clients as well as the purpose and process of observing. This training includes the use of an hourly checklist and protocol for contacting professional staff if needed.

the treatment program. New policies may need to be specific to suicide or may address larger issues in the program, such as clinical supervision, how emergencies are handled, or screening for a variety of co-occurring disorders. Every substance abuse treatment program should, at the least, have a policy statement that acknowledges that suicide is a significant issue for clients in substance abuse treatment and that the program has a role in identifying suicidality among its clients by screening all clients for suicidality and a responsibility to help those clients get the services they need, either through program staff or referral. The policy should then elaborate on procedures for addressing those issues.

New programmatic elements that might need to be instituted include training for all clinical supervisors regarding when services for clients with suicidal thoughts and behaviors can be provided in-house, how referrals are made, and managing suicidal crises in the agency.

Helping Your Program Develop and Improve Capabilities in Working With Clients Who Are Suicidal

Well-written policies and implementation plans to address suicidal thoughts and behaviors will be ineffective without clinical and support staff who have the training, skills, and motivation to carry them out. It is your responsibility to ensure that staff are prepared to address these needs.

Part 1, chapter 1 lists eight core competencies for substance abuse counselors working with clients who are suicidal. These competencies offer a good baseline for defining the knowledge, skills, and attitudes required of frontline counselors. In addition, senior counseling staff and clinical supervisors should be skilled in recognizing and managing suicidal crises, using consultations with external experts, and working with clients who are suicidal and resistant to counseling interventions. (See vignettes 5 and 6 in Part 1, chapter 2. Vince and Rena are clients who require more advanced skills.) The checklist below reflects some of the skills applicable to senior clinical staff and clinical supervisors that extend beyond the eight competencies mentioned above.

Checklist: Characteristics and Competencies of Clinical Supervisors
Attitudes ____ Clinical supervisors have the basic characteristics needed to provide services to treat clients with suicidal thoughts and behaviors and to supervise others to manage such clients ____ Clinical supervision extends beyond talking about treatment to directly observing and coaching counselors ____ Awareness of compassion fatigue or vicarious trauma in counselors and when to facilitate help for counselors experiencing these symptoms
Knowledge Clinical supervisors need to have all of the training of frontline counselors. In addition, they need the following knowledge specific to supervision: ____ The role of clinical supervision in substance abuse treatment ____ How to train frontline substance abuse counselors in screening of suicidal clients ____ When a client with suicidal thoughts and behaviors needs additional services beyond the qualifications of substance abuse counselors ____ The role of transference and countertransference in the counseling and supervisory relationship ____ How to recognize resistance to change among clinical staff and strategies to address it ____ Change processes, process steps, and strategies for supporting them
Supervisory Skills ____ Articulates his or her approach and philosophy to clinical supervision as it relates to approaches described in the literature ____ Identifies and responds to variations in learning styles among counselors ____ Is comfortable with and able to resolve conflict among team members ____ Models advanced counseling skills, including development of therapeutic alliance, termination, and managing client resistance ____ Uses direct observation or taping to conduct supervisory sessions ____ Can teach and model skills in a variety of approaches to counseling that are applicable to substance abuse clients with suicidal thoughts and behaviors ____ Can determine when referral to a QMHP for a suicide assessment is required ____ Facilitates referrals to QMHPs both within and outside the treating agency ____ Provides incentives through encouragement and support for counselors to enhance skills in treating clients who are suicidal ____ Can assess counselor competence and develop professional learning plans and supervisory interventions

It is important that training reflect the skills needed by substance abuse counselors. This TIP emphasizes that the role of the substance abuse counselor in working with clients with suicidal thoughts and behaviors is to screen, obtain supervision or consultation, take appropriate action (including potentially making a referral), monitor (under clinical supervision), and follow up with clients who are suicidal. Treating suicidality is beyond the scope of practice for most substance abuse counselors, as it requires advanced training in mental health disciplines and, preferably, advanced training in assessment, treatment, and intervention. Trainers should understand the needs and limits of practice of substance abuse counselors and not offer skills that most counselors are not prepared to use.

Rather than a one-time training, the training plan for developing skills in working with clients who are suicidal in substance abuse treatment needs to be ongoing. Shorter training sessions extending over several weeks are preferable to a single full-day session. Regardless of the format for initial training, followup refresher programs lasting 2 hours and emphasizing actual experiences of the participants in working with clients who are suicidal are essential. Training should emphasize building on existing skills and applying existing skills (for instance, in making referrals) to clients who are suicidal, rather than introducing new skills sets. For instance, if counselors in Program A have already received extensive training in motivational interviewing (MI), then the skills training for addressing suicidal thoughts and behaviors should

emphasize MI methods (e.g., Gathering information from clients who may be at risk in a manner that does not create defensiveness).

In addition to didactic training sessions, other ways to stimulate dialog and the development of clinical skills for use with clients who are suicidal are:

- Have the topic be a regular agenda item in treatment team meetings and include all high-risk clients in the discussion.
- Have a brown-bag lunch with a senior staff member as trainer.
- Designate one senior counselor or clinical supervisor in a treatment unit to be the "go-to person" on suicide and give that person time (on the job) to take an online or continuing education course.
- Peer review accompanying group supervision.
- Make it a topic of the month for clinical supervision for all counselors.
- Have a training session on treatment planning for suicidal clients.
- Have pairs of counselors role play various parts of GATE.
- Keep GATE active as a clinical tool by having annual 1-hour refreshers on suicide and the use of GATE.

Helping Your Agency Develop and Improve Its Response to Suicidal Crises

Suicide risk management too often is reactionary and reserved for clients in acute, suicidal crisis. However, most clients experiencing suicidal thoughts and behaviors are not in an acute crisis and do not warrant crisis management. Indeed, most situations can be managed adequately in a matter-of-fact, methodical manner that is not crisis driven. This TIP encourages programs to screen, educate, and intervene early when clients experience suicidal thoughts and/or behaviors, and to take action across the continuum of risk. By doing so, you are likely to prevent many situations from erupting into full blown crises, and be more effective in managing suicide risk within your agency.

That said, there will inevitably be situations that arise suddenly and unpredictably where a crisis response is required. Programs should have specific policies that address those crisis situations. Three examples of suicidal crises are the vignettes of Clayton, Vince, and Rena in Part 1, chapter 2. Clayton reveals suicide ideation and acknowledges that he as taken a gun in his house out of safekeeping and examined it while thinking of suicide. Vince receives news that his wife has filed an order of protection against him, and he rapidly spirals into a preoccupation with suicide. He also alludes to potential violence towards his wife and her lawyer. Rena begins drinking, re-experiences childhood trauma, finds herself losing her psychological supports, and begins to have intense thoughts of suicide. These are just a few of the myriad circumstances that can occur even in the face of the best treatment and organizational planning and for which specific agency policies and procedures need to be in place.

Policy and procedure for suicidal crises are often best considered in the context of larger issues of crisis management in the agency. CSAT is developing a tool entitled "Crisis Management: A Guide for Substance Abuse Counselors" that addresses this issue. The kinds of crises that can occur in a program include active suicidality on the part of a client, aggressiveness, violence, threats of violence toward others, death of a client, severe injuries or health crises with clients, and special protective issues for children and adolescents at risk for endangerment or abuse. In addition to providing a rationale for crisis management, the tool offers specific advice on what steps counselors should plan for, the varieties of contact information front line staff should have available in crisis situations, and the importance of documentation.

Some of the components of effective policy and procedures for suicidal crises that need to be considered include:

- Defining a situation requiring a crisis response (compared with a non-crisis event).
- Specific actions that the counselor or treatment provider should take to ensure the client's safety (e.g., taking action to reduce availability of methods of suicide).
- Who should be notified and how quickly that notification should take place.
- What kinds of consultation or clinical supervision should occur and how it should be requested.
- The situations under which significant others or first responders should be notified and how pertinent confidentiality regulations can be upheld.

- How a client’s possession of a weapon or other suicide method (such as medication) should be addressed by the counselor and/or the clinical supervisor or other senior staff.
- How clients should be monitored during the crisis (e.g., the policy might specifically state that clients should not be left alone in an office, the waiting room, or other unsecured areas without supervision). A policy of physical restraint needs to be clearly stated.
- How staff who greet clients and receive incoming telephone calls are to respond to crisis calls or events in the agency.
- How a counselor can access immediate help by telephone or other emergency notification process
- How emergency referrals should be made, who should actually make the referral, and what kind of information should be released to the referral program or institution.
- How to address a client’s resistance to receiving care for suicidality or resistance to accepting referral for consultation or treatment.
- How clients should be transported to other programs or resources.
- What followup contact should be made with other programs or resources after the referral.
- What kinds of documentation should occur throughout this process.

Program policies should specifically state that it is not the counselor’s role to make a final determination of whether the client is at acute or imminent risk for suicide. This judgment needs to be left to providers with the necessary training and education. It is the counselor’s role to help the client get to the appropriate resources where those kinds of evaluations can be made.

Specific agency policies should spell out how clinical supervisors should address suicidal crises. Such policies might indicate when the supervisor should step in and become actively involved in the client’s care (as opposed to being a resource for the counselor); when program senior administration should be notified; when first responders (such as police and emergency medical services) should be contacted; and the types of incident documentation the supervisor needs to prepare and file.

As mentioned earlier, the Commitment to Treatment Statement (see figure 1 below) is one procedure that can be adopted when suicidal thoughts and behaviors are noted. Having both the client and counselor sign

Figure 1. Sample Commitment to Treatment Statement

I,____________________________, agree to make a commitment to the treatment process. I understand that this means that I have agreed to be actively involved in all aspects of treatment, including:

1. Attending sessions (or letting my counselor know when I can’t make it).
2. Setting goals.
3. Voicing my opinions, thoughts, and feelings honestly and openly with my counselor (whether they are negative or positive, but most importantly my negative feelings).
4. Being actively involved during sessions.
5. Completing homework assignments.
6. Taking my medications as prescribed.
7. Experimenting with new behaviors and new ways of doing things.
8. Implementing my crisis response plan when needed.

I also understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount of energy and effort I make. If I feel that treatment is not working, I agree to discuss it with my counselor and attempt to come to a common understanding as to what the problems are and identify potential solutions. In short, I agree to make a commitment to living. This agreement will apply for the next 3 months, at which time it will be reviewed and modified.

Signed____Date ___________________________________

Witness _______________________________________

Adapted from Rudd, 2006.

the statement helps promote engagement in treatment.

A related technique is a safety card, which gives clients resources to use in a crisis (see p. 21 in Part 1, chapter 1). Counselors might want to use both techniques.

The goal of agency policy for managing clients who are acutely suicidal is to give enough direction to clinicians and clinical supervisors to guide them in crisis situations, while at the same time not attempting to anticipate every kind of crisis situation related to suicidal thoughts and behaviors. Counselors and supervisors need to be able to use their clinical training, experience, and judgment to address specific situations. Policy needs to guide how the counselor's and supervisor's clinical skills are used.

Finally, every serious adverse event (e.g., suicide attempt at the facility, suicide attempt by a client that leads to significant injury regardless of where the attempt occurred, suicide death) should result in a debriefing and postvention that considers how the event unfolded, how the specific action steps facilitated or hindered resolution of the crisis, how policy worked (or didn't work) to address the crisis, and how policy and procedure can be improved to further enhance the capability of the agency in responding to crises.

Postvention refers to dealing with the aftermath of suicide with survivors who may be family, friends, fellow students, teachers, coworkers, supervisors, fellow patients, counselors, physicians, or any other people who knew the individual and may be affected by the suicide. Additionally, the postvention needs to address how the emotional and psychological responses of the staff involved in the situation were considered. Staff should emerge from the postvention feeling supported and capable and guided by agency policy, senior administration, and clinical supervisors. They should feel their emotional responses to the event were addressed and that they had an opportunity to resolve unfinished business that may have arisen during the crisis. Counselors who provided direct services to clients who died by suicide may also benefit from counseling to help them work through the situation, ideally by a provider experienced in postvention. Counselors who have experienced a suicide in their personal life may especially benefit. Time is often an ally in the healing process.

Building Administrative Support for All Levels of GATE

This TIP has advocated a protocol, GATE, that recognizes the skills of substance abuse counselors and how those skills can be applied in substance abuse treatment settings with clients who are experiencing suicidal thoughts and behaviors. The protocol emphasizes screening for suicidality, obtaining supervision or consultation, taking appropriate actions, and following up on the actions taken.

GATE recognizes that two components frequently addressed in training for suicide prevention and intervention are beyond the skill level of many substance abuse counselors and should be left to persons in mental health disciplines with advanced training and skills in suicidology. These two components are:

1. Suicide assessment, in which the extent of suicidal thinking and behavior is determined, an assessment of risk for self-injury or death may be undertaken, and clinical diagnoses (such as depression and trauma syndromes) may need to be made.
2. Treatment of suicidal states, which may include addressing co-occurring disorders, prescribing medication, decisions about hospitalization, challenging suicidal beliefs, and other treatment methods beyond the scope of most substance abuse counselors.

It is imperative that administrators, senior organizational policymakers, and clinical supervisors recognize the strengths and limitations of practice of substance abuse counselors and not ask staff to practice in areas beyond the scope of their skills and knowledge. That said, it is also important that substance abuse counselors be supported by administration in their efforts to address the needs of suicidal clients.

Gathering Information

Because of the elevated risk of suicidality among clients in substance abuse treatment, it is important for programs to have a clear policy statement affirming that all clients entering substance abuse treatment are screened for suicidal thoughts and behaviors. There should also be procedures for screening for suicidality when client risk factors increase, such as

Figure 2. Gathering Information Regarding Suicidality		
Check all that apply		
Warning Signs	**Risk Factors**	**Protective Factors**
Direct warnings:	___ History of attempt	___ Religious attendance
___ Suicidal communication	___ Family history of suicide	___ Internalized teachings against suicide
___ Seeking a method of suicide	___ Mood disorder	___ Child in the home
___ Making preparations for suicide	___ Substance use disorder	___ Childrearing responsibilities
Indirect warnings:	___ Anxiety disorder	___ Intact marriage
___ I= Ideation	___ Psychotic disorder	___ Trusting relationship with a provider
___ S= Substance Abuse	___ Select personality disorder	___ Treatment adherent
___ P= Purposelessness	___ Child abuse	___ Employed
___ A= Anxiety	___ Stressful life circumstances	___ Trait optimism
___ T= Trapped	___ Aggressive or impulsive	___ Abstinent from substances
___ H= Hopelessness	___ Avoidant or isolated	
___ W= Withdrawal	___ Rigid or inflexible	
___ A= Anger	___ Firearm ownership or access	
___ R= Recklessness	___ Minority sexual orientation	
___ M= Mood Changes	___ Chronic pain	

Summary: ____

____

____

Plan: ____

____

____

Counselor signature:______________________ Date:______________________

Counselor signature:______________________ Date:______________________

after a substance use relapse, after an emotional crisis, or during a treatment transition.

The procedure should spell out a specific screening mechanism or protocol and should specify actions to be taken if suicidality is detected. If there are positive answers to any of the screening questions, follow-up questions should be asked to gather further information (see the section on Gathering Information in Part 1, chapter 1, pp. 15–18).

An example of a checklist for gathering information regarding suicidality is presented in figure 2. Note that the information obtained is the basis for making a plan for addressing suicidal thoughts and behaviors.

Clinical supervisors should make sure that all clinical staff are aware of the policy and that the policy procedures are followed. Clinical supervisors should conduct a periodic review of all staff to ensure that all clinical staff are current on suicide policy in the agency. Procedures for documentation of screening and actions taken as a result of screening should be standardized to ensure that appropriate documentation occurs. Clinical supervisors should be responsible for ensuring that documentation efforts are carried out by counselors.

Accessing Supervision and/or Consultation

Clinical supervision or consultation from persons knowledgeable and skilled in addressing suicidal behavior is essential for quality care of clients with suicidal thoughts and behaviors. Substance abuse

counselors working with clients who are suicidal need to have a clear understanding, guided by agency policy and procedure, of when and how to access supervision and consultation. They need to know when to seek immediate supervision versus supervision at some later time, what kinds of information need to be brought to the supervisor's attention, and how to access supervision or consultation in crisis situations. Even counselors with substantial experience and training in addressing suicidal thoughts and behavior need to have an opportunity to access consultation for treatment planning, and program policy should reflect this. In some settings, the treatment group may serve as an adjunct or alternative to more formal clinical supervision. Where work groups are used as a primary support system for counselors, policy should define how the group is used and how consultation is documented.

Administrators have an essential responsibility to ensure that supervision or consultation (either in the program or from outside consultants) is available and accessible and that program policy defines the role of the supervisor or consultant. The policy should be clear about the circumstances in which a counselor should obtain consultation and make provisions to ensure that consultation is immediately available in crisis situations. It should also differentiate the roles that supervisors might play in intervening with suicidal clients (in addition to roles as a consultant or teacher) and specify which actions (such as contacting first responders outside the program) can only be taken by or with approval of a senior staff person or clinical supervisor.

Supervisors can only undertake such roles with adequate training and knowledge (of suicidality, treatment, and community resources) and with a sense of competence to respond to crises and to the concerns of the counselor. In addition, clinical supervisors have to be able to respond sensitively and professionally to the emotional needs of counselors who may find their work with clients with suicidal thoughts and behaviors to be emotionally provocative and stressful.

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 provided 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 suicidal thoughts and behaviors. It rates the areas of suicidal ideation, behavior, general mood, and cognition/perception. Although this tool is more appropriate for an inpatient psychiatric setting, it can be adapted to a variety of substance abuse treatment settings—especially therapeutic communities, detoxification centers, and residential rehabilitation environments. 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 settings. 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 behavior patterns	• Inconsistent impulse control • Some changes in usual behavior patterns	• Unpredictable at times or inconsistent impulse control • Distinct changes in behavior patterns	• Impulsive and unpredictable 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 helplessness and hopelessness • Calm resolution • Severe anxiety • Unbearable psychological pain
Cognition/ Perception	• Problem solving intact • Accurate perception of reality	• Limited problem solving • Inconsistent or narrowed perception	• Poor problem solving • Impaired reality testing	• Unable to problem solve • Psychotic with command 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 ____________________

PART 2

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.