

SAMHSA ADVISORY

Substance Abuse and Mental Health
Services Administration

ADDRESSING SUICIDAL THOUGHTS AND BEHAVIORS IN SUBSTANCE USE TREATMENT

Suicide is a serious public health problem that ranks as the tenth leading cause of death in the United States (Centers for Disease Control and Prevention, 2020). Death by suicide is tragic, and has lasting harmful effects on families, friends, neighbors, colleagues, and communities (Substance Abuse and Mental Health Services Administration (SAMHSA), 2020). Among adults aged 18 or older in 2019, 4.8 percent (12 million people) had serious thoughts of suicide; 1.4 percent (3.5 million people) had made a suicide plan; and 0.6 percent (1.4 million people) had attempted suicide (SAMHSA, 2020). Below are some key terms used when referring to suicide.

Key Terms

- **Suicidal ideation** refers to thinking about, considering, or planning suicide (National Institute of Mental Health, 2021).
- **Self-injury** (also called non-suicidal self-injury [NSSI] or self-harm) is the act of deliberately harming one's own body. It does not involve intent to die (Mayo Clinic, 2018).
- **Suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.
- **Suicide** is death caused by self-directed injurious behavior with intent to die as a result of the behavior (National Institute of Mental Health, 2021).

Substance use disorders (SUDs) are associated with an increase in the likelihood and severity of suicidal thoughts and behaviors, as well as suicide attempts and deaths. To improve outcomes of SUD treatment, co-occurring mental disorders associated with suicidal thoughts and behaviors should be assessed and treated when appropriate. SAMHSA identifies the following co-occurring mental disorders as risk factors for suicidal thoughts and behaviors:

1. Depression (including substance-induced depression)
2. Anxiety disorders (especially post-traumatic stress disorder [PTSD])
3. Severe mental illness (schizophrenia, bipolar disorder)
4. Personality disorders (borderline and antisocial personality disorders)
5. Anorexia nervosa

This *Advisory* provides guidance on identifying and addressing suicidal thoughts and behaviors among individuals with SUD. It is based on SAMHSA's Treatment Improvement Protocol (TIP) 50, [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). It summarizes key messages, promotes use of the Zero Suicide framework, part of the Surgeon General's national strategy for suicide prevention, and provides additional resources for substance use clinicians and program administrators regarding the treatment of clients with suicidal thoughts and behaviors in SUD treatment settings.

Key Messages

Key Messages for Substance Use Counselors

- Acquiring basic knowledge about the role of warning signs, risk factors, and protective factors as they relate to suicide risk.
- Understanding the impact of their own attitudes and experiences with suicidal thoughts and behaviors on their work with clients.
- Screening clients in substance use treatment for suicidal thoughts and behaviors at intake and routinely throughout treatment.
- Providing empathic and nonjudgmental support to people who experience suicidal thoughts and behaviors.
- Developing safety plans with individuals who are at increased risk for a suicide attempt.
- Implementing the Zero Suicide framework, which incorporates key screening and assessment, safety planning, and linkage to care considerations for counselors to use as suicide prevention strategies.
- Understanding available resources for the management of suicidal ideation and suicidal behaviors.
- Understanding the crisis care system to provide navigation and handoff, as needed, and to facilitate care coordination.
- Accessing supervision to address knowledge deficits, emotional reactions, and secondary trauma.

Key Messages for Substance Use Administrators and Leadership

- Raising awareness about the importance of addressing suicidal thoughts and behaviors in substance use treatment programs.
- Advancing their roles, and the roles of staff, in providing care for clients with suicidal thoughts and behaviors.
- Maintaining knowledge about the different levels of program involvement in addressing the needs of clients with SUD who are experiencing suicidal thoughts and behaviors.
- Implementing the Zero Suicide framework at all levels of the organization.
- Considering legal and ethical issues in managing and providing treatment to clients with suicidal thoughts and behaviors.
- Supporting training and IT (information technology) development to identify and treat individuals at risk for suicide.
- Using data to evaluate processes and promote continuous quality improvement.

Considerations for Clinicians

Attitudes toward suicide

Attitudes toward suicide vary widely. Before working with clients with suicidal thoughts and behaviors, substance use disorder treatment counselors are advised to conduct their own suicidal attitude inventory.

Some of the items to consider in an inventory may include:

- What is my personal and family history with suicidal thoughts and behaviors?
- What personal experiences do I have with suicide or suicide attempts, and how do they affect my work with clients who have suicidal thoughts or behaviors?
- What is my emotional reaction to clients who exhibit signs of suicidal ideation, self-harm, or attempts?
- How do I feel when talking to clients about their suicidal thoughts and behaviors?
- What did I learn about suicide in my formative years?

Three elements that are key to identifying and addressing suicidal thoughts and behaviors among individuals in substance use treatment are:

1. Screening and assessment
2. Safety planning, including lethal means counseling (i.e., assessing the individual's access to firearms, medications, or other potentially fatal substances or objects)
3. Linkage to care

Each of these three elements has been carefully incorporated into the [Zero Suicide](#) framework, a key component of the U.S. Surgeon General's and the National Action Alliance for Suicide Prevention's [2012 National Strategy for Suicide Prevention](#). (See page 6 for more information on the Zero Suicide framework).

Warning signs

According to SAMHSA's Suicide Prevention Resource Center (<https://www.sprc.org/>), some behaviors that might indicate a person is at immediate risk for suicide include:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

Other behaviors or warning signs that may indicate a serious imminent risk include:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing use of alcohol or drugs
- Acting anxious or agitated or behaving recklessly
- Sleeping too little or too much
- Giving away important/meaningful possessions
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

General [risk factors](#) that can increase an individual's likelihood of attempting or dying by suicide include:

- Previous suicide attempt(s)
- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance use disorders
- Family history of suicide
- Hopelessness
- Deliberate self-harm
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illnesses
- Loss of relationship(s)
- Easy access to lethal means
- Local clusters of suicide
- Lack of social support and sense of isolation
- Stigma associated with asking for help
- Lack of healthcare, especially mental health and substance use disorder treatment
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Exposure to others who have died by suicide (in real life or via the media and Internet)

If clinicians need assistance in working with a client who exhibits suicidal thoughts and behaviors, SAMHSA's Suicide Prevention Resource Center operates the [National Suicide Prevention Lifeline](#), a 24-hour toll-free phone line for people in suicidal or emotional distress: 1-800-273-TALK (8255). An [online chat option](#) is also available.

Beginning July 16, 2022, individuals in crisis will be able to access the National Suicide Prevention Lifeline by calling [988](#), which will become the '911' for suicide prevention and mental health crisis services. This easy-to-remember, 3-digit number will make it easier for individuals to access the help they need and reduce stigma related to suicide, suicidal ideation, and mental health issues.

Protective factors

Protective factors are buffers that lower long-term risk for suicide. Known and likely protective factors include:

- Identifying reasons for living
- Being substance-free
- Attending 12-step support groups
- Internalizing religious and/or spiritual teachings against suicide
- Having a child in the home and/or childrearing responsibilities
- Having supportive relationships with significant others

- Establishing a trusting relationship with a counselor, physician, or other service provider
- Obtaining and maintaining employment
- Demonstrating trait optimism (a tendency to look at the positive side of life)

A caution about protective factors: If acute suicide warning signs and/or multiple risk factors are present, protective factors will not change the current assessment that preventive actions are necessary. Although protective factors may sustain someone showing ongoing signs of risk (e.g., due to chronic depression), they do not prevent clients from having suicidal thoughts or behaviors and afford no protection in acute crises.

Protective factors also vary with cultural values. For example, in cultures where extended families are closely knit, family support can act as a protective factor. Faith in and reliance on traditional healing methods among those individuals with a strong affiliation with a clan, tribe, or ethnic community may also serve as a protective factor.

Screening and Assessment

Evidence-based screening tools for suicide risk include the [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#), [Suicide Behaviors Questionnaire-Revised \(SBQ-R\)](#), [Patient Health Questionnaire-9 \(PHQ-9\)](#), and others. If an agency does not use a standardized suicide screening tool, a clinician should ask the following questions:

Introducing the topic (ask either question):

- *Now I am going to ask you a few questions about suicide.*
- *I have a few questions to ask you about suicidal thoughts and behaviors.*

Screening for suicidal thoughts (ask either question):

- *Have you thought about killing yourself or wished to be dead?*
- *Have you thought about carrying out suicide?*

Screening for suicide attempts (ask either question):

- *Have you ever tried to take your own life?*
- *Have you ever attempted suicide?*

Clinicians should ask follow-up questions if a client answers “yes” to any of the above questions or when a clinician notes a warning sign of imminent suicide risk. Follow-up questions allow information to be gathered so that a clinician can accurately convey a client’s risk to a supervisor, team, or another provider.

Follow-up questions about suicidal thoughts can include:

- *Can you tell me about the suicidal thoughts? For example, what brings them on?*
- *When was the last time you had these thoughts?*
- *How strong are they?*
- *How long do they last?*
- *How easy is it to put these thoughts out of your mind?*

- *Is there anything that helps you not want to act on these thoughts?*
- Have you made a plan?
- What is your plan?
- Do you have access to a method of suicide? A gun? An overdose?
- Do you intend to attempt suicide?

Strategies for Program Administrators

To be successful, Zero Suicide must be implemented at all levels of the organization, and program administrators must have a supportive role. This section includes information on the Zero Suicide framework and additional strategies for suicide prevention by administrators, including program-wide recommendations and an understanding of the three levels of program involvement in suicide prevention and intervention.

Recommendations for Administrators

- The administrator should be able to articulate the goals and objectives of the program as they relate to suicide, client safety, and crisis intervention, and must be actively involved in crisis resolution.
- Personnel should be trained to a level of competence within their range of expertise and licensure or certification to manage interventions with clients who have suicidal thoughts and behaviors.
- Substance use treatment and prevention programs should have a risk management plan that addresses the needs of clients who have suicidal thoughts and behaviors.
- Substance use treatment programs need to have protocols accessible to all staff that offer guidelines for addressing the needs of clients who exhibit suicidal thoughts and behaviors.
- Personnel should be knowledgeable of the social and medical resources available to people in suicidal crisis and the procedures or protocols to follow for their use.
- Community relationships should be developed and maintained that will support interventions with clients who have suicidal thoughts and behaviors within the program or the referral system.
- Substance use treatment programs should develop and implement standardized methods for documenting how suicidal thoughts or behaviors are identified, the supervision or consultation sought as a result, actions that are taken, and follow-up that occurs.
- Crisis services, either as a component in the treatment program or through arrangement with other agencies, should be available 24 hours a day.

Zero Suicide

[Zero Suicide](#) is a transformational framework for health and behavioral health care systems and provides a comprehensive approach to suicide prevention. To be successful, this framework requires commitment from counselors and other clinicians, program administrators, and other stakeholders within the health system. Zero Suicide was developed by clinicians and practitioners to transform systemic approaches to suicide prevention. Zero Suicide calls on healthcare settings to set an explicit goal of full success in preventing suicide among the patients in their care; a [toolkit](#) is available that outlines this framework in detail.

Foundational principles of Zero Suicide

The core values of Zero Suicide include the belief and commitment that suicide can be eliminated in a population under care by improving service access and quality and through practicing continuous quality improvement.

Zero Suicide manages systems by systematic steps across systems of care to create a culture that no longer finds suicide acceptable, setting aggressive but achievable goals to eliminate suicide attempts and deaths, and organizing service delivery and support accordingly.

Finally, Zero Suicide uses evidence-based clinical care practices, adopting interventions that research shows reduce suicide behaviors and deaths, that are delivered through the entire system of care, and that emphasize productive patient-staff interactions.

The seven elements of Zero Suicide, described below, represent what experts in the field of suicide prevention have identified as the core components of safe care for individuals with suicidal thoughts and urges. They represent a holistic approach to suicide prevention within health and behavioral health care systems.

Core Components of the Zero Suicide Framework

1. Lead system-wide culture change committed to reducing suicides
2. Train a competent, confident, and caring workforce
3. Identify individuals with suicide risk via comprehensive screening and assessment
4. Engage all individuals at-risk for suicide using a suicide care management plan
5. Treat suicidal thoughts and behaviors directly using evidence-based treatments
6. Transition individuals through care with warm hand-offs and supportive contacts
7. Improve policies and procedures through continuous quality improvement

Addressing Suicidal Thoughts and Behaviors in SUD Treatment Programs: Levels of Program Involvement and Core Components

[SAMHSA's TIP 50, *Suicidal Thoughts and Behaviors in Substance Abuse Treatment*](#), identifies three levels of program involvement in suicide prevention and intervention.

Level 1 programs have the capacity to identify clients at risk and to identify warning signs of suicide as they emerge. All programs providing substance use treatment to clients should be Level 1.

In a Level 1 program, all clinical staff recognize that clients in substance use treatment are at increased risk for suicidal thoughts and behaviors. All clinical staff have had basic classroom education in risk factors, warning signs, and protective factors for suicide. They have also received basic classroom education in recognizing misconceptions about suicide, have had an opportunity to replace them with accurate and contemporary information, and have explored their own attitudes toward suicide and suicidal behavior. Finally, all clinical staff have had basic classroom education and clinical supervision in recognizing clients' direct and indirect expressions of suicidal thoughts.

In addition to classroom education, all clinical staff have the skills to talk with clients about suicidal thoughts and behaviors and collect basic screening information. The Level 1 substance use treatment program has basic protocols for responding to clients with suicidal thoughts and behaviors. The program has formalized referral relationships with programs capable of addressing the needs of clients with suicidal thoughts and behaviors, as well as specific protocols available to all staff for how a referral is made and managing suicidal crises.

Level 2 programs have the capacity to provide integrated care to clients with suicidal thoughts and behaviors.

In a Level 2 program, there is at least one staff member with an advanced mental health degree (e.g., licensed Ph.D. psychologist, licensed clinical social worker) who is specifically skilled in providing suicide prevention and intervention services and in providing clinical supervision to other program staff working with clients with suicidal thoughts and behaviors. The program has the capability to continue substance use treatment services for clients with suicidal thoughts and behaviors while monitoring those clients for suicidal symptoms and an exacerbation of psychiatric symptoms of depression, anxiety, or other co-occurring disorders. The program has formalized ongoing relationships (within the agency or in the community) with mental health professionals trained in suicide intervention to address emergency needs. Finally, the Level 2 program can offer consultation services to Level 1 programs on an as needed basis.

Level 3 programs have the capacity to provide integrated care to clients in acute suicidal crisis.

Level 3 programs are linked to a mental health or hospital setting that provides care for people with acute suicide-related needs and who are at high risk for a suicide attempt. Program staff have frequent, regular contact with the client, and the program has crisis beds or an area designated for close/regular observation. Clinical staff can perform comprehensive suicide assessments in-house that determine level of risk, treatment needs, and necessity for legal commitment of the client. Finally, the treatment agency has the appropriate certifications to legally commit clients who are deemed a danger to themselves or others. Such certifications are more commonly held by mental health rather than substance use treatment facilities.

Ethical and Legal Issues

Clients with suicidal thoughts and behaviors raise unique ethical and legal issues, which must be considered for both substance use counselors and SUD treatment program administrators. Ethical issues are often gray areas without defined proscriptions for counselor behavior, and ethical issues often overlap with legal issues. The legal issues regarding suicide prevention for SUD programs are primarily related to standards of care, maintaining appropriate confidentiality, and obtaining informed consent.

It is the clinician's responsibility to determine what services are legally and ethically appropriate to provide within the scope of practice. While ethics is often thought of as an issue for frontline staff, including counselors, physicians, nurses, psychologists, and social workers, it also pertains to clinical supervisors regarding:

- Standards of care, including malpractice and additional training
- Confidentiality during admission, transfer, and treatment termination
- Informed consent

Standards of care

Ethical concerns relate to professional standards of care and the moral issues that arise in the conduct of professional services. Each profession concerned with substance use treatment (e.g., SUD counselors, social workers, professional counselors, psychologists, physicians) has a different set of professional standards. Additionally, each professional association, such as the Association for Addiction Professionals, the National Association of Social Workers, the American Counseling Association, the American Psychological Association, and the American Psychiatric Association, has a set of ethical standards to which their membership agrees to adhere. Finally, in states where these professional groups are licensed, the state licensing board may have an additional set of ethical standards to which persons licensed by that group must adhere. For example:

- Both the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) provide standards of care for clients at risk of suicide that programs must consider for accreditation.
- The American Psychiatric Association and other professional organizations offer practice guidelines for the clinician that set appropriate and reasonable standards of care.

While many of these guidelines are for professional activities beyond the scope of SUD counselors, they offer a resource for issues such as confidentiality, informed consent, referral procedures, treatment planning, and malpractice liability that have relevance to counselors working in SUD treatment agencies.

Maintaining appropriate confidentiality

Administrators should understand existing ethical and legal principles and potential areas of conflict. For example, safety and protection of the client supersedes confidentiality in certain crisis situations. When clients first enter the SUD treatment program, and as appropriate during the course of treatment, administrators and clinicians should explain that, in the event of suicide risk, they may take steps to promote the client's safety (including the potential for breaking confidentiality, arranging for an emergency evaluation over the client's objections, and involving emergency personnel). Clients should not be given the false impression that everything is confidential or that all types of treatment are always voluntary. Furthermore, when working with family members, administrators and clinicians should honor ethical and legal constraints on confidentiality and obtain appropriate consents for release of information from the client.

Obtaining informed consent

Informed consent should be part of collaboration with the client. Informed consent documentation should include an explanation of the limits of confidentiality (e.g., the duty to warn in specific situations). In addition, administrators should implement a policy and procedure for obtaining a release from clients who are at significant risk or have warning signs of suicidal thoughts and behavior to contact a family member or significant other if the counselor, with appropriate clinical supervision, feels the client may be at significant risk of attempting suicide. In order to contact family members during a crisis, counselors and administrators need to have access to the appropriate phone numbers and know which family members offer healthy, supportive relationships. This requires careful planning early in the treatment process. However, clients, in most cases, must still have the right to revoke the consent if they desire.

Resources

- **Substance Abuse and Mental Health Services Administration**
 - [A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors: After an Attempt](#)
 - [EPLC: Suicidal Behaviors in Clinical High Risk Populations \(New England Mental Health Technology Transfer Center Network\)](#)
 - [National Suicide Prevention Lifeline 1-288-273-8255](#)
 - [National Suicide Prevention Lifeline Wallet Card: Having Trouble Coping?](#)
 - [National Suicide Prevention Lifeline Wallet Card: Suicide Prevention: Learning the Warning Signs](#)
 - [We Can All Prevent Suicide](#)
 - [Navigating Risk of Suicide in the Context of Substance Misuse: Best Practices for Supporting Youth and Young Adults \(Pacific Southwest Mental Health Technology Transfer Center Network\)](#)
 - [Preventing and Responding to Suicide Clusters in American Indian and Alaska Native Communities Report](#)
 - [Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities \(SPARK Kit\)](#)
 - [SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians](#)
 - [Suicide Prevention Resource Center](#)
 - [Suicide Risk Assessment & Crisis Response Planning \(Southeast Mental Health Technology Transfer Center Network\)](#)
 - [Suicide Safe Mobile App](#)
 - [TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#)
 - [Treatment for Suicidal Ideation, Self-harm, and Suicide Attempts Among Youth](#)
- [American Association of Suicidology](#)
- [American Foundation for Suicide Prevention](#)
- **Centers for Disease Control and Prevention**
 - [Preventing Suicide: A Technical Package of Policy, Programs, and Practices](#)
- **Commission on Accreditation of Rehabilitation Facilities**
 - [Quality Practice Notice on Suicide Prevention](#)
- **Federal Communications Commission**
 - [Fact Sheet: 988 and Suicide Prevention Hotline](#)
- **The Joint Commission**
 - [Suicide Prevention](#)
- **National Action Alliance for Suicide Prevention**
 - [Zero Suicide in Health and Behavioral Health Care](#)
 - [2012 National Strategy for Suicide Prevention](#)
- **Zero Suicide**
 - [Zero Suicide Toolkit](#)

Bibliography

Centers for Disease Control and Prevention. (2020, September 8). *Suicide Prevention*. <https://www.cdc.gov/violenceprevention/suicide/index.html>

Mayo Clinic. (2018, December 7). *Self-injury/cutting*. <https://www.mayoclinic.org/diseases-conditions/self-injury/symptoms-causes/syc-20350950>

National Institute of Mental Health. (2021, January). *Suicide*. <https://www.nimh.nih.gov/health/statistics/suicide.shtml#:~:text=A%20suicide%20attempt%20is%20a.%2C%20considering%2C%20or%20planning%20suicide>

Substance Abuse and Mental Health Services Administration. (2020). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*. <https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFR1PDFWHTML/2019NSDUHFFR1PDFW090120.pdf>

Acknowledgments: This *Advisory, Addressing Suicidal Thoughts and Behaviors in Substance Use Treatment*, was written and produced under contract number HHSS283201700001/75S20319F42002 by Abt Associates for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Christine Cichetti served as Product Champion, Donelle Johnson served as the Contracting Officer's Representative (COR), and Tanya Geiger served as the Alternate COR.

Nondiscrimination Notice: SAMHSA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SAMHSA cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, o sexo.

Recommended Citation: Substance Abuse and Mental Health Services Administration. (2021). *Addressing Suicidal Thoughts and Behaviors in Substance Use Treatment. Advisory.*

Publication No. PEP20-06-04-005

Published 2021