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TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

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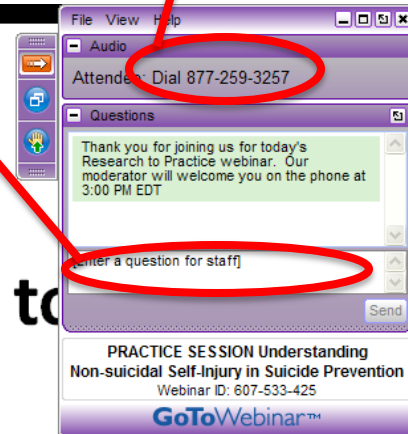
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Addressing Suicidal Thoughts and Behaviors with Clients in Treatment for Substance Use Disorders (TIP 50)

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Suicide Prevention Resource Center
Research to Practice Webinar
September 28, 2010

TIP 50 is provided by the:

Substance Abuse and Mental Health
Services Administration (SAMHSA)

Center for Substance Abuse
Treatment (CSAT)

Addressing Suicidal Thoughts And Behaviors in Substance Abuse Treatment

A Treatment Improvement Protocol **TIP** **50**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov



Nature of TIP 50

TIP 50 is a practical manual of recommended practices.

TIP 50 was developed by a panel of researchers, clinicians, and administrators with expertise in suicide and substance abuse

The panel actively sought input from expert field reviewers, stakeholders, and an advisory panel

TIP 50 has yet to be formally evaluated; an evaluation of TIP 50 is currently being conducted in the VA

TIP 50 Panel

Panel Chair, Kenneth R. Conner, Psy.D., MPH

Part 1 Consensus Panel Members

Bruce Carruth, Ph.D.

Sean Joe, Ph.D., M.S.W.

M. David Rudd, Ph.D., ABPP

Barbara M. Teal, M.A., M.B.A., ICADC, CET II

James D. Wines, Jr., M.D., M.P.H.

Part 2 Consensus Panel Members

Bruce Carruth, Ph.D.

Lisa Laitman, M.S.Ed., LCADC

Edna Meziere, M.S., M.L.S., R.N.

TIP Layout

- Part One: Skills and Knowledge for Substance Abuse Counselors and Supervisors
- Part Two: Administrators' guide
- Part Three: Web based bibliography

Goals of TIP 50

Increase motivation, self-efficacy, and ability of counselors and their supervisors to effectively manage suicide risk in substance abuse treatment settings.

Increase motivation, self-efficacy, and ability of administrators to implement effective suicide prevention programming.

TIP Content – Part One

Counselors' Guide

Review risk factors, warning signs, protective factors

Points to Keep You on Track

Teach Core Strategy (GATE)

G = Gather Information

A = Access Supervision

T = Take Appropriate Action

E = Extend the Action

Part 1 Cont'd, Vignettes

Six clinical vignettes

Detailed dialogue and case description

“How-To” Boxes

provide step-by-step specific techniques and procedures

Master Clinician Notes

provide supervisory observations and comments inviting the counselor to consider choices and options

Part Two: Chapter Two

Administrators Guide

Clear strategies and tools for implementation of evidence-based and best and promising practices illustrated in Chapter One

Different levels of capability depending on program size, staffing, and resources

Part Three

The literature review and bibliography

A review of the literature on the relationship of substance abuse and suicide and clinical interventions for suicidal people with substance use disorders

An annotated bibliography of approximately 100 of the most pertinent articles in the literature

A comprehensive bibliography of the literature on the subject.

Updated every 6 months for 5 years. Web-based

Definitions

Suicidal ideation, also referred to as “suicidal thoughts,” is the idea to carry out an act of suicide.

Suicide attempt is a deliberate, self-injurious behavior with at least some intent to die that is non-fatal.

Suicide is a deliberate, self-injurious behavior with at least some intent to die that is fatal.

Non-suicidal self-injury is a deliberate, self-injurious behavior with no intent to die (not a focus of TIP 50)

Administrative Considerations

Recommendations for Administrators

Able to articulate goals and objectives as they relate to suicide risk management

Risk management plan is in place

Written protocols accessible to all staff that provide clear guidance for suicide risk management

Standardized methods of documentation of risk and related interventions including use of supervision/consultation and therapeutic actions taken

Recommendations for Administrators cont'd

Personnel trained to a level of competence consistent with their training and licensure

Personnel are knowledgeable of the social and medical resources available to suicidal clients

Community relationships developed and maintained to support interventions with suicidal clients

Crisis services, either as part of the program or as arranged with other agencies, should be available 24 hours a day

Levels of Program Capability

Level 1:

- Lowest level of capability
- Has all of the aforementioned attributes

Levels of Program Capability cont'd

Level 2:

- At least 1 staff member with an advanced mental health degree
- Capability to continue treatment services with clients with suicidal thoughts or behaviors
- Formalized ongoing relationships, within the agency or externally, with mental health professionals trained in suicide prevention
- Can offer consultation services to Level 1 programs

Levels of Program Capability cont'd

Level 3 programs:

- Linked to a mental health or hospital setting providing security for acutely suicidal clients
- Capacity for suicide watch
- Ability to perform comprehensive suicide risk assessments in-house including necessity for legal constraint on the client
- Has appropriate certifications to legally detain clients at imminent risk for suicide

Common Malpractice Failures

Failures in assessment:

- to gather information about suicidality
- to consider that information in treatment planning
- to recognize risk factors and warning signs as they emerge during treatment
- to obtain records from other sources that would have indicated risk

Malpractice Failures cont'd

Failures in treatment:

- To consider the impact of an intense treatment program on suicidality
- To prepare a client for treatment transitions, including administrative discharges
- To make appropriate referrals for clients with suicidal thoughts or behaviors
- To follow-up on referrals

Malpractice Failures cont'd

Failure to safeguard:

- To properly observe clients in inpatient or residential settings who are potentially suicidal
- To make efforts to remove weapons for inpatient clients and outpatient clients who are potentially suicidal
- To consider the impact of medication use by clients who are potentially suicidal

Failures in documentation

Clinician and Supervisor Considerations

Poll

The fundamental difference between a “Warning Sign” and a “Risk Factor” is...

- a) There is no difference between Warning Signs and Risk Factors
- b) Risk Factors indicate acute risk and Warning Signs indicate longer term risk
- c) Warning Signs indicate acute risk and Risk Factors indicate longer term risk
- d) Risk Factors protect clients from suicide and Warning Signs pose risk to clients

Risk Factors

- Prior history of suicide attempts (most potent risk factor)
- Family history of suicide
- Severe substance use (e.g., dependence on multiple substances, early onset of dependence)
- Co-occurring mental disorder
 - Especially **Major Depressive Episodes** (including substance-induced depression)

Risk Factors Cont'd

- Personality traits
 - Proneness to negative affect (sadness, anxiety, anger)
 - Aggression and/or impulsive traits
- Personality disorder
 - best evidence for borderline
- History of child abuse (especially sexual abuse)

Risk Factors Cont'd

Stressful life circumstances

- Interpersonal events/difficulties
- Unemployment and low level of education, job
- Legal difficulties
- Major and sudden financial losses

Firearm ownership or access to a firearm

Warning Signs (Direct)

Suicidal communication: Someone threatening to hurt or kill him- or herself or talking of wanting to hurt or kill him- or herself.

Seeking access to method: Someone looking for ways to kill him- or herself by seeking access to firearms, available pills, or other means.

Making preparations: Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

Warning Signs (Indirect)

I = Ideation

S = Substance Abuse

P = Purposelessness

A = Anxiety

T = Trapped

H = Hopelessness

W = Withdrawal

A = Anger

R = Recklessness

M = Mood Changes

Poll

Which statement is true about protective factors:

- a) If there a client has protective factor(s), there is little concern about suicide risk
- b) Protective factors may be overwhelmed by risk factors
- c) Increasing protective factor(s) can be a useful clinical strategy to lower risk
- d) Both “b” and “c”

Protective Factors (known and presumed)

- Reasons for living
- Being clean and sober
- Attendance at 12-Step support groups
- Religious attendance and/or internalized spiritual teachings against suicide

Protective Factors Cont'd

- Presence of a child in the home and/or childrearing responsibilities
- Intact marriage
- Trusting relationship with a counselor, physician, or other service provider
- Employment

Points to Keep You on Track

- Point 1:** Almost all of your clients who are suicidal are ambivalent about living or not living.
- Point 2:** Suicidal crises can be overcome.
- Point 3:** Although suicide cannot be predicted with certainty, suicide risk assessment is a valuable clinical tool.
- Point 4:** Suicide prevention actions should extend beyond the immediate crisis.

Points to Keep You on Track Cont'd

Point 5: Suicide contracts are not recommended and are never sufficient.

Point 6: Some clients will be at risk of suicide, even after getting clean and sober.

Point 7: Suicide attempts always must be taken seriously.

Point 8: Suicidal individuals generally show warning signs.

Points to Keep You on Track Cont'd

Point 9: Clients should be asked about suicide, and ask directly.

Point 10: The outcome does not tell the whole story.

Point 11: Don't become the "suicide interrogator."

Point 12: Realize limits of confidentiality, and be open with your clients about such limits.

GATE

4-step process for managing suicide risk in substance abuse treatment settings

G = Gather Information

A = Access Supervision or Consultation

T = Take Appropriate Action

E = Extend the Action

G – Gather Information

Step 1) Screening (standard questions asked of everyone)

“Have you thought about killing yourself?”

Step 2) Follow-up questions

“Can you tell me about the thoughts?”

“What brings them on?”

“How strong are they?”

“How long do they last?”

A - Access Supervision or Consultation

- 1) Immediate supervision: Acute/emergent situations require obtaining immediate supervision/consultation.
- 2) Regular supervision: Non-acute situations call for the use of routine supervision or bringing the case to the regular treatment team.

Take Action

Key principle:

Actions should match the severity and immediacy of risk (i.e., *make good sense*)

Potential Actions:

- Gather additional information from the client
- Gather additional information from other sources (e.g., spouse, other providers)

Potential Actions Cont'd

- Arrange a referral
- Temporarily increase the frequency of care, including more frequent telephone check-ins
- Involve a case manager
- Involve the primary care provider

Potential Actions Cont'd

- Encourage attendance at 12-Step meetings
- Involve family members or other supports (as appropriate)
- Observe the client for signs of a return of risk
- Reduce Access to Method of Suicide
Means Matter!

Potential Actions Cont'd

Written safety card:

- 24-hour crisis number (e.g., 1-800-TALK). Phone number and address of nearest hospital emergency department
- Counselor's contact information
- Contact information for additional supportive individuals (e.g., sponsor, supportive family member)

Extend the Action

Key principle:

Suicide prevention efforts are not one-time actions.

Potential Extended Actions:

- Confirm that a client has kept the referral appointment.
- Follow up with the hospital emergency department when a client has been referred for acute assessment
- Coordinate with other providers on an ongoing basis

Extended Actions Cont'd

- Check in with the client about any recurrence of or change in suicidal thoughts or attempts
- Observe the client for signs of a return of risk
- Keep family members engaged in the treatment process after a suicide crisis passes

Extended Actions Cont'd

- Confirm that the client still has their safety card
- Confirm that the client still does not have access to a major method of suicide (e.g., gun, stash of pills)
- Follow up with the client about suicidal thoughts or behaviors if a relapse (or other stressful life event) occurs
- Document all relevant information about the client's condition and your responses, including referrals made and the outcomes of the referrals. Update treatment plan.

Obtaining TIP 50

TIP 50 is free!

Ordered on web at <http://www.samhsa.gov/shin>

Ordered by phone at 1-877-SAMHSA-7
(1-877-726-4727)

May also inquire to SAMHSA about the
VA-sponsored Training Tape based on TIP 50