

Practice Guidance: Suicide as an Addiction Treatment Risk Factor

Suicide is a preventable public health problem and is among the leading causes of injury deaths in the US. It is also one of the leading causes of death among people who misuse alcohol and other drugs.¹ The purpose of this Practice Guidance is to provide information about emerging best practices and stimulate review of existing practices, prevent suicides, improve treatment of substance use disorders (SUDs), and promote lifelong recovery.

Definitions

Suicide - Death caused by self-directed injurious behavior with intent to die as a result of the behavior.

Suicide Attempt – A non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt may not result in injury.

Suicidal Ideation – Thinking about, considering or planning suicide.

<https://www.nimh.nih.gov/health/statistics/suicide>

After declining in 2019 and 2020, suicide deaths increased approximately 5% in the United States in 2021. Provisional estimates indicate that suicide deaths further increased in 2022. They rose from 48,183 deaths in 2021 to an estimated 49,449 deaths in 2022, an increase of approximately 2.6%. Deaths by suicide among those age 65 and older increased by 8%. However, two groups saw a decline in numbers of suicide deaths, American Indian and Alaska Natives (down 6.1%) and people 10-24 years old (down 8.4%).²

In Massachusetts in 2019,³ 642 deaths were ruled as death by suicide; a decrease from 2018 (725 deaths). When COVID-19 hit in early 2020 the number went down dramatically (615). Provisional 2022 data shows that Massachusetts deaths rose to 626, a 3.6% increase from 2021(604).²

Nationwide, suicide has long been seen at higher rates in certain socially marginalized groups, particularly the LGBTQIA+ community. Before the pandemic up to 40% of transgender individuals had attempted suicide, with suicidality highest among trans youth.⁴

Substance Use

Suicidal thoughts and behaviors, and substance use disorders, are risk factors for each other and share similar underlying risk factors. Mood disorders and behaviors like risk-taking and impulsivity have also been noted as significant shared risk factors.⁵

Many clients in substance use disorder treatment settings suffer silently from suicidal ideation. Thoughts about suicide are often the result of unbearable and unrelenting physical, emotional, and spiritual pain. Like the disease of addiction, suicide is unbiased and can impact anyone, anywhere, at any time.

Individuals diagnosed with SUDs are at increased risk of suicidal ideation. Up to 40% of those seeking substance use disorder treatment have a suicide attempt history. Importantly, a previous attempt is a key predictor of future suicide.⁶

* References to 'clients' throughout refer to clients, residents and/or patients in various treatment settings.

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Of US deaths by suicide, more than 22% involve alcohol intoxication.⁷ Alcohol is a central nervous system depressant which lowers inhibitions and is involved in about 40% of suicide attempts.

In addition, 16% of suicides are from poisoning (including drug overdoses).⁸ However, unless an individual leaves a suicide note, it is difficult to differentiate intentional and accidental death by overdose. People who use opioids are at an elevated risk. SAMHSA's 2014 National Survey of Drug Use and Health noted that opioid use was significantly associated with suicidal ideation, suicidal planning, and suicide attempts. Opioid overdoses may be 'silent contributors' to suicide deaths. People suffering with mood disorders and/or chronic pain (some with opioid prescriptions) have greater suicide risk. Regular opioid users have been 75% more apt to make a suicide plan and twice as likely to make an attempt than people who do not use opioids. For some there may be no clear line between the intention to end one's life and one's motivation to continue living.⁹

Screening is important

One study found that fewer than half of substance use disorder (SUD) treatment providers said they screened incoming clients for suicide risk, and only one quarter screened existing clients.¹⁰ Fewer than half did further assessments even when a suicide risk was found. Treatment transitions or relapses may be experienced as crises by clients and may also increase suicide risk.¹¹

People with SUDs often seek treatment when they're most vulnerable; this can lead to suicidal ideation. As suicide is currently the eleventh leading cause of death in the United States, this is an important concern for Massachusetts SUD treatment providers. Providers working with teenagers and transitional aged youth encounter a population where suicide is the second leading cause of death.

One way to remember observable signs:

"IS PATH WARM"

- I - Ideation
- S - Substance use
- P - Purposelessness
- A - Anxiety
- T - Trapped
- H - Hopelessness
- W - Withdrawal
- A - Anger
- R - Recklessness
- M - Mood changes

People in treatment for SUDs are at especially high risk of suicidal ideation or thoughts. Many enter treatment:

- when their substance use is out of control;
- when several co-occurring life crises/losses may be present (e.g., relationship, legal, job);
- during peaks in depressive symptoms; and

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- with co-occurring mental health problems associated with suicidality (e.g., depression, post-traumatic stress disorder, anxiety disorders, some personality disorders).¹²

Addiction changes the brain's communication system. The reward and pleasure pathways in the brain are rewired during intoxication, withdrawal, and the post-acute withdrawal period. Impulse control is weakened, and judgement is impaired. As such, the individuals in treatment are at higher risk of suicide attempt.

Risk

Populations at highest risk of suicide are veterans¹³, incarcerated people¹⁴, non-Hispanic American Indian and Alaska Natives¹⁵, and all LGBTQ+ individuals.¹⁶ Young people have high risk¹⁷ – especially those ages 14-18, Asian American youth ages 15-24¹⁸, lesbian, gay, bisexual and trans youth, and black youth – especially young black females¹⁹.

There are racial and gender disparities within these statistics. Individuals of American Indian or Native Alaskan descent are more than twice as likely to attempt suicide as other racial and ethnic subgroups. The highest rates of suicide among white and Hispanic individuals occur in males ages 70 and older. The highest suicide rates in Native American and African American individuals occur in adolescents and young adults. Each suicide attempt and discussion about suicidal ideation should be taken seriously. Women are more likely to attempt suicide, and men are more likely to die by suicide. Men more often use more lethal means.

Post COVID-19 Impacts

The aftermath of coronavirus pandemic has shown a wave of psychiatric illnesses resulting from the entire population's exposure to extraordinary situations. Symptoms can range from changes in mood, to impaired sleep and appetite, severe mental illness, or suicidal ideation. An increase in suicidal ideation is one of the unforeseen impacts of the COVID-19 pandemic, notably in SUD treatment programs. The pandemic has affected the public's mental health and well-being in a variety of ways, including through isolation and loneliness, job loss and financial instability, and illness and grief. It is especially important for treatment providers to recognize these residual effects on mental health and suicidal ideation going forward. Elevated mental health needs continue well beyond the pandemic itself. Providers should take measures to address early assessment and proper treatment of suicidal ideation in the clients they care for in SUD treatment settings.

Many treatment providers may have also experienced worsened mental health due to increased risk of contracting or becoming severely ill from COVID-19. Navigating the challenges of the pandemic led to an increase in depression and anxiety, especially in essential workers, such as those in SUD treatment programs. Similarly, the social isolation associated with teleworking had a unique set of difficulties. Provider self-care is paramount. Proactively seeking supervision and support as needed can help foster mental wellness. The link below has resources for self-care and mental wellbeing.

<https://www.activeminds.org/about-mental-health/self-care/>

Guidance

Treatment providers should be prepared to screen for suicidal ideation. They should gather information routinely from all clients, refer as needed, and participate in the treatment of those at risk for any suicidal behavior. Screening should also be done at specific points during treatment.^{20, 21}

* References to 'clients' throughout refer to clients, residents and/or patients in various treatment settings.

Clients should be individually assessed at admission for their ability to engage in any service setting. There should never be a categorical exclusion of an individual entering treatment on the basis of their mental health diagnoses (105 CMR 164.070 (A)(3)). Programs shall identify whether a prospective patient is appropriate for the respective ASAM level of care based on their current clinical presentation. It may be useful to contact the referring agency for an updated mental status or conduct a phone screening developed by your program.

Organizations need to provide clarity on when each client is to be screened as universal practice for suicide risk. It is important to screen at intake as well as at other times during the treatment process - especially if risk has been noted.

Identifying and helping people at risk for suicide is extremely important. The link below provides further information and resources.

[Identify and Assist Persons at Risk – Suicide Prevention Resource Center \(sprc.org\)](https://www.sprc.org/)

Screening Tools

Several different screens can help identify a person at risk, and whether/how their risk has changed over time - so screeners should be used at intervals and timepoints.

- Colombia-Suicide Severity Rating Scale (C-SSRS), an evidence-based support tool that is appropriate across the lifespan: [The Lighthouse Project The Columbia Lighthouse Project](https://www.columbia.edu/~c4/lighthouse/)
- Ask Suicide-Screening Questions (ASQ), a free resource utilized within many different service types: [NIMH » Ask Suicide-Screening Questions \(ASQ\) Toolkit \(nih.gov\)](https://www.nimh.nih.gov/health/topics/ask-suicide-screening-questions-asq-toolkit/). Appropriate across lifespan; works well with younger clients.
- Patient Health Questionnaire – 9 (PHQ-9), implemented widely in primary care settings. An individual would be referred to a behavioral health care provider based on their PQH-9 screening: <https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf>

For helpful information on screeners and assessments see:

[Toolkit | Zero Suicide \(edc.org\)](https://www.edc.org/resources/toolkit/zero-suicide/)

SAMHSA TIP 50 suggests all clients be screened for suicidal ideation as a matter of routine. The following steps are recommended:

- Screen for suicide and ask follow-up questions;
- Follow up with a patient who has previously documented risk (e.g., past suicide attempts);
- Take appropriate action when risk is detected;
- Document suicide-related screening and interventions; and
- Communicate suicide risk to any another professional or organization with which the client is working or to which the client is referred.

WARNING SIGNS

Starting a conversation with a client about how they feel is the first step. Sometimes clients are not willing to share thoughts about suicide. Providers can still open a dialogue by identifying warning signs or behavior changes. Some examples are:

- Talking about
 - Wanting to die or kill oneself
 - Feeling hopeless or having no reason to live
 - Feeling trapped or in unbearable pain
 - Being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge

Assessments

BSAS regulations (105 CMR 164:072) also state that the assessment of an individual for admission and treatment includes:

“...An assessment of the client’s psychological, social, health, economic, educational/ vocational status; criminal history; current legal problems; co-occurring disorders; trauma history; and history of compulsive behaviors such as gambling. The assessment must be completed before a comprehensive service plan is developed for the patient.”

In 2016 CARF International standards²² incorporated suicide prevention steps. In 2019 it required programs accredited under its Behavioral Health and Opioid Treatment Program Standards Manuals to conduct suicide risk screening for all persons served, ages 12 and older.²³

According to SAMHSA’s Tip 50 all counselors should:

- acquire basic knowledge about warning signs, along with both suicide risk and protective factors;
- understand the intersections between suicide and addiction;
- be empathic and non-judgmental with people who experience suicidal thoughts and behaviors;
- recognize the impact of their own attitudes and experiences with suicidality on their counseling work; and
- understand the ethical and legal principles, and potential areas of conflict that exist when working with those who have suicidal thoughts and behaviors.²⁴

Policy

It is possible for a person to experience suicidal ideation at any point in their recovery journey. Each organization must have a policy and procedure on responding to clients who become a risk to themselves (105 CMR 164.078). Programs should document when a patient, in any level of care, is a danger to themselves (105 CMR 164.083). To ensure that each voice is heard, and each patient is given a chance to have their conversation started:

- Train all staff to recognize the warning signs of suicidal ideation;
- Discuss suicide, warning signs, and how to help during staff meetings as part of clinical review and supervision;
- Create program policy that includes how to use assessment tools and the protocol for follow through and support, including direct referral to the region’s Mobile Crisis Unit and/or the Emergency Department; and

- Outline within the policy the safety structure for clients who are receiving prescriptions and/or take-home medications.

Organizational policy should be clear about situations when a counselor should seek and get consultation about suicide risk. Consultation should be immediately available in crisis situations.

- Counselors and other frontline staff should be provided with ongoing training and supervision so that they can also support clients in non-crisis situations. Supervisors and administrators need training for their levels as well.

BSAS/IHR CRISIS RESPONSE INITIATIVE

To support staff and help people recover as quickly as possible, BSAS contracts with IHR to provide on-site and virtual crisis response services to BSAS-funded organizations across the Commonwealth.

A **critical incident** is an abrupt, powerful event that overwhelms an individual's or group's ability to cope. It can be any life-threatening, extremely harrowing or exceedingly distressing incident. Such events can have a significantly disturbing, powerful impact whether experienced personally or witnessed. Some examples of critical incidents:

- Death of a client
- Death of a co-worker
- Suicide of client or co-worker
- Violent events that threaten workplace safety
- Significant events involving children; i.e., removal of child from parent's care while in a program
- Natural disasters/acts of terrorism

BSAS-funded organizations wishing to take advantage of this service can call IHR at 617-661-9036.

An IHR Trauma Team member will take initial information. Within 48 business hours a trauma team member will contact the Program Director and work with them to develop a plan to support the staff.

- Administrators are responsible for ensuring that supervision or consultation (either in the program or from outside consultants) is available and accessible when needed, and that program policy defines the role of the clinical supervisor and/or consultant.
- Counselors working with those who may be suicidal need a clear understanding, guided by agency policy and procedures, of when screenings should be done, and when and how to access clinical supervision and consultation. They need to know when to seek immediate supervision, how to access supervision or consultation in crisis situations, and what kinds of information should be brought to the supervisor's attention.
- Counselors must be given time to complete important documentation of clinical actions taken with individuals who are suicidal. Forms should be developed to ensure all necessary information is consistently obtained. To build a pathway, see <https://zerosuicide.edc.org/toolkit/engage>. SAMHSA's TIP 50 also provides sample forms.
- A named supervisor/administrator should be responsible for tracking forms to assure that all necessary information has been gathered and the plan is being carried out or adjusted as needed.
- If there is any concern that staff cannot address suicidal concerns, the client should be referred elsewhere and that referral should be followed up closely to ensure the individual gets appropriate care.

- If a referral is made, counselors/supervisors should check that referral appointments are kept and continue to monitor clients after any crises have passed. This effort requires ongoing coordination with mental health providers and other practitioners, family members, and community resources, as appropriate.

Operations

- Regular screening for suicide risk should be incorporated into routine assessment and follow-up protocols. If a level of risk is noted, a clear protocol should be in place in place for necessary next steps.
- Program responsibilities do not end with referral to another provider and/or organization. Monitoring requires oversight by specified SUD program staff (like clinical supervisors) to ensure the continuum of treatment. Both the counselor and administrators need to ensure that:
 - the individual follows through on the referral,
 - the referring organization accepts the client for treatment,
 - treatment is actually implemented, and
 - the client's SUD treatment needs do not get lost in the referral process.
- Administrators can assign clinical supervisors the responsibility of ensuring that tasks involved in extending care beyond the immediate actions are carried out. Tasks may include:
 - Following up on referrals;
 - Case management as needed;
 - Regular check ins with the individual and significant others (if warranted and with proper consent) to ensure that that care is progressing;
 - Continued observation and monitoring for suicidal thoughts and behaviors that may reemerge once the initial crisis has passed; and/or
 - An organized system of follow-up by the supervisor, such as a checklist of clients with suicidal ideation or behavior may be required.
- Each program should have a standardized system of documenting follow-up (See TIP 50 p. 121).²⁵

Supervision, Training & Workforce Development

Suicidal ideation may occur at any time during a client's recovery process. It is important to embrace mental wellness to support recovery holistically. Remember, asking if someone is experiencing suicidal ideation does not increase the likelihood that they will attempt suicide.

Training for both counselors and supervisors should not be a one-time effort. Training should be based on jobs/roles in the organization. Confidence in implementing necessary steps is critical to assuring that screening and appropriate follow-up are done.²⁶

- Counselors at all levels should learn the importance of and methods for screening for suicidal behaviors and the critical next steps to provide safer suicide prevention care.
 - The DPH Suicide Prevention Program regularly offers [trainings](#) for professionals.
- Clinical supervisors must be able to respond sensitively and professionally to the emotional needs of counselors who may find work with clients with suicidal thoughts and behavior to be emotionally upsetting and stressful.
- Supervisors need adequate training and knowledge of suicidality, treatment and community resources and a sense of competence to respond to crises and concerns of the counselor. Clinical supervision training should emphasize the need for ongoing follow-up.²⁷
 - For more information, including risk and protective factors, warning signs of suicide, and frequently asked questions, visit: <https://www.mass.gov/service-details/general-information-about-suicide>

- The Department of Public Health Suicide Prevention Program offers trainings, along with Massachusetts specific resources, at: [Suicide Prevention Program trainings, conferences, webinars, and events | Mass.gov](#)

Service Delivery & Treatment

It should be standard procedure in all settings to provide ongoing ‘suicide safer care’ as a core responsibility when risk has been identified. This involves regular screening, discussion of Safety Plans, working with a plan and ongoing monitoring (see below).²⁸

NOTE: Safety contracts are not a best practice.

Massachusetts residential treatment providers can refer to one of the 24 BSAS-funded Co-occurring Enhanced (COE-RRS) residential programs which are well equipped to address suicidal thoughts and behaviors. See the - [Massachusetts Substance Use Helpline \(helplinema.org\)](#).

The Helpline also directs families to co-occurring treatment for youth and young adults at <https://helplinema.org/for-parents/>.

Planning

- Counselors should prepare a Treatment Plan that includes coordination with other providers, involves the client, and documents the Plan along with other clinical information.
- Supervisors should consult and, when needed, assist in Treatment Plan development; then regularly monitor and ensure the plan is implemented.²⁹
- Two related, relatively simple interventions have been shown to reduce attempts and deaths for people at high risk for suicide:
 - **Creating or updating a Safety Plan:** Safety planning is an evidence-based brief intervention that is typically created following a comprehensive suicide assessment. The plan is a written list of a client’s coping strategies and sources of support. It is developed by the individual in collaboration with a clinician. The person’s unique plan, in their own words, involves:
 - recognition of signs that precede thoughts of suicide,
 - coping strategies or safe social situations/environments,
 - personal support systems,
 - professionals or agency-based support systems (i.e., therapist, crisis services, 988 Suicide & Crisis Lifeline).
 - making the environment safe.

This living document that outlines coping skills and supports should be easily accessible to the client, can be shared with others by the client or with client consent and updated as needed. It’s important to ask a client with a history of suicidal thoughts or actions if they have a safety plan and, if so, whether it might need to be updated.

Resources to guide creation of a safety plan are:

- [Forms - Stanley-Brown Safety Planning Intervention \(suicidesafetyplan.com\)](#)
- [Zero Suicide ToolkitSM | Zero Suicide \(edc.org\)](#)
- [NIMH » Ask Suicide-Screening Questions \(ASQ\) Toolkit \(nih.gov\)](#)

There are also apps available: “MY3 safety plan” or “Safety Plan.”

- **Collaborative Means Safety Planning:** It is important to include a focused conversation to identify possible available means of harm (especially those that a client may have considered, like using a firearm or overdosing on medications) and reducing access by taking specific steps, like locked storage. This discussion may be particularly critical for outpatient treatment situations or for discharge planning. Family and other social supports may be helpful in this effort.^{30,31}

Free online training resources for counseling on Access to Lethal Means:

<https://zerosuicidetraining.edc.org/enrol/index.php?id=20>) and

<https://www.mass.gov/lists/resources-for-talking-to-patients-about-gun-safety>

It is difficult to identify options and problem solve when navigating extreme emotions. A safety plan clearly outlines steps, options, contacts within the support system, and coping skills. Safety plans are useful when a person is experiencing a psychiatric crisis, suicidal ideation, and increased symptomology.

Staff collaborate with a patient to identify which important information to include. The patient's own words can be used within the plan. It is important to highlight the safety plan as a tool with great options for support. This is similar to a relapse prevention plan commonly created in SUD treatment programs.

Of note, programs should always follow their Behavior Management policy and contact appropriate staff members when suicidal ideation or risk of suicide is identified. Only staff members trained in safety planning should implement this intervention.

See the Safety Plan Template at the end of this document to review an example.

NOTE: A safety contract is not the same as a Safety Plan and is not recommended. Contracts are **not in line with best practice guidance.** The contract, a formal-looking written agreement, is signed by a person at risk of suicide agreeing with a clinician and others not to die by suicide. Asking a person to sign a contract for safety is NOT effective. It may also be dangerous or give a false sense of security. Though it has the appearance of a legal document, it is not one and does not protect a clinician from liability.

Coordination of Care

Suicide risk may increase at transition points in care (inpatient to outpatient, intensive treatment to continuing care, discharge), especially when a planned transition involves difficulties or breaks down. Anticipating risk at these points should be an important part of treatment planning.³²

- Suicidal ideation may occur at any time during a patient's recovery process. Remember, asking if someone is experiencing suicidal ideation does not increase the likelihood that they will attempt suicide.
- It is important to work with the client before discharge to develop a community Safety Plan for the situation they will return to or for their new setting. Involve family members or other support individuals. Provide National 988 Hotline number and MA Behavioral Health Hotline 833-773-2445 numbers to all.
- Suicide rates are very high post-discharge from any setting. The National Action Alliance for Suicide Prevention recommends making a follow-up first contact within 24 hours of discharge coordinated through the treatment setting or another behavioral health provider, and then follow-up again in 7 days.³³

Education

The Massachusetts Department of Public Health Suicide Prevention Program offers regular trainings, along with Massachusetts specific resources, at the following link: [Suicide Prevention Program | Mass.gov](#)

Further information to help identify and help people at risk for suicide can be found here: [Substance Abuse Treatment – Suicide Prevention Resource Center \(sprc.org\)](#)

[Homepage | Zero Suicide \(edc.org\)](#) has more information and implementation resources on ways to incorporate safer suicide care into health and behavioral health care

Measures

Programs can assess their effectiveness by:

- Percent of counselors and other staff who are regularly trained on warning signs, appropriate responses and organizational policies and procedures, and that the ongoing trainings fit their job level;
- Clear written policies and procedures for addressing suicide risks and ensuring that they are known and understood by all counselors and supervisors;
- Documentation that all clients are regularly screened for suicide risk;
- Names of one or more supervisors in the organization who are specifically trained to address suicidal thoughts and attempts, and to guide counselors through organizational processes to keep clients safe while continuing to work on their SUD issues; OR ensuring all supervisors know who at the site has been trained to address emergency suicide risks and/or how to reach outside consultants being used by the organization.

If you believe a patient or resident is in danger of suicide:

- **Call Regional Mobile Unit or 988**
- **Ask the patient/resident** if they are thinking about killing themselves.
 - Asking if someone is having thoughts of suicide does **not** make it more likely that they will attempt suicide. In asking an individual if they are thinking of suicide, you create a connection and acknowledge their pain.
 - Avoid leading questions like: “You’re not thinking of killing yourself, are you?”
 - Ask direct and unbiased questions.
- **Listen empathically** and show you care.
- **Stay with the client**, or make sure the client is in a safe place with another staff member until help arrives.

RESOURCES

You are not alone! There are many resources available for providers and patients alike. The resources below include further information surrounding suicide and suicide ideation, specifically in individuals using substances.

[Suicide Prevention Program | Mass.gov](#)

Zero Suicide offers guidance through a toolkit and suicide safer framework:

[Homepage | Zero Suicide \(edc.org\)](#)

[TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment | SAMHSA Publications and Digital Products](#)

[Substance Use and Suicide: A Nexus Requiring a Public Health Approach \(samhsa.gov\)](#)

[Addressing Suicidal Thoughts and Behaviors in Substance Use Treatment \(samhsa.gov\)](#)

[Substance Abuse Treatment – Suicide Prevention Resource Center \(sprc.org\)](#)

[Home Page | National Action Alliance for Suicide Prevention \(theactionalliance.org\)](#)

[Facts About Suicide | Suicide | CDC](#)

[JCAHO Suicide Prevention recommendations required of accredited organizations](#)
[Jhttps://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/](https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/)

[Support After a Death by Overdose | Support After a Death by Overdose \(sadod.org\)](#)

[Mental Health Promotion and Suicide Prevention for LGBTQIA2S+ Youth – Suicide Prevention Resource Center \(sprc.org\)](#)

TRAINING RESOURCES

The Massachusetts Department of Public Health Suicide Prevention Program offers [trainings](#), along with state specific resources: [Suicide Prevention Program | Mass.gov](#)

For information on risk and protective factors, warning signs of suicide, and frequently asked questions, and more: [General information about suicide | Mass.gov](#)

The 2012 U.S. Surgeon General’s report: [2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention - PubMed \(nih.gov\)](#)

A key concept is *zero suicides*, where health care and community systems provide support to specific patient populations. The toolkit can be found at: [Homepage | Zero Suicide \(edc.org\)](#)

American Indian and Alaskan Native Communities Toolkit

<https://theactionalliance.org/communities/american-indian-alaska-native/hope-life-day-toolkit>

PROVIDER TOOLS

BSAS funded Co-occurring Enhanced (COE-RRS) programs:

[Massachusetts Substance Use Helpline \(helplinema.org\)](https://helplinema.org)

For youth and young adults see: <https://helplinema.org/for-parents/>

[TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment | SAMHSA Publications and Digital Products](#)

[Support After a Death by Overdose | Support After a Death by Overdose \(sadod.org\)](#)

CRISIS HOTLINES: MASSACHUSETTS

988 - [SUICIDE & CRISIS LIFELINE](#) [AYUDA EN ESPAÑOL : LIFELINE](#)

Provides free and confidential emotional support to people experiencing emotional distress and/or thoughts of suicide. Call or text “988” 24/7/365 to be connected to a local crisis call center.

Press 1 for Veteran’s Crisis Live, Press 2 for Spanish, Press 3 for LGBTQIA+. TTY is available for deaf & hard of Hearing. Additional translation services available. Online chat is also available [here](#).

The Massachusetts Behavioral Health Help Line (BHHL) is available 24/7, 365 days per year and is available for all residents of Massachusetts. Call or text 833-773-2445. Visit the website to chat online. The Behavioral Health Help Line (BHHL) connects individuals and families to the full range of treatment services for mental health and substance use offered in Massachusetts, including outpatient, urgent, and immediate crisis care. [Behavioral Health Help Line \(BHHL\) FAQ | Mass.gov](#)

Statewide Advocacy for Veteran’s Empowerment (SAVE): Veterans and military personnel are largely impacted by suicide, the most vulnerable are younger veterans aged 18-39. Per the National Strategy for Preventing Veteran Suicide about 67 percent of death by suicide in the veteran population is the result of firearms. [Statewide Advocacy for Veterans' Empowerment \(SAVE\) Program | Mass.gov](#)

CRISIS HOTLINES: NATIONAL

988 - [SUICIDE & CRISIS LIFELINE](#)

Provides free and confidential emotional support to people experiencing emotional distress and/or thoughts of suicide. Call or text “988” 24/7/365 to be connected to a local crisis call center. Press 1 for Veteran’s Crisis Live, Press 2 for Spanish, Press 3 for LGBTQIA+. TTY is available for deaf & hard of Hearing. Additional translation services available. Online chat is also available [here](#). [Ayuda En Espanol. Ayuda En Español : Lifeline \(988lifeline.org\)](#)

SafeLink: 877-785-2020 for anyone impacted by domestic or dating violence. Volunteers speak both English and Spanish and translation is available for over 130 languages.

The Trevor Project: 866-488-7386 A crisis intervention and suicide prevention hotline for LGBTQ+ youth. Volunteers are available to speak by phone, or text “Trevor” to 202-304-1200 to access the chat feature on the Trevor Project website <https://www.thetrevorproject.org>

The Trans Lifeline: <https://translifeline.org/>

Suicide Loss Survivors: <https://allianceofhope.org/>

Safety Plan Template

SAFETY PLAN	
Step 1: Warning Signs:	
1.	_____
2.	_____
3.	_____
Step 2: Internal Coping Strategies- Things I can do to take my mind off my problems without contacting another person:	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction:	
1. Name	_____
Phone	_____ - _____
2. Name	_____
Phone	_____ - _____
3. Place-----	_____
4. Place-----	_____
Step 4: People whom I can ask for help:	
1. Name	_____
Phone	_____ - _____
2. Name	_____
Phone	_____ - _____
3. Name	_____
Phone	_____ - _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician

Name _____ Phone _____

Clinician Emergency Contact # _____

2. Suicide Prevention Lifeline: 1-800-273-TALK (8255)

3. Local Emergency

Service _____

Emergency Services

Address _____

Emergency Services

Phone _____

Step 6: Making the environment safe:

1. _____

2. _____

Step 7: Reasons for Living:

1. _____

2. _____

3. _____

Name: _____

Date _____

REFERENCES

¹ Wilcox HC, Conner KR, Caine ED. [Association of alcohol and drug use disorders and completed suicide: An empirical review of cohort studies](#). *Drug Alcohol Depend*.2004 76Suppl:S11-9. Doi:10.1016/j.drugalcdep.2004.08.003.

² [Suicide Data and Statistics | Suicide | CDC](#)

³ <https://www.mass.gov/doc/2020-suicide-data-table/download> - 2020 data

⁴ Austin A, Craig SL, D'Souza S, McInroy LB. [Suicidality Among Transgender Youth: Elucidating the Role of Interpersonal Risk Factors](#). *J Interpers Violence*. 2022 Mar;37(5-6):NP2696-NP2718. doi: 10.1177/0886260520915554

⁵ Rizk MM, Herzog S, Dugad S, Stanley B. Suicide Risk and Addiction: The Impact of Alcohol and Opioid Use Disorders. *Current Addiction Reports* <https://doi.org/10.1007/s40429-021-00361-z>

⁶ Yuodelis-Flores C, Ries RK. [Addiction and Suicide: A Review](#). *AM J Addict*, 24 (2): 98–104, 2015 ISSN: 1055-0496 print / 1521-0391 online DOI: 10.1111/ajad.12185

⁷ Substance Abuse and Mental Health Services Administration. (2016). [Substance Use and Suicide: A Nexus Requiring a Public Health Approach \(samhsa.gov\)](#). In Brief. *HHS Publication* No. SMA-16-4935.

⁸ Trust for America's Health and Well Being Trust. [Pain in the Nation: The Drug, Alcohol and Suicide Crises and the Need for a National Resilience Strategy](#). November 2017.

⁹ Oquendo MA, Volkow ND. (2018). [Suicide: A silent contributor to opioid-overdose deaths](#). *The N Engl J Med*. 378;17 nejm.org April 26, 2018.

¹⁰ Harris BR, et al. [Suicide safer care in behavioral health settings: A comparative analysis of perceptions, training completion, and practice between mental health and substance use disorder treatment providers](#). *Journal of Substance Abuse Treatment*. 2021; 126:108330.

¹¹ Substance Abuse and Mental Health Services Administration. (2017). [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). TIP 50: Treatment Improvement Protocol (TIP) Series. HHS Publication No. (SMA) 154381

¹² Substance Abuse and Mental Health Services Administration. (2017). [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). TIP 50: Treatment Improvement Protocol (TIP) Series. HHS Publication No. (SMA) 154381

¹³ [2022 National Veteran Suicide Prevention Annual Report, VA Suicide Prevention, Office of Mental Health and Suicide Prevention, September 2022](#)

¹⁴ Carson EA. Suicide in Local Jails and State and Federal Prisons, 2000-2019 – Statistical Tables. October 2021, US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. NCJ 300731. [Suicide in Local Jails and State and Federal Prisons, 2000-2019 – Statistical Tables \(ojp.gov\)](#)

¹⁵ Curtain SC, et al. Provisional Numbers and Rates of Suicide by Month and Demographic Characteristics: United States, 2020. NVSS Rapid Release. Report No. 16. November 2021. [Vital Statistics Rapid Release, Number 016 \(November 2021\) \(cdc.gov\)](#)

¹⁶ The Trevor Project [The Trevor Project: 2022 National Survey on LGBTQ Youth Mental Health](#)

¹⁷ CDC/NCHS, National Vital Statistics System, Mortality 2017. [LCWK1. Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age groups, by race and sex: United States, 2017 \(cdc.gov\) p 165 166](#).

¹⁸ [LCWK1. Deaths, percent of total deaths, and death rates for the 15 leading causes of death in 5-year age groups, by race and sex: United States, 2017 \(cdc.gov\)](#)

¹⁹ Shain BN. [Increases in Rates of Suicide and Suicide Attempts Among Black Adolescents](#). *Pediatrics*. 2019;144(5): e20191912.

²⁰ Yuodelis-Flores C, Ries RK. [Addiction and Suicide: A Review](#). *AM J Addict*, 24 (2): 98–104, 2015 ISSN: 1055-0496 print / 1521-0391 online DOI: 10.1111/ajad.12185.

²¹ Substance Abuse and Mental Health Services Administration. (2017). [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). TIP 50: Treatment Improvement Protocol (TIP) Series. HHS Publication No. (SMA) 154381

²² CARF International. Suicide Prevention in CARF-Accredited Organizations: Advancing Clinical and Service Workforce Preparedness. Quality Practice Notice – September 2016. http://www.carf.org/QPN_SuicidePrevention_Sept2016/

²³ [CARF adds screening for suicide risk to its assessment standards](#)

²⁴ Substance Abuse and Mental Health Services Administration. (2017). [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). TIP 50: Treatment Improvement Protocol (TIP) Series. HHS Publication No. (SMA) 154381

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- ²⁵ Substance Abuse and Mental Health Services Administration. (2017). [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). TIP 50: Treatment Improvement Protocol (TIP) Series. HHS Publication No. (SMA) 154381
- ²⁶ Harris BR, et al. [Suicide safer care in behavioral health settings: A comparative analysis of perceptions, training completion, and practice between mental health and substance use disorder treatment providers](#). *Journal of Substance Abuse Treatment*. 2021; 126:108330.
- ²⁷ Substance Abuse and Mental Health Services Administration. (2017). [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). TIP 50: Treatment Improvement Protocol (TIP) Series. HHS Publication No. (SMA) 154381
- ²⁸ Brodsky BS, Spruch-Feiner A, Stanley B. [The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care](#). *Front Psychiatry*. 2018; 9: 33. doi:10.3389/fpsyt.2018.00033
- ²⁹ Substance Abuse and Mental Health Services Administration. (2017). [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). TIP 50: Treatment Improvement Protocol (TIP) Series. HHS Publication No. (SMA) 154381
- ³⁰ National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). [Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe](#). Washington, DC: Education Development Center, Inc.
- ³¹ <https://www.hsph.harvard.edu/means-matter/lethal-means-counseling/>
- ³² Substance Abuse and Mental Health Services Administration. (2017). [Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#). TIP 50: Treatment Improvement Protocol (TIP) Series. HHS Publication No. (SMA) 154381
- ³³ National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). [Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe](#). Washington, DC: Education Development Center, Inc.