Carleton University

Suicidal Ideation Protocol for Use in Research

1. **Guiding Principles**

1.1. This protocol applies when a research participant discloses suicidal ideation (i.e., any thoughts about suicide) in the context of a research study; these thoughts can range from brief consideration to detailed plans. This protocol applies regardless of

a) the assessment/data collection method or instrument (for example, self-report questionnaires, a sample of which are found in Appendix B, and structured or semi-structured interviews), or

b) whether or not findings of suicidal ideation are intentional (i.e., the researcher planned to elicit responses about suicide) or incidental (i.e., the researcher did not plan to elicit responses about suicide ideation, but a participant expresses suicide ideation nonetheless), or

c) Whether the suicidal thoughts or behaviours were present prior to coming into the study session.

1.2. Researchers are not clinicians and are not required to provide direct intervention. Nonetheless, in line with Carleton's Supporting Students in Distress, all research personnel should follow the *R* rules:

i. *Recognize* signs of suicidal ideation,
ii. *Respond* in a caring and non-judgmental manner,
iii. *Refer* participants to appropriate services, and
iv. *Report* the incident (detailed decision-making guidelines to follow).

1.3. Training Requirements: Researchers proposing to use measures that explicitly ask about suicide ideation or pose questions that are likely to elicit disclosures of suicide ideation, are required to provide documented evidence (to the REB) that they have completed training in a suicide awareness-training program endorsed by a reputable organization such as the Canadian Mental Health Association (e.g., Safe Talk). The principal investigator and all research personnel who will interact with participants shall complete the requisite training. This also includes on-line survey (confidential) research.

1.4. Respect for participant confidentiality, well-being, and safety remain paramount in any decision made in the context of research. As such, confidentiality may only be breached when the evidence reasonably suggests that the risk of suicide is urgent (see Decision Rules in s. 2.2e)). Further, the limits of confidentiality must be explicitly described within the informed consent form.

1.5. This Policy is written in accordance with broader university policies (i.e., SMHF), provincial privacy laws [Freedom of Information and Protection of Privacy Act (FIPPA), Personal Health Information Protection Act (PHIPA)], as well as current evidence-based and best-practice

guidelines within the suicide literature). This protocol replaces the suicide ideation protocol originally developed by the former Psychology Research Ethics Board.

2. Protocol

2.1. Overview

- There are various questionnaires and interview schedules currently used to assess suicide ideation and imminence. Moreover, all extant measures are not equally valid tools for assessing the imminence of suicide risk.
- A sample of these commonly used instruments, and the relevant questions relating to suicidal ideation are listed in Appendix B, with those responses that would trigger adherence to this Protocol highlighted in gray. A fuller list of risk assessment tools is found in the Suicide Risk Assessment Toolkit, developed by the Canadian Patient Safety Institute and the Mental Health Commission of Canada.
- In every case, when suicidal thoughts or behaviours are identified by the participant, the researcher should ask whether these occurred within the past year. If no such thoughts and behaviours are identified, then the Semi-Structured Suicide Screening Interview (Appendix B) need not be undertaken.
- The onus is on investigators to be aware if any items or questions in their research protocol, which includes verbal responses given during an interview, would reveal thoughts or plans of suicide.
- If a researcher uses an instrument that lacks suicide-specific questions, or omits such relevant items, the researcher is still required to undertake the Semi-Structured Suicide Screening Interview (Appendix B) if any participant response reveals thoughts or plans of suicide within the past year.
- Any similar diagnostic or non-diagnostic process that reveals any indication of suicidal thoughts within the past year requires a more thorough interview-based assessment to determine urgency (see Appendix B, Semi-structured suicide screening interview below).

2.2. Measures **Are Returned In-person, NOT anonymous**

a) **Interpret questionnaire results and assess next steps:** When participants have completed the instrument, the researcher must immediately check responses to the relevant item. Researchers may, for example, check responses to these items while getting compensation information and/or debriefing ready for participants.

b) **If the response to the relevant question is one that is not highlighted, and no other response indicating thoughts or plans of suicide is given,** debrief participants (with written Debriefing Form, based on Appendix A)**.** The debriefing includes a summary of the goals of the study as well as a list of contact numbers (e.g., Health and Counselling Services, see Appendix A for a sample debriefing).

c) **If the response to the question is highlighted, or the participant has given a response indicating thoughts or plans of suicide within the past year,** the participant is spoken to

privately (researchers assessing suicide risk must ensure data collection facilities allow such a conversation to occur in private). The researcher will state that she or he has noticed the question responses and is concerned about the welfare of the participant.

d) Next, the **researcher** will ask the following questions in a private setting:

- Are thoughts of suicide present? How long have they been present for?
- Does the person have a current plan? How well developed is the plan? Do they have the means to execute the plan (e.g., painkillers readily available)?
- When does the person intend to carry out the plan?
- Is the person in pain? Do they have feelings of hopelessness, helplessness and do they want to die?
- What are their resources? Are they alone? Do they have supports (formal and informal)?
- Are they seeing a therapist currently? Have they talked to anyone about these thoughts?
- Do they have prior suicidal behaviour?
- Are they particularly vulnerable because of current/previous mental health concerns?
- Are there any on-going stressors (e.g., financial, school-related) or new stressors (e.g., recent death of a loved one)?

Based on your training, determine whether the participant's responses to the above-noted questions warrant an urgent response (participant is told that the researcher is concerned for his/her welfare and that people who can help further will be notified immediately—see below) or a non-urgent response (i.e., no further action is taken, participant is debriefed as usual).

Supervisors (or equivalent authority) must be immediately available to novice interviewers to assist in making decisions regarding urgent vs. non-urgent responses.

e) Decision **Rules** for determining that suicide risk is **urgent** and hence requires confidentiality breach and subsequent reporting (CUREB Reporting Form in Appendix C):

- Determining whether a participant is at risk for suicide and whether that risk is urgent is not a straightforward task. Follow the protocol established in your training for determining suicide risk urgency. If possible, consult your supervisor (or equivalent authority) immediately.
- In general, the risk for suicide is considered urgent if a participant has the means and a current plan to kill themself, and there is good reason to believe that the individual may in fact carry out the suicidal thoughts soon. However, the absence of a plan and means does not necessarily negate a determination of urgency. For example, individuals who have current thoughts of suicide, express a sense of hopelessness, and admit to having attempted suicide in the past may still be rated urgent. However, ultimately, it is a judgment call grounded in training and/or consultation with supervisor/equivalent authority.

f) If suicide **risk is determined to be urgent:**

- If the participant is a student, then the participant is informed that the researcher will

be calling campus security (x4444) for research conducted on campus, or 911 for off-campus research. If the student is off campus, the person in charge should dial 911 and notify the Department of University Safety by dialing 613-520-2600 x4444.

- During the call, the police/campus security is informed of the individual's current and urgent thoughts of suicide. The person's name and phone number are given to the police/campus security. If the participant is NOT a student, the researcher must follow the local reporting protocols (e.g., within the prison, hospital, schools, etc.).
- Although this step involves breaking confidentiality, under accepted legal and professional standards, the welfare of the participant takes priority. The situation is documented, and the Ethics Chair and Research Supervisor are contacted as soon as possible.
- The PI shall report to the REB using the Urgent Suicidal Ideation Reporting Form (Appendix C) attached to this Protocol.

g) If suicide risk is assessed as **non-urgent:**

- No further action is taken apart from debriefing the participant. Note that the debriefing will remind the participant about counseling services available on campus, in the community and the emergency room at the hospital. If the participant is also seeing a therapist, it is suggested that the participant speak with the therapist about this. Compensation and debriefing are subsequently given.
- The research team is required to keep detailed records, which CUREB may request to see, but there is no need to report this to CUREB.

h) **Things to avoid in-person, synchronously online, and in telephone situations:**

- Do not give out your research lab number as a resource for somewhere to call for help.
- Do not give out personal phone numbers or email addresses of research personnel or other contact information.
- Do not intervene directly with the participant. That is, do not escort the person to the hospital or health services. If a participant does call the researcher(s) or lab for help, refer them again to the resources, such as Health Services or the Distress Centre or hospital. Assess for urgency of suicidal intention, and follow the steps outlined above.
- Do not engage in a helping relationship with the participant. Provide information about resources, but, for example, do not make follow-up calls to check up on the person and see how they are doing.

2.3. On-line survey, research participant is anonymous:
When measures are completed anonymously, researchers are unable to identify the individual (nor do they anticipate being identified). Nevertheless, the additional debriefing statement (Appendix A) and PI contact information is included with on-line materials so that the participant may seek help if they are distressed.

Complete the Urgent Suicidal Ideation Reporting Form and submit to the REB if required in s. 2.2 e) and f)

Appendix A: Sample Debriefing Statement

Depression is a condition that can occur for many reasons, including workplace, school, or relationship stressors, traumatic life events, discrimination, as well as physical/biological imbalances. Approximately 10-15% of people will suffer some degree of depression during their lifetime. With advances in modern medicine, most people can readily be treated for this illness, which if unattended can be long lasting and affect many aspects of one's life.

The symptoms of depression include:

- Poor or depressed mood, or a reduction in the pleasure gained from otherwise positive experiences
- Sleep disturbances
- Eating disturbances (loss of appetite, or overeating despite not being hungry), which may be linked to weight changes
- Lack of sexual interest
- Fatigue and lethargy (you don't feel like doing anything)
- An inability to focus (e.g., you have a hard time reading)
- Reduced interactions with family and friends
- Thoughts of suicide

Someone who is depressed may experience several (3-4), but not necessarily all of the above symptoms. It is likewise the case that 60% of individuals will encounter a severe traumatic event in their lives and of these people, a fair number will develop symptoms that cause severe anxiety. Illnesses of this nature, including posttraumatic stress disorder (PTSD) can be treated. Once again, if unattended, the repercussions can be severe.

Symptoms include:

- Hyperarousal (e.g., feelings of anxiety and reactivity even to minor situations)
- Intrusive thoughts (memories of the event come into your head frequently)
- Avoiding thoughts or stimuli related to the event

These symptoms can persist for more than a month following the event and influence your day-to-day functioning.

If you are not already receiving help for this problem, it is suggested that you contact your family physician. It is not a good idea to allow problems to fester, as ruminating over these problems will typically not make them go away. Your family physician or counsellor will usually be able to help you or to refer you to someone who can. If you do not have a family physician, then you can contact either of the following:

- Mental Health Crisis Line: within Ottawa (613) 722-6914
- outside Ottawa 1-866-996-0991, Web Site: http://www.crisisline.ca/
- Ottawa Distress Centre: (613) 238 1089, Web Site: www.dcottawa.on.ca
- Carleton University Health Services 613 520 6674
- Canada's national Suicide Crisis Helpline, 9-8-8, available for free calls or texts.

Appendix B: Some Common Depression and Suicide Scales

The scales below are commonly used; however, there may be other scales or instruments to which this policy should apply.

BDI original:

9. ___ 0 = I don't have thoughts of harming myself
___ 1 = I have thoughts of harming myself but I would not carry them out
___ 2a = I feel I would be better off dead
___ 2b = I have definite plans about committing suicide
___ 2c = I feel my family would be better off if I were dead
___ 3 = I would kill myself if I could

Source: Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory of measuring depression. *Archives of General Psychiatry, 4*, 561-571

BDI-II

9. ___ 0 = I don't have any thoughts of killing myself
___ 1 = I have thoughts of killing myself but I would not carry them out
___ 2 = I would like to kill myself
___ 3 = I would kill myself if I had the chance

Source: Beck, A.T., Steer, R.A., & Brown, G.K. (1996). Manual for the Beck Depression Inventory-II. San Antonio, TX: Psychological Corporation.

Quick Inventory of Depression Symptomatology (QIDS SR-16)

12. Thoughts of Death or Suicide:
_____ 0 I do not think of suicide or death.
_____ 1 I feel that life is empty or wonder if it's worth living.
_____ 2 I think of suicide or death several times a week for several minutes.
_____ 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

Source: Rush, A. J., Trivedi, M. H., Ibrahim, H. M., Carmody, T. J., Arnow, B., Klein, D. K., … Keller, M. B. (2003). The 16-Item quick inventory of depressive symptomatology (QIDS), clinician rating (QIDS-C), and self-report (QIDS-SR): psychometric evaluation in patients with chronic major depression. Biological Psychiatry, 54,573-583.

SBQ-R Suicide Behaviours Questionnaire-Revised

1. Have you ever thought about or attempted to kill yourself? (check one only)

D 1. Never
D 2. It was just a brief passing thought
D 3a. I have had a plan at least once to kill myself but did not try to do it
D 3b. I have had a plan at least once to kill myself and really wanted to die
D 4a. I have attempted to kill myself, but did not want to die
D 4b. I have attempted to kill myself, and really hoped to die

If the participant answers 3 or higher for question 1, the following qualifier question appears:

Was this in the past year?

___No

___Yes

2. How often have you thought about killing yourself in the past year? (check one only)

D 1 . Never
D 2. Rarely (1 time)
D 3. Sometimes (2 times)
D 4. Often (3-4 times)
D 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

D 1. No
D 2a. Yes, at one time, but did not really want to die
D 2b. Yes, at one time, and really wanted to die
D 3a. Yes, more than once, but did not want to do it
D 3b. Yes, more than once, and really wanted to do it

If the participant answers '3a' or '3b' for question 3, the following qualifier question appears:

Was this in the past year?

___No
___Yes

4. How likely is it that you will attempt suicide someday? (check one only)

D 0. Never
D 1. No chance at all
D 2. Rather unlikely
D 3. Unlikely
D 4. Likely
D 5. Rather likely
D 6. Very likely

Source: Osman A, Bagge CL, Guitierrez PM, Konick LC, Kooper BA, Barrios FX., The Suicidal Behaviors Questionnaire- Revised (SBQ-R): Validation with clinical and nonclinical samples, Assessment, 2001, (5), 443-454