Suicidal Thoughts Protocol for use in Research Settings

1. Guiding Principles

1.1. This protocol shall be followed 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. Importantly, this protocol shall be followed regardless of (1) the assessment method [e.g., self-report questionnaires such as the Beck Depression Inventory-II (BDI-II, Beck, Steer, & Brown, 1996)], structured or semi-structured interviews—standardized or not, or (2) 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).

1.2. Researchers are not clinicians and are not required to provide direct intervention. Nonetheless, in line with our university's Student Mental Health Framework (SMHF; Office of the Associate Vice-President—Students and Enrolment, 2009) all research personnel should follow the *R* rules:

i. *recognize* signs of suicidal ideation,
ii. *respond* in a caring and non-judgemental 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. Further, the limits of confidentiality must be explicitly described within the informed consent form.

1.5. This SOP (prepared by a joint CUREB-A/CUREB-B ethics subcommittee) is written in accordance with broader university policies (i.e., Student Mental Health Framework; Office of the Associate Vice-President—Students and Enrolment, Carleton University, 2009), 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 (e.g., Bolton, 2015; Nock, 2014; Pokorny, 1993; Posner, Subramany, Amira, & Mann, 2014). Lastly, this protocol replaces

the suicide ideation protocol originally developed by the former Psychology Research Ethics Board (PREB).

2. Standard Operating Procedures

- It is important to note that there are various questionnaires and interview schedules currently used to assess suicide ideation and imminence (Nock, 2014). Moreover, all extant measures are not equally valid tools for assessing the imminence of suicide risk (see Emergency Nurses Association Development Committee, 2012 for list of endorsed measures).
- For the purposes of illustration, the discussion below uses the Beck Depression Inventory-II (BDI-II, Beck et al., 1996). If researchers plan to use alternative measures they must provide a comparable decision-making framework grounded in established research and clinical practice.
- Note. If a researcher chooses to use the BDI-II and omits item 9—the item that asks suicide specific questions- they ***do not*** have to follow this SOP; however if depression-based questionnaires are utilized (without suicide-specific items) the researcher is still required to provide a detailed debriefing as illustrated in Appendix A.
- Possible BDI-II Item 9 responses include:
    - '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"

- Any similar diagnostic or non-diagnostic process that reveals any indication of suicidal thoughts automatically requires a more thorough interview-based assessment to determine urgency (see **"Semi-structured suicide screening interview"** below).

2.1. MEASURES ARE RETURNED In-person, NOT anonymous

2.1.1 ***Interpret questionnaire results and assess next steps***: When participants have completed the Beck Depression Inventory-II, the researcher must immediately check responses to Item 9 (from 21-item version). Researchers may, for example, check responses to these items while getting compensation information and/or debriefing ready for participants.

(a) If BDI-II, item 9 is scored 0, debrief participants and provide compensation**.** 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).

(b) If BDI-II item 9 is scored 1, 2 or 3 the participant is spoken to privately (researchers assessing suicide risk must ensure data collection facilities allow such a conversion to occur in private). The researcher will state that she or he has noticed the Beck item(s), and is concerned about the welfare of the participant.

i) Next, the researcher shall ask the following questions in a private setting:

Semi-structured Suicide Screening Interview (adapted from the Student Mental Health Framework):

- 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 intent 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)?

ii) Based on your training determine whether the participant's responses to the above-noted questions either warrant an urgent response (i.e., 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).

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

iv) **DECISION RULES** for determining that suicide risk is urgent and hence requires confidentiality breach and subsequent reporting:

- Determining whether or not a participant is at risk for suicide and whether or not that risk is considered urgent is not a straightforward task. First and foremost, 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 will be considered urgent if a participant has means and a plan to kill him/herself,** 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 also 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.

    - **If suicide risk is determined to be urgent** and 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 also 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 intent to commit 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 etc.).

Although this step involves breaking confidentiality, the welfare of the participant takes priority [(American Psychological Association (APA), Canadian Psychological Association (CPA) , Tri-Council Policy Guidelines, Freedom of Information and Protection of Privacy Act (FIPPA)]. The situation is documented, and the Ethics Chair and Research Supervisor are contacted as soon as possible.

- If suicide risk is assessed as **non-urgent** than no further action is taken apart from debriefing the participant. Note that the debriefing will remind 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.

v) **Things to avoid in-person 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 home phone numbers of research personnel.
- 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 the information about resources, but, for example, do not make follow-up calls to check up on the person and see how they are doing.

Note: A written record is kept documenting the assessment and is immediately submitted to appropriate REB (either CUREB-B or CUREB-A)

2.2. MEASURES ARE not RETURNED In-person (DROP-OFF/ON-LINE SURVEY) but not anonymous:

2.2.1 Response to BDI-II Item 9 is checked, as above, immediately upon receiving the questionnaire. All further procedures are followed as indicated in 2.1.1.1 and 2.1.1.2 but over the phone (thus researchers are required to ask for phone numbers in these cases).

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). Questionnaires involving such sensitive measures include the additional debriefing statement below and contact information so that the individual is in a position to seek help if they are distressed.

See Appendix B for a flow chart representation of all steps

References

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Nock, M.K. (Ed.). (2014). *Oxford handbook of suicide and self-injury* (pp. 323-336). New York: Oxford University Press.

Office of the Associate Vice-President—Students and Enrolment, Carleton University. (2009). *Student Mental Health Framework: A guide for helping students in distress*. Retrieved from http://carleton.ca/studentsupport/wp-content/uploads/Carleton-University-Student-Mental-Health-Framework1.pdf. Author: Carleton University

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APPENDIX A

Sample Debriefing

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.

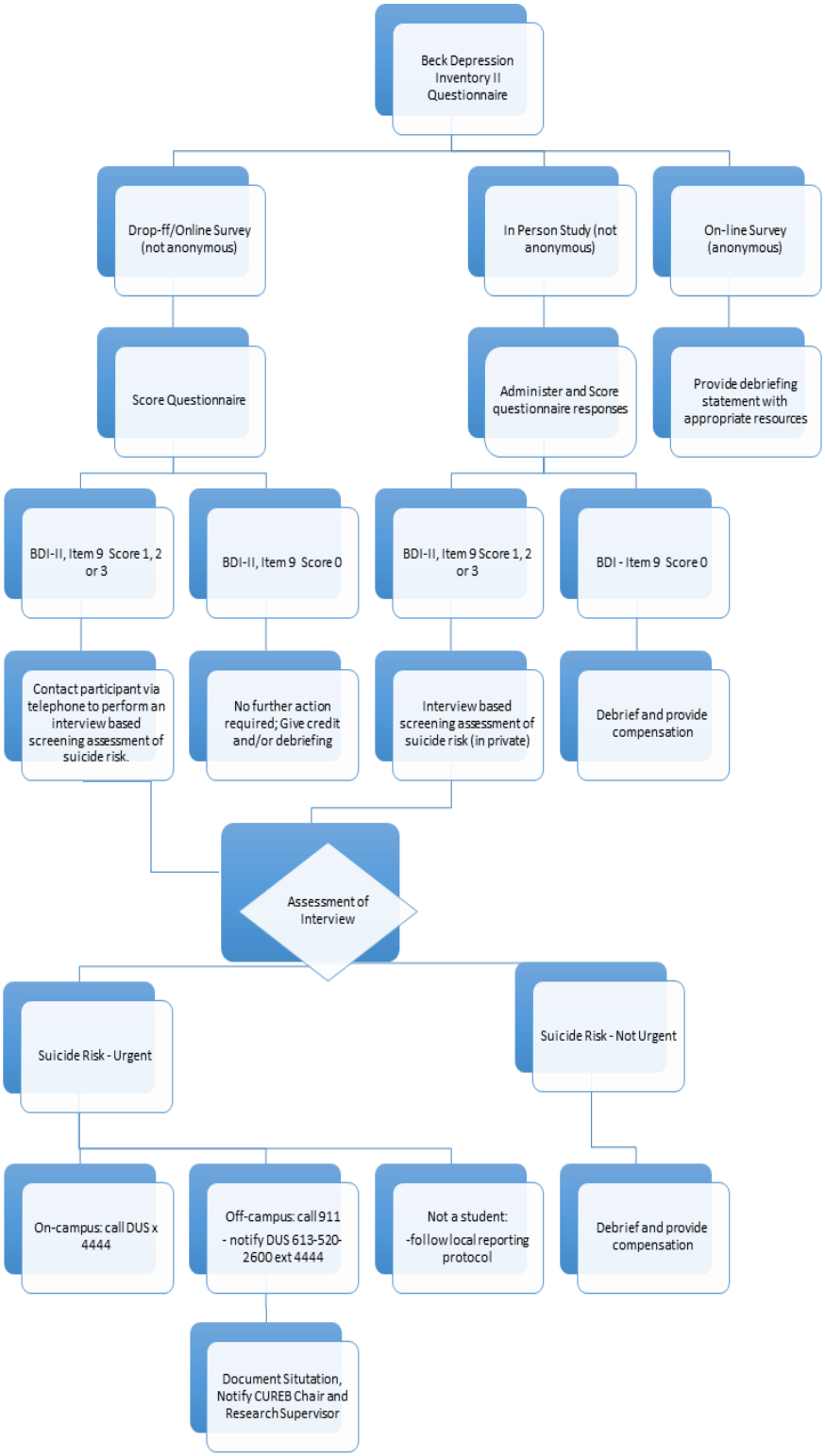
If you are not already receiving help for this problem, it is suggested that you contact your family physician. It is not a good idea to allow problems to fester, as ruminating over these problems will typically not make them go away. Your family physician or counsellor will usually be able to help you 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

Print option for online

APPENDIX B

Flow Chart



Semi-structured Suicide Screening Interview

- Are thoughts of suicide present? How long have they been present for?
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