Working With the Client Who is Suicidal:

A Tool for Adult Mental Health and Addiction Services

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Appendix 3: Clinical Examples

The following are examples of the challenges and dilemmas presented to mental health clinicians involving suicidal clients. Questions are included for reflection and provide examples of considerations about what ought to be done given the complexity of the clinical situation. The questions are not meant to be an exhaustive listing but rather suggest some of the key issues that should be considered by the clinician.

EXAMPLE #1 – Substance Use & Suicidality

Jake is a 23-year-old male who has been referred to you by his family physician with chronic suicidal ideation. During your first session Jake tells you that he uses alcohol and marijuana regularly and that his substance use combined with his 'obsession' (his word) with hard rock music often makes him feel like he wants to kill himself. Based on his ideation, substance use, and impulsivity, in addition to other risk factors, you determine his risk for suicide is high. You need to learn more of his recent losses and events that precipitated the escalation of suicide risk. On the positive side, he has a concerned and caring mother, the pastor from the family's church is a supportive influence, and the physician is actively committed to assisting Jake.

Jake appears quite willing to attend counselling sessions. You are concerned with his immediate safety, develop a safety plan, and schedule treatment sessions twice a week for the next three weeks. Jake has also agreed to check in by phone on a regular basis. You determine that Jake needs to address his substance use issues - which are significantly contributing to his current suicide ideation - and you inquire into the availability of outpatient drug and alcohol counselling services. The waiting list to get in to see a drug and alcohol counsellor may be several weeks. Furthermore, Jake needs a psychiatric assessment since his chronic suicide ideation could mean a need for appropriate medications after a diagnosis. Meanwhile, how will you ensure his safety and manage his current suicide ideation?

Questions for Reflecting on This Case: What Ought to Be Done?

- How can you capitalize on the consultation services of the drug and alcohol program while Jake awaits his first appointment (e.g., can you consult by phone with the alcohol and drug counsellor regarding appropriate treatment goals and the interim management of his substance use disorder)?
- How might you arrange to work with the drug and alcohol counselling service in the future so that a co-managed approach is taken to working with Jake, which would include dealing with what appears to be a dual diagnosis?
- What does Jake identify as the most important area to work on?
- Given Jake's interest and willingness to participate in counselling, how can you actively build on, and give attention to, his life-affirming choice in the sessions?
- How can you maximize the support and involvement of the physician and church pastor?

- Given that Jake's substance use problem may interfere with his ability to keep regular appointments and may compromise his ability to comply with treatment recommendations, what safeguards may need to be put in place to maintain ongoing and close vigilance of Jake?
  How can you help Jake to get even a little bit more of what he wants other than by suicide?
- What behaviours/cognitions/emotional skills does Jake identify as being useful (e.g.“ to be able to walk away when I'm angry", "to drink and have fun without getting depressed, "to not care so much when my girlfriend seems to like someone else")?

EXAMPLE #2: Chronic Suicidality

Jane is a 27-year-old First Nations woman who lives in a small northern town. The head nurse of the Aboriginal village nursing station referred her to you after a suicide attempt (20-30 Tylenol, 15 ibuprofen and a number of unknown medications). Jane has a lengthy history of suicidal ideation, as well as a longstanding mood disorder. Three years ago her best friend, with whom she had a suicide pact, died by suicide. Since the death, Jane has had constant thoughts of suicide. Recently, she broke off a romantic relationship, and left her home community to escape physical abuse from her former partner. Jane is now living in this new village, with her aunt, away from her immediate family community. She is using alcohol and drugs excessively and feels a constant guilt regarding her two children, who were apprehended five years ago by the Ministry for Children and Families, following allegations that Jane had failed to protect them from her abusive partner.

You have determined that Jane is at high to imminent risk due to her mood disorder, alcohol and drug use, her exposure to her friend's suicide, her previous involvement in a suicide pact, the break-up that triggered her most recent suicide attempt, and her guilt resulting from her separation from her children. Hospitalization was given serious consideration, given the recent escalation of her risk status, particularly the break-up from the abusive relationship, her relocation from her support and home community, and her guilt regarding her children. After careful consideration, you have determined that there are some considerable protective factors to capitalize on and you make the decision to see her in an outpatient counselling setting. For example, in spite of her high-risk status she still maintains a strong personal commitment to reunite with her children and she enjoys the support of her mother, aunt, and the village community health nurse. Although she is living away from her home village, she is staying with her aunt in the new community, and her mother has conveyed the family's interest and willingness to help her. You know from talking with the village community health nurse that the community is making substantial gains in their health care programs (including traditional healing approaches) and is involved in treaty negotiations. This complex case calls for a well thought out, multidimensional approach to treatment that will address Jane's immediate safety, her long term mental health and substance use issues, while at the same time appreciating the broader community context within which she is living.

Questions for Reflecting on This Case: What Ought to Be Done?

- What can you do to increase Jane's immediate safety?
- Are there some specific additional Aboriginal resources you can draw on (e.g., assisting Jane in benefiting from her community's renewed commitment to adopting more traditional healing practices)?
- How might you capitalize on the support and commitment being demonstrated by Jane's mother, aunt, and community health nurse?
- How will you know when her risk level escalates to a point that hospitalization might need to be re-considered?
- How might you draw on her future orientation towards reuniting with her children as a significant protective factor?
- Who do you need to share information with about this case?

EXAMPLE #3: Failure to Follow-Through with Treatment

Casey is a 65-year-old man who was referred to you by a counsellor at the local senior's centre, following Casey's disclosure that he was considering suicide. Casey has lived alone since his wife of over 40 years died 10 months ago. Casey retired three months ago after working for an automotive plant for over 30 years. He has one daughter, who lives nearby with her husband and three children. Casey's daughter accompanied Casey to his first treatment session, but you did not obtain explicit consent to speak to her about his ongoing treatment. Casey does not have a current suicide plan; however, he has been speaking of suicide for approximately one month. The anniversary of his wife's death is in six weeks. Your initial risk assessment determined that his suicide risk was low to medium. After two treatment sessions, Casey failed to return for a scheduled visit. What type of follow-up should be initiated?

Questions for Reflecting on This Case: What Ought to Be Done?

- Can the counsellor who made the initial referral offer any information about Casey's current status? What have staff at the senior's centre noticed in terms of his behaviour, affect, and attitude (assuming he is still attending the senior's centre)?
- As you do not have explicit consent to speak to Casey's daughter, can you work with the counsellor at the local senior's centre to either obtain Casey's permission to talk to his daughter, for the counsellor to have Casey's daughter phone you and provide input, or for the counsellor to talk to the daughter and relay her input to you?
- Who else can help? How can you work with others to share responsibility for keeping Casey safe?
- Is there any reason to think that his suicide risk status may have increased? If so, what actions need to be taken to ensure his safety?
- Are significant others aware of potential suicide warning signs and specific actions that should be undertaken if they believe his risk for self-harm has increased? Has he seen his physician to check for

medical issues for which depression may be a side effect (e.g., diabetes)? Are the family/counsellor aware of the specific issues that put seniors at risk for suicide (e.g., multiple losses; isolation; poor pain management)?

- Can the family and senior centre staff establish a safety plan to help Casey through this first anniversary?
- What options are available in terms of seeing Casey "off-site," (e.g. at the senior's centre)?
- What strategies exist for "maintaining contact" with Casey (e.g. leaving messages at home with his daughter)?
- How can you communicate your intentions to "leave the door open" for Casey to make a return visit?
- Have the repeated efforts to "make contact" been documented in the clinical record?

EXAMPLE #4: Release of Information to Family

Jacqueline is a 23-year-old female who has been referred to you by her family physician for treatment of depression. You have seen Jacqueline for 3 treatment sessions. During your intake assessment, in which you routinely assess for past and present suicidality, Jacqueline expresses to you that she has thoughts of suicide. She reports having no specific plan, and has no history of attempts. Jacqueline describes that she has felt 'pretty depressed' for years. She indicates that she lives with her mother, with whom she experiences considerable conflict. Jacqueline states that her mom knows that she is seeing you for treatment, but that she doesn't want her mother to know anything about her treatment at all, as that would just 'make things worse'. One day, you receive 3 phone messages from Jacqueline's mother, asking you to call her back as she would like to discuss her daughter's case with you. What do you do?

Questions for Reflecting on This Case: What Ought to Be Done?

- What would be the impact on the therapeutic relationship if you communicated with Jacqueline's mother?
- Consider the ways that you can work with Jacqueline on improving her relationship with her mother. Could you suggest joint family sessions with Jacqueline's mother to address the conflict in their relationship?
- If Jacqueline declines providing consent for you to speak to her mother, consider encouraging her to involve her mother, or another support system, as part of your therapy.
- You may want to consider phoning the mother back, and indicating that Jacqueline has indicated that she would not like her mother to be informed of her ongoing treatment. You may indicate to the mother that issues around confidentiality limit your ability to disclose to the mother information regarding the daughter, without her specific consent.
- Recognize that limits of confidentiality prevent you from disclosing information to Jacqueline's mother, but that there are not restrictions around you obtaining information from Jacqueline's mother. Consider that information you obtain from Jacqueline's mother may assist you in your ongoing treatment with Jacqueline.
- After discussion with her mother, use information that the mother has provided. Use your clinical judgment to consider your next steps.

EXAMPLE #5: Release of Information to Family

Karim is a 25-year-old male who has been admitted to the hospital where you work following a suicide attempt, by way of prescription medication overdose. You have been asked to see Karim in the few hours following his suicide attempt. You perform a suicide risk assessment of Karim while he is still in the intensive care unit. Karim indicates to you that he was at home, was 'pissed off' at life and had been drinking (approximately 5-6 beer) and that he decided to take approximately 25 antidepressant medication pills. When asked where he got these pills, he states that they were 'just lying around'. He refuses to provide you with any further information about mental health history. When you ask how he got to hospital, Karim said that he thinks his girlfriend, with whom he lives, came home and saw Karim 'out of it' so called the paramedics. He remembers seeing his father in the emergency room, and said he thought his girlfriend must have called his father as well. You ask if you can speak to his girlfriend and father. Karim says that he knows that his father is in the waiting room, but that he does not want you to speak to him as he 'feels stupid'. You are approached by his father and girlfriend as you are leaving the intensive care unit, asking questions about how they can help.

Questions for Reflecting on This Case: What Ought to Be Done?

- As Karim is still in the intensive care unit, is he competent to provide you with consent (or lack of) to communicate with others?
- What are the potential benefits of obtaining information from Karim's family (e.g., to perform an informed and thorough risk assessment), despite his request that you not speak to his girlfriend or father?
- Be aware that legislation around release of information indicates that you are able to obtain information from family members, but not necessarily able to disclose.
- Consider that in situations where someone is at acute risk (such as being in the emergency room following a suicide attempt) it may be appropriate to break confidentiality.
- What is your assessment of Karim's level of risk while in intensive care? Is there a need for further precautions to ensure his safety?
- Consider the value in providing information on general suicide prevention and management to both his girlfriend and his father. What type of information (e.g., information on risk factors; crisis line numbers; reading materials) can you provide to Karim's girlfriend and father?
- Consider explaining to Karim's significant others that he has indicated concern about you talking to them, due to feeling embarrassed. Indicate that this is a normal response post-suicide attempt. You may want to consider speaking to Karim's father and girlfriend about ways that they can speak to Karim about his suicide attempt.

Suggested Reading for Clinicians

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