[Edited for grammar and clarity by CAMH]

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Episode #10: What all physicians need to know about suicide prevention

[Musical intro]
On this podcast, we discuss topics that could be difficult or triggering for some listeners. If you're in crisis, please visit your local emergency department or call 911. If you are not in crisis, please contact your family physician. More information about getting access to care can be found at camh.ca or at ConnexOntario.ca.

Dr. David Gratzer: I remember our last conversation. He had had a lengthy inpatient hospitalization under my care, but we'd turned a corner. He looked good, he sounded good and he was looking forward to discharge—and there was nothing remarkable about our interaction. If anything, it was a feel-good conversation because we were both so happy about his progress. I never saw him again. He went on a pass and at some point in the pass, he suicided. I think all of us clinicians have stories like this. Perhaps for a person like myself with a few grey hairs, too many stories like this. Suicide is something that is difficult for us providers to deal with. And, wow, imagine the impact on families and on friends. Today we're talking about this very weighty topic: suicide and suicide prevention. It is *Quick Takes* and my name is Dr. David Gratzer. I'm a psychiatrist here at the Center for Addiction and Mental Health, and we're joined by Dr. Juveria Zaheer, who is a psychiatrist at CAMH, and as well, she's a clinician scientist with the Institute for Mental Health Policy Research. Dr. Zaheer, thank you for joining us.

Dr. Juveria Zaheer: Thank you so much for having me.

David: Doctor, this is a weighty topic. Why don't we talk . . . why don't we start our talk with something very relevant. Do you think suicide rates will climb during this pandemic?

Juveria: I think in my career as a suicide prevention researcher, I have not been asked more about my work than I have in the last five months. I think people have linked COVID and suicide in their minds, and I think that the answer might be more complicated. Traditionally, we think about economic hardship, we think about social isolation, decrease access to care, trauma as being risk factors for suicide, all of which we can see during the COVID-19 pandemic. I think it's important to remember, though, that the situation is completely unprecedented in our lifetimes, and it's very difficult to know what to expect. And we know that in the past, when we had increased social cohesion—during the World Wars, for example—when people have a feeling that we're all in it together, suicide rates can actually come down. And the early data suggests that in some nations, like Japan, the rates have actually come down in the short term. But I think we need to be vigilant and we need to monitor and we need to figure out how we can support people who are experiencing financial hardship, trauma, experiences of difficulty accessing care.

David: Which makes the research so much more important.

Juveria: Yeah, I think initially when I was starting out as a researcher, people would say, stay away from suicide because suicide is not a predictable outcome or suicide is a very rare outcome. But one thing that you mentioned off the top is that suicide is a tragedy that affects families and communities and society. And it's a major public health issue. And I think we need really creative and innovative solutions to address it.

David: What are some things about the literature that has surprised you?

Juveria: I think one of the things that really surprises me in terms of the literature—when you are a medical student, you think about sad persons and you think about the risk being higher for men or people with a previous episode of suicidal behaviour. I think what surprised me in our work is how resilient people are. So the rates of experiencing suicidal ideation are a lot higher than one might expect. And I think any time someone has suicidal thoughts, it's extraordinarily distressing. And that in itself is a target for treatment. But the vast majority of people, again, don't die by suicide. There is hope and there is recovery. And if we understand how we can support people through crisis, treat their underlying mental health issues and create a world where every life is worth living, I think we can be on the right track.

David: That's a very hopeful message, but often when we speak to colleagues, understandably, people feel daunted by suicide. Why do you think that is?

Juveria: It's interesting. We're doing a study where we're interviewing psychiatrists who have lost patients to suicide, and two themes come out. One is: How could I have let this happen? How could I have lost this person who I was caring for and who I was meant to shepherd to recovery? And the second theme that comes out as well is: Suicide isn't a predictable outcome. That no matter what I do, I can't prevent this awful outcome. And that can lead to the sense of therapeutic nihilism. And I think when we work on these two extremes, it can be very distressing for both the patient and the provider. And I think that there can be a way that we can move forward, away from these sort of opposites. And that's: How do we understand someone's suicide risk in context? How do we understand the pain rather than predicting the risk? And how do we strengthen their protective factors and reduce their risk factors and come up with a plan that makes sense?

David: What are some practical tips you might offer to one of our clinician colleagues?

Juveria: So I think this is a really important question. And I have a colleague with whom I work who has lived experience with suicidal behaviour, and she says that when you disclose suicidal ideation, you can see the clinician flipping into risk-assessment mode. We want to know about the intent and the plan and how likely we are and do we have any past attempts. So I think when I think about risk assessment, I think about three things. One is that we need to be rigorous. We need to understand that there are risk factors that come with a person: a history of trauma, past history of suicidal behaviour. We need to understand the impact of mental health. So are people having increasing depression or anxiety? And we need to look for the warning signs of suicide. So are they communicating suicide, are they engaging in preparatory behaviour? And I think clinicians, by and large, are quite good at making sure they collect all of the information.

So I think the next two pieces are maybe even more important. What do we do with that information? So one of the things that I think is really important is we can't lose sight of the suffering in the interest of collecting information. So I think it's really important for clinicians to understand what the suicidal ideation means for somebody. Is it something that is distressing? Is it a function of feeling burdensome? Is it a function of feeling pain? And one of the questions that I ask is—when people have suicidal thinking, they're often not thinking about ending their lives. They're thinking about ending something else: pain, exhaustion, tiredness, hopelessness.

David: What's something you do differently today, after all these years of experience?

Juveria: I think when I was starting and when you become staff—and I've worked in the CAMH emerg now as a resident or staff for 14 years—you want to make sure that you get it right. You want to make sure that you don't miss any information and that you've reviewed the chart and you've come up with a perfect plan. I think what's changed for me—and I think part of that, too, is becoming a parent and having siblings that remind me of some of the people I see in the department, as they grow older—but just to be able to say to someone, "I'm so glad that you're here. And I know it must have been difficult to come, and I'm so glad that you're here. And how are you feeling in this moment?" I think as I've become more confident and present, I can share that with the people I'm seeing. And I think that in itself can feel really disarming and really real. That there's a person here sitting with me, and not just collecting information, but they want to provide some comfort and they want to understand where I'm coming from.

And I think the other thing that's been helpful for me—and in one of our studies, we reviewed suicide notes from the coroner and others, we hear about people's lived experiences of suicidal behaviour, and I think suicide can feel really scary, talking about it can feel really scary, hearing about distress and pain . . . we want to paper it over and make it better—but I think there's some humility in listening to someone's experience and being with them and sitting with that pain. You're not going to fix it in that moment, but hearing it, I think, shines a light on the shame and the darkness, and it does bring hope.

David: Very helpful. You mentioned research. What do you think research over the next few years might help us better understand about suicide and suicidal behaviour?

Juveria: I think one of the things that's been remarkable about the shift in suicide prevention research is for a long time, suicide prevention research was more about treating underlying mental illness. So how do we reduce suicidal ideation and depression? How do we reduce suicidal ideation and schizophrenia? And we use the gold standard, and research is always randomized controlled trial, but suicide is an extraordinarily, mercifully rare outcome. And so this becomes really tricky. And in many studies, you actually eliminate anyone who has suicidal ideation, and they don't qualify to be in the study. They are ruled out. And so I think one of the things I think is really important for suicide prevention research is thinking about the narrative. And to understand a story, we need to look at it from the top and the bottom. So from the top: really understanding data. And we can think about AI, we can think about population-based data to understand how risk and different populations look different. And then we can use from the ground up: we can understand people's stories. We can harness the expertise of families and patients who've been through the system, understand their stories to better identify people at risk and to co-create interventions that work.

And I think importantly, we need to take the longer view. We need to think about social interventions because it's not just the work of a psychiatrist to prevent suicide. It takes all of us to prevent suicide. And I think that commitment from government and from institutions and from churches and families and these micro-connections and commitments are going to make a huge difference. And then more practically, when I think about suicide research, I think about public health intervention and social infrastructure and bridge barriers and gun control. And I think about treating underlying mental illness; things like clozapine and lithium that are shown to reduce suicide rates. And then finally, interventions that are specific to people experiencing suicidal ideation: safety planning, close-contact follow-up, particular psychotherapeutic approaches. And if we say suicide is an extraordinarily complex problem, we need complex and integrated solutions.

David: So let's focus on practical tips for a moment. Of course, all of us who are listening to this podcast now have had suicidal patients and will in the future have suicidal patients. What are your thoughts with regard to safety planning?

Juveria: So I think it's really important for a clinician to think about suicidal ideation every time you see a patient. There are very practical tools, like a Columbia Screener or a PHQ-9, which has suicidal ideation as the last item.

So I think when we're thinking about how to practically support people with suicidal ideation, one

piece that's really important is understanding how someone's risk evolves over time. And one way that we can do that as clinicians is to make sure that we screen for suicide risk at our first encounter. Do a robust risk assessment early, so you have that background information when you need it. And if we ask about suicidal ideation at every encounter, whether it's verbally or whether it's through a scale, it can help us identify risk early. And I think that's really important.

I think another really important measure for suicide risk assessment and management is thinking about safety planning. So a safety plan is a tool that is evidence based that can help a person when they're in a moment of crisis remember their reasons for living and remember their skills. In a suicidal ideation, it ebbs and flows—that can feel very painful in one moment and feel better in others. And so it's our responsibility that when a person feels distressed, they have the tools available to them in that moment to keep themselves safe, whether it's people they can reach out to, strategies that they can use, ways to keep their environment safe. And one of the things that's so great about safety plans is every time you use it, it's reinforcing. So every time I use a safety plan and I can keep myself safe, I'm reminded of the fact that I have these skills. So it's a really wonderful tool and it's a really great tool to get to know your patient, to get to know what's meaningful for them and what's important for them.

David: Do you use a specific form?

Juveria: So one of the safety plans I use is a draft adapted from Brown and Stanley, which is kind of the gold standard. And here at CAMH and in our work with the Canadian Armed Forces, we've included a "Reasons for living" module in there, which I think is really useful. And so that's the one that I use, and I think that we can make sure that's available.

David: And you populate it with the patient, and you suggested to me before, you actually get the patient to take a picture with the iPhone or smartphone, so it's accessible to the person. Useful?

Juveria: I think very much so. And it's interesting because all of us are kind of at different ages. And I see in the department that people always have their phone with them, and I always have my phone with me, and so taking a picture of it means it's always going to be with you. I always ask people to print off a copy for their care team or for their family members. If you find that your suicidal thoughts are worse before bed, have a copy by your bed. If you find that it's the worst when you're getting out of your car and you're driving to work, have a copy in your glove compartment. So thinking about ways that you can personalize it and make it be the most useful for you.

David: Some of our patients are at very high risk. They've had multiple attempts before. As a provider, sometimes we can get very frustrated. What are some things that you remind yourself of when you're in the emergency department, seeing one of these patients?

Juveria: I think a lot about trauma, and I think it's interesting because we do trauma histories on people and say, "Have you ever had any trauma?" If someone has had recurrent suicidal behaviour, each time is a trauma. You know, it's an event that might mean that they're not going to be alive anymore, that might lead to medical consequences. And I think using a trauma lens is really helpful for me to understand recurrences of a behaviour. This person is in pain and they're suffering and that suffering is manifesting in self-harm behaviour. And I think we often use the words in mental health care—and I think this is falling out of favour—but manipulative or attention seeking. But could you ever imagine hurting yourself for attention? To me, these are signs of distress, and signs of distress means that there are signs that we can help.

David: And then pivoting over to society. What are some changes we need to make?

Juveria: We recently did some teaching with residents around suicide prevention. We asked, "When was the

first time you heard about suicide?" And the answers were really sad. You know, we talk about shame and stigma and not wanting to talk about it, or losing someone and no one talking about it later. We think about people feeling embarrassed or grieving or feeling abandoned, and it becomes this tragedy that we don't talk about. And I think as we start to talk more about suicide, we can understand that there is hope and there is recovery and that people can survive this awful feeling inside of them, and they can survive and move forward. I think we can also see that there are treatments that work and that people care about you. And when we talk about suicide more broadly, we can shine a light on a problem that has affected all of us. I think if you have a room of a hundred people, a hundred people in that room have been affected by suicide. And when we talk about it out loud, it can make it a lot easier for people to ask for help.

David: Doctor, as you know, it is a *Quick Takes* tradition that we close with a minute of quick questions. Can we put a minute on the clock? Are you ready?

Juveria: Absolutely.

David: Here we go. Doctor, what's one change you'd like to see in people's practices around suicide?

Juveria: I think we need to focus more on prevention and less on prediction.

David: What worries you about the way people do suicide risk assessments?

Juveria: I think we focus so much on predicting a terrible outcome that we miss the pain and the modifiable pieces that can be easily addressed.

David: What's something that somebody with lived experience taught you about suicide prevention?

Juveria: I think the important piece is to focus on someone's pain and their story and not try to see them as a source of data.

David: What's your favourite paper on this topic?

Juveria: There's a lovely paper by Yvonne Bergmans, who is an incredible clinician and researcher here in Toronto, that has narratives of people who have presented to the emerge with recurrent suicidal behaviour and talks to them when they're well about what their experiences are. And I think it's extraordinarily moving.

David: We're almost out of time. So at the buzzer, I know you're a big history buff. What's your favourite presidential biography?

Juveria: I was just saying today to Dr. David Goldbloom that I love *What It Takes,* which is a book about the 1987 U.S. presidential primaries. And it's been particularly useful right now. I suggest you pick it up.

David: I very much appreciate your time and very much appreciate your answers. I very much appreciate your academic scholarship on this very important topic. Thank you, Doctor.

Juveria: Thank you so much.

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