

SUICIDE AND THE WORKPLACE

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KEY FACTS ABOUT SUICIDE

- The losses faced by families, friends, workplaces and communities as a result of death by suicide are enormous. Worldwide, more people die by suicide than by homicide and war.
- In BC, suicide is the second leading cause of death among young people aged 15-24.
- There were a total of 492 suicide deaths in the province of British Columbia in 2004; 75% of these were males (BC vital Statistics 2005).
- For every death by suicide there are likely between 50 to 100 attempts (Bland, Newman & Dyck, 1994; Health Canada, 1994).

Suicidality and suicide attempts may manifest for a number of reasons. Accumulated workplace stressors may be a precursor to depression and burnout, which can elevate risk for suicide.

Features of work such as client dependence, status integration & social isolation may increase suicide risk.

The following occupational groups were found to have elevated suicide risk, in comparison to their working peers:

- Social workers (1.52x greater risk)
- Nurses (1.58x greater risk)
- Doctors (1.94x greater risk)
- Dentists (4.45x greater risk)

Stack, S., (2001). *Occupation and suicide. Social Science Quarterly, 82(2), 384-396.*

After a suicide attempt... return to work may be as difficult for managers and coworkers as it is for the individual, particularly if a suicide attempt takes place onsite at the workplace. An employee may be concerned about returning to work after a suicide attempt, fearing what their colleagues will think of them.

WHEN AN EMPLOYEE DIES BY SUICIDE

Suggested guidelines for handling information about suicide deaths include:

- Refrain from sharing specific or sensational details about the incident.
- Restrict information to the general facts, as they are known.
- Defuse anxiety by framing the suicidal act as a way of coping with significant, unbearable problems and emotional pain.
- Provide information to other employees about where additional help - such as written resources and counselling - is available.
- Make crisis line numbers available.

WORKING WITH THE CLIENT WHO IS SUICIDAL: A TOOL FOR ADULT MENTAL HEALTH AND ADDICTION SERVICES

Working With the Client Who is Suicidal: A Tool for Adult Mental Health and Addiction Services (Ministry of Health, 2007)

provides an overview of recommended practices in assessing and treating suicidal behaviour in adults. This document is consistent with the goals identified in the *Blueprint for a Canadian National Suicide Prevention Strategy*, developed by the Canadian Association for Suicide Prevention (CASP) in 2004. Specifically, this document responds to the following goals as identified by CASP: to increase training for key gatekeepers, volunteers, and professionals regarding recognition of risk factors, warning signs and at-risk behaviours; to provide effective interventions; and to develop and promote effective clinical and professional practice to support clients, families and communities. *This document is available for free download at: www.carmha.ca or www.health.gov.bc.ca/mhd.*

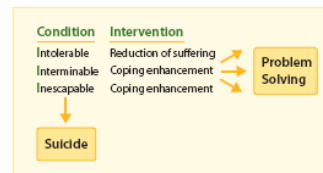
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Model of Suicide

People think seriously about suicide when they experience the 3 I's in their life situation: **Intolerable** (meaning their life situation is so painful that it seems unbearable), **Interminable** (it seems like it's going to go on like this forever), and **Inescapable** (it seems like nothing they've tried has changed or will change their experience).

Problem-Solving Model of Suicidal Behavior



The workplace may provide access to means (e.g., poisons, heavy machinery), as well as distance from family members or other significant others.

Table 1 Suicide and undetermined intent deaths, highest occupational proportional mortality ratios with confidence intervals for men aged 16-45 years, 1981-1999

Scotland Occupation	Number of Deaths	PMR	Lower Confidence Interval	Upper Confidence Interval
Counter hands, assistants	16	195	112	316
Medical practitioners	26	180	118	265
Hotel Porters	20	165	101	254
Forestry workers	40	163	116	231
Hospital, ward orderlies	22	163	102	247
Gardeners, groundsman	126	146	122	173
Students at University / College	233	143	126	163
Security guards and officers, patrolmen, watchmen	81	137	110	170
Chef, cooks	95	126	103	154
Building and civil engineering labourers	159	119	102	139
Labourers and unskilled workers n.e.c.	644	117	108	126

Table 2 Suicide and undetermined intent deaths, highest occupational proportional mortality ratios with 95 per cent confidence intervals for men aged 46-64 years, 1981-1999

Scotland Occupation	Deaths	PMR	Lower Confidence Interval	Upper Confidence Interval
Plant operators and attendants not elsewhere classified	11	229	114	410
Judges, barristers, advocates, solicitors, lawyers	12	224	114	392
Farmers, horticulturists, farm managers	86	216	175	267
Medical practitioners	13	205	109	351
Hotel and residential club managers	18	194	115	304
Builders (so described)	16	187	107	302
Fishermen	26	164	107	241
Deck, engineers room hands, bargemen, boatmen	34	159	108	228
Managers not elsewhere classified	46	148	108	198

Source: Stark, C. et al. (2006). *Male suicide and occupation in Scotland. Health Statistics Quarterly, 29, 26-29.*

Workplace managers can make valuable contributions to suicide prevention efforts by doing the following:

- **Develop workplace policies** that articulate recommended procedures and guidelines for dealing with mental health issues, life crises, suicidal crises (threats, attempts), and deaths by suicide.
- **Obtain training** to recognize mental health problems, including warning signs of suicide.
- **Address organizational culture factors** that may contribute to elevated stress in the workplace (e.g., bullying, unexpected organizational changes).
- **Provide support to employees** who are experiencing stress and depression (employees are more likely to seek help if they believe they are being supported).
- **Ensure that employees are aware** of any special counselling services and other benefits they have available through the workplace (e.g. employee and family assistance programs). Explain that counselling services are confidential, and that information is not shared with the employer without the employees consent.
- **Develop an environment** in which co-workers support each other.
- **Create a safety protocol** that can be utilized in the event an employee experiences a mental health crisis, to ensure their safety and the safety of their co-workers until a clinical assessment occurs.
- **Develop and implement return to work and accommodation policies and protocols** for employees with mental or physical health difficulties. The reintegration of employees with emotional and/or suicidal crises should be facilitated with respect and sensitivity. A non-punitive, supportive approach enables successful return to work efforts, creates a safe work environment, and contributes to an overall climate of wellness.



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FURTHER INFORMATION ABOUT THIS AND OTHER SUICIDE RELATED PROJECTS & ACTIVITIES CAN BE FOUND AT:

www.carmha.ca or
www.health.gov.bc.ca/mhd

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