

SOCIAL WORKERS' SUICIDE INTERVENTIONS: LISTENING TO THE NEEDS OF
SUICIDAL PEOPLE

By Melissa Thibault-Canas

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Warning: The opinions and arguments expressed in this *mémoire* are those of the author and are not necessarily representative of the positions of the director, whose role is to accompany students in their own research processes in the context of a Master of Social Work (Professional).

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Abstract

Abstract in English

The massive financial investments in suicide prevention strategies encouraging people to consult healthcare professionals and discuss their suicidal ideations creates the assumption that current practices offer people opportunities to express suicidal thoughts. Studies show that many people with suicidal thoughts express the need to be heard, but they are often denied a safe space to express their feelings and thoughts. Social workers encounter and work with people with suicidal thoughts in a variety of settings, including in general and psychiatric hospitals, at universities, on school boards, in correctional institutions, through children's aid services, family agency services, and in long-term care homes. My research aims to determine which intervention strategies social workers in Canada employ with suicidal people and what impacts these strategies have on suicidal people. My research identifies various social work interventions when dealing with people who express suicidal thoughts, analyzes the impacts of these interventions on suicidal people from a critical perspective, and provides recommendations for alternative interventions and practices with suicidal people. The methodology of my research is based on a critical review of literature on intervention strategies used with suicidal people by social workers in Canada and their impacts on suicidal people. This review indicates that interventions providing suicidal people with a safe space to express their suicidal thoughts and be listened to should be made a priority, while treating suicidal people coercively should be avoided. To conclude, recommendations are provided for various public institutions, public policies, and social awareness to improve intervention strategies with suicidal people.

Keywords: suicide, suicidal people, social work, social workers, intervention, suicide prevention, treatment, coercive treatment

Résumé

Résumé en français

Les investissements financiers massifs dans les stratégies de prévention du suicide visant à encourager les gens à consulter un-e professionnel-le de la santé et à discuter de leurs idéations suicidaires laissent supposer que les pratiques actuelles offrent des possibilités d'exprimer des pensées suicidaires. Cependant, bien que de nombreuses personnes ayant des pensées suicidaires expriment le besoin d'être entendues, elles se voient souvent refuser un espace sécuritaire pour exprimer leurs sentiments et leurs pensées. Les travailleurs-euses sociaux rencontrent des personnes ayant des pensées suicidaires et travaillent avec elles dans divers contextes, notamment dans les hôpitaux, les universités, les commissions scolaires, les établissements correctionnels, les services d'aide à l'enfance, les services d'agences familiales et les foyers de soins de longue durée. Ma recherche vise à déterminer quelles stratégies d'intervention les travailleurs-euses sociaux au Canada emploient avec les personnes suicidaires et quels sont les impacts de ces stratégies sur les personnes suicidaires. Ma recherche identifie diverses interventions des travailleurs-euses sociaux auprès des personnes qui expriment des pensées suicidaires, analyse les impacts de ces interventions sur les personnes suicidaires d'un point de vue critique et fournit des recommandations pour des interventions et des pratiques alternatives auprès des personnes suicidaires. La méthodologie de ma recherche est fondée sur une revue critique de la littérature sur les stratégies d'intervention utilisées avec les personnes suicidaires par les travailleurs-euses sociaux au Canada et leurs impacts sur les personnes

suicidaires. Cette revue critique indique que les interventions offrant aux personnes suicidaires un espace sécuritaire pour exprimer leurs pensées suicidaires et être écoutées devraient être prioritaires, tandis que le traitement coercitif des personnes suicidaires devrait être évité. Pour conclure, des recommandations sont formulées à l'intention des diverses institutions publiques, des politiques publiques et au plan de la sensibilisation sociale afin d'améliorer les stratégies d'intervention auprès des personnes suicidaires.

Mots clés : suicide, personnes suicidaires, travail social, travailleurs-euses sociaux, intervention, prévention du suicide, traitement, traitement coercitif

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LIST OF ACRONYMS AND ABBREVIATIONS

ASIST: Applied Suicide Intervention Skills Training

BSW: Bachelor of Social Work

CAMS: Collaborative Assessment and Management of Suicidality

CASW: Canadian Association of Social Workers

CASWE: Canadian Association of Social Work Education

CBT: cognitive behavioural therapy

CBT-SP: cognitive behavioural therapy – suicide prevention

DBT: dialectical behaviour therapy

MSW: Master of Social Work

PD: professional development

INTRODUCTION

In the context of one of my internships during my training as a social worker, following an intervention with a person expressing suicidal thoughts, I was told by my supervisor to note everything down to protect myself from malpractice in case the person attempted or completed suicide, which is what I did. I instinctively felt I had to look out for myself and my career before anything else, making me momentarily forget about the person and how they must be feeling. My reaction is an example of how unprepared I was to work with suicidal people. Not only was I unable to determine the right course of action for this person, but I was also guided by a fear of malpractice, a fear fuelled by co-workers, supervisors, and the institutional settings I was in. However, one of my strengths has always been my compassion and empathy toward people. Generally, I believe social workers have great intentions when working with people, or they would not have chosen a career as a social worker. However, social workers have expressed feeling unprepared when working with individuals expressing suicidal thoughts despite their motivation and willingness to help (Feldman & Freedman, 2006; Ruth, Gianino, Muroff, McLaughlin, & Feldman, 2012; Sanders, Jacobson, & Ting, 2008). This research paper will provide a critical literature review of social workers' interventions with suicidal people.

For the purposes of this research, as O'Corroll et al. outline, the term *suicidal person* will be used to define a person engaging in "self-inflicted fatal injury with the intent to kill oneself [or] suicide-related behaviour [...] as suicidal ideation or nonfatal self-inflicted injury with the intent to kill oneself" (as cited in Joe & Niedermeier, 2006, p. 3). Because the term *suicide* has often been conceptualized as a problem that needs to be fixed and as an irrational action, it has negative and stigmatizing connotations (Baril, 2020). In an attempt to eliminate these negative connotations, this research will refer to various forms of the word *suicide* to positively reclaim the term and destigmatize suicidality (Baril, 2020).

The Research Problem

Billions of dollars have been invested in suicide prevention strategies to encourage people to “reach out and speak out” (Baril, 2020, n.p.). Therefore, one would assume that current practices offer opportunities to express suicidal thoughts. However, people are suffering in silence and dying by suicide because of lack of effective intervention (Baril, 2018; Jenkins & Kovess, 2002). Many people with suicidal thoughts express the need to be heard but are often denied a safe space to express these feelings and thoughts (Stefan, 2016). Too often, when individuals speak about their suicidal thoughts, they are arrested, institutionalized, and/or medicalized against their will (Baril, 2017; 2020). Current global suicide rates lead us to ask the following questions: Are we effectively providing opportunities for people to talk about their suicidal thoughts? Do suicidal people feel safe to express their desires to die (Baril, 2018; Szasz, 1999)? I believe that commonly used current practices related to suicide are preventing social workers from engaging in interventions that allow people with suicidal ideation to safely express their thoughts.

Therefore, in this text, I ask the following research question: Which intervention strategies do social workers in Canada employ with suicidal people and what impacts do these strategies have on suicidal people? In order to guide my research question, my objectives are to 1) identify various interventions by social workers when dealing with people who express suicidal thoughts; 2) analyze the impacts of those interventions on suicidal people with a critical perspective and; 3) provide recommendations for alternative interventions and practices.

Research Contributions

This research contributes to social work by highlighting the lack of effective training courses and workshops for social workers working with suicidal people (Corrigan, 2004; Schmitz et al., 2012). Healthcare professionals, such as social workers, have indicated they lack adequate

suicide-related training and education (Ruth, Gianino, Muroff, McLaughlin, & Feldman, 2012; Schmitz et al., 2012). If professionals lament their lack of effective training, how can they be well-placed to help suicidal people? Providing effective and rigorous suicide and suicide prevention training may equip social workers and healthcare professionals to better intervene with suicidal people. Therefore, social workers need to receive adequate suicide-related training and education in order to provide suicide-related training and education.

This research helps to fill the gap of little available data on providing safe opportunities for people to express their suicidal intentions, as highlighted by Baril (2017; 2020) and Stefan (2016). For example, little research exists to determine the effectiveness of hospitalizing or institutionalizing suicidal individuals (Stefan, 2016). Furthermore, Stefan (2016) indicates that research related to mental illness and suicide is based on “bad science” (p. 67), indicating that, based on psychological autopsies, 90% of people who have completed suicide in North America had some form of mental illness, statistics that are unreliable. In many cases, a mental illness diagnosis is made by healthcare professionals after the person has died by suicide based on interviews with the person’s family and friends (Stefan, 2016). Even if the person was never diagnosed or treated for mental health problems, they are often still considered to have had a mental illness when they died by suicide (Stefan, 2016). Even if the person did have a mental health problem, whether they had a mental illness remains uncertain among healthcare professionals (Stefan, 2016). Therefore, more scientific research is needed to understand the underlying causes of suicide and the perspectives expressed by suicidal people themselves. This research paper gives space to their voices through some of their testimonials in scientific and grey literature.

At the social level, suicidal people, social workers, and society in general may benefit from policies and procedures that offer opportunities for more humane approaches (Baril, 2018).

Baril (2018) suggests a harm reduction approach to suicidal policies and procedures, moving away from the medical model's primary principle of healing individuals and toward finding alternative ways to relieve the suffering of suicidal people. This research may be relevant in providing suicidal people with compassionate and supportive interventions, as described by Baril (2017; 2020).

In order to achieve the previously mentioned objectives, the **first chapter** presents the theoretical frameworks and methodology of this research. I will present the theoretical frameworks of epistemic injustice and suicidism to indicate their pertinence to the realities of suicidal people. More specifically, I will draw on the concepts of hermeneutical marginalization and testimonial smothering from the framework of epistemic injustice, and the concepts of silencing suicidal people and compulsory liveness from the framework of suicidism. These frameworks will serve as a basis for critically reviewing the interventions of social workers in Canada with suicidal people and the experiences of suicidal people with current suicide prevention practices. In order to respond to my research question regarding the intervention strategies employed by social workers in Canada with suicidal people, as well as their impacts, my methodology employs a critical literature review of suicide interventions and the experiences of suicidal people with these interventions. The **second chapter** presents a review of social workers' intervention strategies with suicidal people. This chapter critically reviews social workers' experiences, the social work code of ethics, and social workers' training and interventions, including community-based interventions, dialectical behaviour therapy (DBT), cognitive behavioural therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), and Applied Suicide Intervention Skills Training (ASIST). The **third chapter** presents a critical review of the impacts of social workers' interventions with suicidal people. This chapter reviews the negative impacts of suicide intervention strategies on people who are suicidal, while

also reviewing strategies that have been deemed more effective. Essentially, testimonies from suicidal people and scientific evidence have indicated that society needs to establish suicide interventions that differ from the ones commonly practiced. The **fourth chapter** proposes recommendations for alternative and practical intervention strategies for suicidal people.

Fundamentally, social workers have expressed feeling unprepared when encountering suicidal people and suicidal people have expressed feeling that their needs are left unmet by commonly used suicide prevention interventions. Therefore, this chapter makes recommendations for various sectors in relation to suicidality, including the field of social work, government, and health and community service sectors.

CHAPTER 1 – THEORETICAL FRAMEWORKS AND METHODOLOGY

1.1. Suicide and its Conceptualizations: Historical Background

Historically, suicide has been portrayed as a sin, an abnormality, a form of self-murder, a crime, and, currently, as a mental health problem. It has also been conceptualized through medical, social, and biopsychosocial models of suicidality, which all represent suicide as a problem that needs to be fixed (Baril, 2020). Philosophers, such as Socrates, Aristotle, and Plato, believed that “man was the property of gods: Without their permission, self-killing was wrongful” (Szasz, 1999, p. 10). If an individual “self-killed,” then, according to Plato, their punishment should be that “the graves of such as perish [...] they must be buried ignominiously in waste and nameless spots [...] and the tomb shall be marked by neither headstone nor name” (Szasz, 1999, p. 11). Historically, Christians considered suicide a sin, meaning those who completed suicide were forbidden burial in a Christian cemetery (Gearing & Lizardi, 2009). Even Immanuel Kant agreed that suicide was impermissible and abnormal, despite his belief in the “freedom of condition of life” (Szasz, 1999, p. 14). Throughout the eighteenth, nineteenth, and most of the twentieth century, suicide and suicide attempts were generally treated as crimes (Gearing & Lizardi, 2009; Szasz, 1999). Suicidal people were considered a danger to themselves and to others (Szasz, 1999). When suicide attempts failed, suicidal people were brought to trial, fined, put on probation, imprisoned, or even condemned to death by hanging (Szasz, 1999). Previously seen as a sin and a crime, suicide then became seen as a sign of illness, madness, or insanity (Baril, 2020; Szasz, 1999). Currently, in Western culture, suicidal people are most often treated as having a mental illness (Baril, 2020; Borecky, Thomsen, & Dubov, 2019; Britton, Patrick, Wenzel, & Williams, 2011; Stefan, 2016).

Today, multiple conceptualizations of suicide exist, including medical, social, and biopsychosocial models to theorize suicidality, which each offer different perspectives on mental

health problems and suicide. The medical model presents people with mental illness and disabilities as being in need either of rehabilitation or cure in order to be “normal” (Baril, 2018; Dewsbury, Clarke, Randall, Rouncefield, & Sommerville, 2004; Shyman, 2016). The medical model conceptualizes suicide as “an individual pathology to be cured with drugs or various therapies” (Baril, 2020, n. p.). Although the social model of suicide tends to focus less on individual pathology and more on social and structural issues, it upholds the idea of suicide as a pathological problem, similar to the medical model of suicide, and situates this pathology in the social realm (Baril, 2020). Finally, the biopsychosocial model highlights the importance of considering “biological, psychological, social, environmental and cultural factors” (World Health Organization, as cited in Baril, 2020, n. p.) to conceptualize suicide. The intent of the biopsychosocial model is to present illness and health as the result of interactions between an individual’s biology, psychology, and social factors (Wade & Halligan, 2017; Alonso, 2004). A commonality of all three models, which attempt to conceptualize suicide, is the notion that suicide is a pathology, be it physiological, social, etc., and suicidal people need to be fixed (Baril, 2020). The current models adopt a posture of suicide prevention and perceive suicide as being bad, never as a solution. As a result, the current models and “their unilateral negative perception of suicidality prevents suicidal people from reaching out and talking about their suicidal ideations” (Baril, 2020, n. p.) Preventing suicidal people from reaching out and talking will be further explored in the discussion of the theoretical framework of suicidism, as well as throughout this research paper.

To summarize, suicide has historically been cast in a very negative light: from sin to crime to an individual pathology. Most conceptualizations of suicide portray it as something extremely negative to be avoided at all costs. In the next section, I will present theoretical

frameworks that will allow me to conceptualize suicide and suicidal people through a less stigmatizing lens.

1.2.Theoretical Frameworks

First, I focus on the theoretical framework of epistemic injustice to analyze forms of violence committed against people in their capacity as knowers, which will be useful for analyzing suicide, as Baril (2020) points out. Second, I explore the theoretical framework of suicidism, which challenges current practices related to suicide commonly used by social workers, allowing for a detailed analysis of suicidal people's realities. The relevance of these theoretical frameworks to this research will further be elaborated later in this chapter.

1.2.1. Epistemic injustice: History and definition

Several concepts from the theoretical framework of epistemic injustice will guide my critical literature review, in order to respond to the research question: Which intervention strategies do social workers in Canada employ with suicidal people and what impacts do these strategies have on suicidal people? The notion of *epistemic injustice* was developed by Miranda Fricker (2007) in her book, *Epistemic Injustice: Power and the Ethics of Knowing*, to explain the extent to which an individual's knowledge is undermined by their social identity. As such, interpretation of information provided by individuals depends on their perceived credibility (Crichton, Carel, & Kidd, 2017). Those who are perceived through negative stereotypes and prejudices are often seen as lacking credibility (Crichton et al., 2017; Fricker, 2007). Two main forms of epistemic injustice exist: testimonial injustice and hermeneutical injustice (Fricker, 2007). In her book, Fricker (2007) explains that testimonial injustice "occurs when a prejudice causes a hearer to give a deflated level of credibility to a speaker's word" (p. 1), providing the example of the police not believing a Black person due to prejudices often held about Black people. Following the same train of thought, some authors, such as Baril, argue that testimonial

injustice occurs with respect to people who are suicidal. Often, suicidal individuals' expressions are perceived as irrational because people with mental health problems are seen to lack credibility and their pain is seen as illegitimate (Baril, 2017, 2020; Crichton et al., 2017). Whereas hermeneutical injustice "occurs at a prior stage, when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker, 2007, p. 1). Here, Fricker (2007) provides the example of sexual harassment, explaining that, in cultures where concepts of sexual harassment do not exist, the social experience of individuals might be obscured. Suicidal people are subject to hermeneutical injustice due to the lack of "easy access to the theoretical tools needed to understand and explain their oppression" (Baril, 2020, n. p.). Therefore, like Baril, I argue that suicidal people are subject to both forms of epistemic injustice, in addition to hermeneutical marginalization and testimonial smothering, concepts defined in the following sections.

1.2.1.1. Hermeneutical marginalization

In order to have a better understanding of the concept of *hermeneutic marginalization*, we must define each word separately, allowing for a concise and clear connection between hermeneutical marginalization and the experiences of suicidal people. *Hermeneutics* is defined as "the interpretation of all human acts [...] and the interpretation of a human life" (Inwood, 1998, n. p.). The word *hermeneutical* refers to social interpretation (Fricker, 2007), while *marginalization* "refers to the processes by which individuals or groups are kept at or pushed beyond the edges of society" (Dean, 2007, n. p.). Thus, hermeneutical marginalization refers to individuals belonging to disadvantaged groups experiencing "the injustice of having some significant area of one's social experience obscured from collective understanding" (Fricker, 2006, p. 99). Furthermore, hermeneutical injustice can potentially lead to hermeneutical marginalization due to individuals lacking equal opportunities "to build knowledge [...] because

they are excluded (or their opinion and ideas are less valued) from certain forms of employment and knowledge building communities” (Baril, 2020, n. p.). More specifically, Baril (2020) indicates that suicidal people do not have equal opportunities to build knowledge about the forms of oppression and discrimination they often experience because their opinions and ideas are excluded from building knowledge, such as in the fields of suicidology and critical suicidology. Therefore, we can imagine the extent to which suicidal people are subject to hermeneutical marginalization. Suicidal people’s experiences and knowledge about suicide are ignored, which further perpetuates the inaccessibility of suicidal people “to the conceptual tools to interpret suicidism as a form of oppression and violence” (Baril, 2020, n. p.).

1.2.1.2. Testimonial smothering

Dotson (2011) first coined *testimonial smothering* to identify the extent to which individuals can be coercively silenced. In order to convey complex social testimonies, individuals modify their statements to be more acceptable and to avoid negative reactions from the audience they are addressing. Dotson (2011) identifies three circumstances in which testimonial smothering may occur:

- 1) The content of the testimony must be unsafe and risky; 2) the audience must demonstrate testimonial incompetence with respect to the content of the testimony to the speaker; and 3) testimonial incompetence must follow from, or appear to follow from, pernicious ignorance. (p. 244)

Testimonial smothering is a form of epistemic violence because it coercively self-silences people, which is especially apparent with suicidal people, as argued by Baril (2020). Examples of these forms of testimonial smothering can be found in this suicidal person’s testimony:

I have been smart enough to talk my way out of that when they want to civilly commit me. You sit down, you shut up and you don’t act out. You explain you understand their concerns and you apologize for having been so upset. I understand the police officer is doing his duty. As long as you’re incredibly reasonable, they will eventually go away. Everyone is entitled to a moment of emotional outburst, but you have to check yourself pretty fast. (Suicidal participant, as cited in Stefan, 2016, p. 174)

In reading this testimony, you may presume the person is afraid the police officer will detain them for acting in what is perceived to be an unacceptable manner. Furthermore, if a police officer is present, we may also presume that they have judged the situation and the person to be a potential danger, stemming from prejudices held about people with mental health problems, including suicidal people (Baril, 2018, 2020). Such prejudices often stem from ignorance. Therefore, suicidal people experience some forms of testimonial smothering and, as a result, may be coerced and reduced to silence.

1.2.2. Suicidism: History and definition

Providing the history and definition of the theoretical framework of suicidism will help us better understand the lived experiences of suicidal people, as well as the need for alternative practices and interventions related to suicide. Alexandre Baril (2017, 2018, 2020) developed the term *suicidism* to describe the oppression that suicidal people experience. Within this theoretical framework, suicidal people experience forms of oppression based on sanist, ableist, and paternalistic approaches to suicidality, oppressions that may be structurally and collectively experienced in society (Baril, 2017, 2018, 2020). Sanism is a form of oppression that contributes to negative stereotypes and/or arguments related to mental health (Baril, 2017). Baril (2017) and Stefan (2016) argue that this form of oppression considers suicidal people mentally incompetent and categorizes them as being delusional, impulsive, or irrational. Ableism refers to the negative stereotypes attributed to people with disabilities, as well as the forms of oppression they experience (Bogart & Dunn, 2019). As Baril (2020) explains,

suicidism is intertwined in forms of ableism and sanism and how these interconnected oppressions function within the larger apparatus of biopower that deploys an injunction to live for subjects deemed "redeemable." In other words, if a person is considered "salvageable," i.e., non-disabled from an ableist point of view, all efforts should be taken to save their life, even if such efforts involve forms of coercion (e.g., forced treatments and institutionalization). (n. p.)

Baril (2017, 2018, 2020) argues that sanist, ableist and suicidist viewpoints reduce suicidal people to silence. The concept of silencing suicidal people will be further elaborated in the next section, which will also include a concise definition and explanation of paternalism.

Furthermore, Baril (2020) refers to the concept of *compulsory liveness*, inspired by compulsory heterosexuality, to illustrate the norms that accompany the suicidist oppression experienced by suicidal people. According to compulsory heterosexuality, individuals may adopt heterosexuality regardless of their sexual orientation because societies perceive heterosexuality as the norm and a deviation from heterosexuality is unfavourable (Rich, 2003). Similarly, with Baril's compulsory liveness, lives are to be saved no matter the cost, while voluntary death is seen as an abnormal deviation from living. The concept of compulsory liveness is further explored below.

The theoretical framework of suicidism highlights the necessity of providing alternative ways to conceptualize the experience of suicidal people and suicidality (Baril, 2020). Baril (2020) recommends a harm reduction approach to suicide, which may be an appropriate response to suicide, using “‘suicide-affirmative’ healthcare” (n. p.). Suicide-affirmative health care may provide a safe space for people to express their suicidal thoughts, responding compassionately to people with suicidal thoughts, while providing “non-coercive approach[es] to intervene with suicidal people” (Baril, 2020, n. p.). Furthermore, after careful consideration, along with the support of healthcare professionals, family, and friends, suicide-affirmative health care “may allow a small number of suicidal people who are determined to die to be accompanied while preparing their death” (Baril, 2020, n. p.). Explaining that this harm reduction approach may allow suicidal people the opportunity “to say goodbye to their loves ones and to leave this world using less lonely and violent means than those usually employed in completed suicide”

(Baril, 2020, n. p.), Baril also argues, more importantly, that a “non-coercive suicide approach could possibly save more lives than current suicidality models and their prevention strategies” (Baril, 2020, n. p.). However, it is important to note that the theoretical framework of suicidism does not encourage suicide and supports suicide prevention strategies. Therefore, the theoretical framework of suicidism is well-suited to a critical literature review of social workers’ interventions with suicidal people. The concepts of silencing of suicidal people and compulsory liveness, using the theoretical framework of suicidism, are relevant to the research and the next sections will clarify the reasons.

1.2.2.1. Silencing of suicidal people

The epistemic violence of testimonial smothering, as well as various forms of oppression highlighted by Baril’s theoretical framework of suicidism, reduces suicidal people to silence. Importantly, several authors have started to point out that, for many reasons, talking does not feel safe for suicidal people (Borecky et al., 2019; Radford, Wishart, & Martin, 2019; Stefan, 2016; Wedlake, 2020). The notion of silencing is a central part of Baril’s theoretical framework of suicidism, within which one of the main consequences of suicidist oppression is silencing the suicidal person.

Discrimination and stigmatization, experienced when accessing health and social services, often reduce suicidal people to silence (Baril, 2017; Stefan, 2016). Many suicidal people have expressed the need to be listened to, but they are criminalized, punished, institutionalized, medicalized, and/or pathologized when they attempt to convey their thoughts (Baril, 2017, 2020; Stefan, 2016; Szasz, 1999). Ironically, campaigns such as “Bell, let’s talk” encourage people with mental health problems to reach out and talk, but people are often persecuted for expressing suicidal thoughts. Furthermore, as illustrated in Stefan’s 2016 book, *Rational Suicide, Irrational Laws: Examining Current Approaches to Suicide in Policy and Laws*, suicidal people describe

knowing what not to say to avoid coercive interventions and forms of oppression, a form of testimonial smothering that indicates the extent to which people who express suicidal thoughts need alternative interventions, different than those currently practiced by healthcare professionals in Canada.

Also, suicidal people are often subjected to paternalistic practices by those in authority, such as social workers. Paternalism refers to people in authority depriving others, including suicidal people, of their civil liberties and responsibilities for the supposed well-being and best interests of society, institutions, and individuals themselves. However, Baril (2018), Stefan (2016), and Szasz (1999) argue that although paternalists claim to be looking out for the well-being and best interests of suicidal people, they are in fact trying to better control them. Paternalistic practices contribute to oppressing suicidal people, determining whether their pain is legitimate or illegitimate, and placing people in authority in positions to decide and even impose what they think is best for others, disregarding the voices of suicidal people. Furthermore, suicide has been treated as a symptom of mental health disorders by paternalistic viewpoints that determine the best course of action for suicidal individuals, imposing the will to live, and silencing suicidal people's desires to die (Baril, 2018). The negative impacts of paternalistic practices reduce suicidal people to silence. In order to help suicidal people with their feelings of distress and pain, we need to create more awareness of suicide and eliminate the existing stigmatizing and discriminating discourse, as well as provide suicidal people with a safe space to express their suicidal thoughts, which may encourage people to reach out and talk (Baril, 2020; East, Doronzenko, & Martin, 2019; Mishna, Antle, & Regehr, 2002; Radford et al., 2019; Stefan, 2016; Wedlake, 2020). In sum, suicidism as a theoretical framework shows the extent to which non-suicidal people decide what is best for suicidal people, excluding and rejecting their "voices, perspectives, needs and claims" (Baril, 2020, n. p.).

1.2.2.2. Compulsory liveness

Baril (2020) explains that “compulsory liveness aims to impose on everyone a will to live and makes the desire/need for death of some people abnormal, unconceivable and unintelligible, like suicidal subjects themselves” (n. p.). Several authors, such as Radford et al. (2019) and Martin (2011), indicate that suicide prevention strategies are often focused on saving lives at all costs. This logic of saving everyone’s lives is founded on compulsory liveness. Baril (2020) explains that non-suicidal people believe that suicidal people want to be like them: people who want to live while enjoying life. In fact, some suicidal people disagree with an assumption non-suicidal people may make that all people have a will to live (Baril, 2020). Baril (2020) refers to an analogy about Deaf people. Mainstream society seeks to cure them, often failing to acknowledge what Deaf people are seeking. Although some Deaf people would like to be “cured,” society fails to consider their needs from their perspectives and experiences, such as developing their own cultural identity, language, and participation in society (Malebranche, Morisod, & Bodenmann, 2020). With respect to suicidal people, is it not possible that they genuinely want to die? Can suicide not be an acceptable solution? But, instead, according to Baril (2020), solutions are “devised by the majority of people who don’t experience [suicidal people’s] realities but who nevertheless believe that they have the best solutions to offer” (n. p.). Similar to the sexist norms regarding being a man or a woman typically imposed by society, including on cultural, economic, political and legal levels, compulsory liveness is the norm of the suicidist system of oppression. Within a suicidist system, people must abide by the norms of living or dying, much like the sexist norms for women and men.

1.3.Theoretical Frameworks: Relevance to this Research

Evidence suggests that suicidal people experience various forms of epistemic injustice, as people expressing emotional pain and distress are often not seen as credible (Baril, 2020; Crichton et al., 2017; Wedlake, 2020). Questioning and diminishing the level of credibility of what is being communicated by suicidal people is a form of epistemic injustice (Crichton et al., 2017). More specifically, as previously stated, suicidal people are subject to particular forms of epistemic violence, such as hermeneutical marginalization and testimonial smothering. Suicidal people are not considered knowers of their own experiences and often avoid disclosing information for fear of being criminalized, punished, institutionalized, medicalized, and pathologized (Baril, 2017, 2018, 2020; Stefan, 2016).

Also, sanism, ableism, and paternalism are just a few of the forms of oppression that suicidal people experience (Baril, 2020; Wedlake, 2020). As previously stated, suicidism describes the oppression to which suicidal people are subject, and they may be reduced to silence to avoid the impact of various forms of oppression. Also, non-suicidal people determine that living must be made a priority for suicidal people, which undermines the latter's realities.

For these reasons, theoretical frameworks of epistemic injustice and suicidism are well-suited to this research. These theoretical frameworks will provide a critical lens through which to review the intervention strategies with suicidal people used by social workers in Canada and their impacts on suicidal people.

1.4. Methodology: Critical Literature Review

The methodology of this research is based on a critical review of literature about the intervention strategies used with suicidal people by social workers in Canada and their impacts on suicidal people. The critical literature review was conducted using Google, Google Scholar,

and the University of Ottawa's library database. To identify literature relevant to this research, the following keywords (used in diverse combinations) were used:

- suicide
- suicidal people
- suicidality
- social work
- social worker
- intervention
- malpractice
- mental health
- training
- education
- recommendation

Since suicidality has been a controversial and complex subject for hundreds of years, the publication years of the materials used for this research vary, ranging from 1995 to 2021, to illustrate the longstanding history of oppression endured by suicidal people in contemporary Canadian society. However, materials that did not contain information about healthcare professionals' experiences with suicidal people, as well as articles that did not contain information about suicidal people's experiences, were excluded. Relevant materials were also found using the reference lists of other articles. In order to expand the research, French-language materials were also included, which allowed for additional depth in this critical review. However, the research was primarily conducted using English-language materials. Relevant materials were

chosen after reading the abstracts and titles, retaining a total of 110 for a thorough reading. Of the materials determined to be relevant, 77 were retained for the purposes of writing this dissertation.

1.5. The Researcher's Position in Relation to the Research Subject

As a future social worker, I recognize that I will be in a position to be perceived as having authority over my clients and must keep in mind the potential implications for people expressing suicidal thoughts. To be honest, I do not feel prepared to work with people who express suicidal thoughts. I have received approximately three hours of suicide education through my master's program in social work, which is clearly not enough, and here I also speak for other social workers who have described receiving little or no suicide-related training and education and who feel unprepared, as documented by numerous authors (Feldman & Freedenthal, 2006; Joe & Niedermeier, 2006; Maple, Pearce, Sandford, & Cerel, 2011; Ruth et al., 2012; Sanders, Jacobson, & Ting, 2008; Schmitz et al., 2012). I have already been in situations where a person expressed suicidal thoughts and I found myself questioning my intervention and approach. Often, I fear making the wrong decision and being held responsible. Other times, I am afraid that I did not welcome what the person expressed with enough compassion. Although this research has provided me with profound knowledge about suicidal people's experiences, as well as about the system's failure to train and educate social workers, I still feel I lack certain skills when working with suicidal people. However, one skill that I have been practicing with whomever I encounter is understanding people's realities from their perspective without minimizing what they are expressing. This skill promotes epistemic justice. Recognizing that an individual's pain and suffering are real and empathizing with them is an important part of social work as a whole. Although I too often feel unprepared when working with suicidal people, I can advocate for their rights, while acknowledging that my experiences differ from theirs. I hope that the chapter on

recommendations may be a starting point for alternative interventions for suicidal people, including meeting their individual needs when they seek mental health services.

CHAPTER 2 – SOCIAL WORKERS’ INTERVENTION STRATEGIES WITH SUICIDAL PEOPLE IN CANADA

Social workers encounter people with suicidal thoughts in a variety of settings, such as in general and psychiatric hospitals, at universities, on school boards, in correctional institutions, through children’s aid services, family agency services, and in long-term care homes (Canadian Association of Social Work, n. d.; Feldman & Freedenthal, 2006; Joe & Niedermeier, 2006; Mishna, Antle, & Regehr, 2002; Maple, Pearce, Sandford, & Cerel, 2017; Ruth, Gianino, Muroff, McLaughlin, & Feldman, 2012; Sanders, Jacobson, & Ting, 2008; Schmitz et al., 2012; Ting, Jacobson, & Sanders, 2011). In addition, “social workers [...] come into contact with those at risk of, or exposed to, suicide on a regular basis, either in direct client practice or indirectly through advocacy, health promotion, and policy work” (Maple et al., 2017, p. 1). In a study conducted by Feldman and Freedenthal (2006), more than 90% of social workers described working at some point with at least one individual who had suicidal thoughts (p. 470). Furthermore, a study conducted by Sanders et al. (2008) indicated that 55% of social workers had worked with a person who had attempted suicide and 31% had a client who completed suicide (p. 1). Therefore, the extent to which social workers are exposed to working with suicidal people and suicide is evident. Not only do they often encounter suicidal people, but they are also indirectly exposed to suicide. In the following pages, I will review a variety of experiences social workers have with suicidal people and suicidality in relation to their fear of malpractice, to the social work code of ethics, and to suicide-related training and education. I will then review various types of social work intervention strategies.

2.1. Social Workers' Experiences when Dealing with Suicidal Individuals

Social workers have expressed difficult feelings when encountering suicidal people. Social workers, as well as social work students, often feel fearful about working with suicidal people, and describe feeling stressed after encountering an individual's suicidal behaviours, even feeling hatred toward the suicidal person. In a study by Ruth et al. (2012), social work students conveyed that working with clients wanting to kill themselves was their biggest fear. Also, "clients' suicidal feelings [...] arouse anxieties and fear in [social work] clinicians" (Feldman & Freedenthal, 2006, p. 468). In addition, social workers stated they felt fearful of being "professionally judged" (Ting et al., 2011, p. 328) following the suicide of an individual. Consequently, social workers' feelings of fear may interfere with their interactions with suicidal people.

Stress is another feeling evoked by social workers due to their experiences with suicidal people. A person's suicide attempt or suicide is considered one of the most stressful experiences a mental health professional will encounter (Feldman & Freedenthal, 2006; Ting et al., 2011). Despite the passing of time, the stress they experience "can have long-lasting negative effects" (Ting et al., 2011, p. 333). Social workers' stress levels were higher in the immediate aftermath of encountering an individual's suicidal behaviour than with respect to such behaviour encountered years previously (Ting et al., 2011). Also, social workers' stress levels are higher when experiencing a person's suicide rather than a person's suicide attempt (Sanders et al., 2008). Social workers who had recently encountered an individual's suicidal behaviour reported feeling stressed about "dealing with factors associated with professional competence, legal ramifications, and job security" (Ting et al., 2011, p. 332). Much like their fear of encountering suicidal people, social workers' stress interferes in their interactions with suicidal people (Ting et al., 2011).

Finally, social workers have expressed feelings of anger when working with suicidal people. Similar to stress levels, social workers experienced increased anger when an individual completed suicide compared to when an individual attempted suicide (Ting et al., 2011). The anger felt by social workers after experiencing an individual's suicide is similar to that felt after other traumatic deaths, involving a bereavement process (Ting et al., 2011). Social workers reported needing specific training to cope with individuals' suicidal behaviours (Sanders et al., 2002). They expressed feeling that their unmet personal and professional needs interfered in their interactions with suicidal people (Sanders et al., 2002; Ting et al., 2011). Coping skills may potentially help social workers deal with their feelings of fear, stress, and anger, positively impacting their interactions with suicidal people.

2.2. The Fear of Malpractice in Interventions with Suicidal People

Before reviewing the subject of social workers' fear of malpractice when encountering suicidal people, I will define and explain liability and malpractice, allowing for a clear and concise understanding, including a social worker's responsibilities when encountering suicidal people. In addition, the impacts of social workers' fear of malpractice when working with suicidal people will be presented, to illustrate the oppression that suicidal people experience.

The healthcare liability system has three functions: to "compensate patients injured by negligence, promote corrective justice by providing a mechanism to rectify wrongful losses caused by defendants, and deter negligence" (Mello, Frakes, Blumenkranz, & Studdert, 2020, p. 352). The notion is that liability contributes to making health care safe and that the possibility of being accused of malpractice will change healthcare professionals' behaviours (Mello et al., 2020). In the United States, healthcare professionals can be held liable for malpractice when an "act or omission by a [healthcare professional] during treatment of a patient [...] deviates from accepted norms of practice in the medical community and causes an injury to the patient" (Bal,

2009, p. 340). In the United States, if negligence of the injured person is established, they often receive monetary compensation (Bal, 2009). In Canada, healthcare professionals can be held liable for medical malpractice if the plaintiff demonstrates “a legal duty of care, a breach of a legal standard of care, injury or loss to a plaintiff that was caused by the breach, and damage not too remote to be recoverable in the law” (Flood & Thomas, 2011, p. 1071). Like in the United States, monetary compensation is also awarded to the plaintiff if negligence is established in Canada. However, the avenue by which compensation is received differs (e.g., private insurance companies, the Canadian Medical Protective Association) (Flood & Thomas, 2011). While the notion of liability exists to make health care safer, fear of liability may have a negative impact on the effectiveness of social workers’ interventions with suicidal people (Stefan, 2016).

Social workers must often make subjective decisions with respect to what they think is best for an individual seeking mental health services. Although the role of a social worker is to help an individual based on what the individual thinks is best for them, at times, social workers are required to follow a set of rules and requirements in order to ensure people’s safety. Social workers may be held liable for malpractice when considered to have “failed to carry out a duty that he or she is ordinarily expected to carry out according to the profession’s standard of care [...] includ[ing] [...] failure to prevent a client’s suicide” (Reamer, 1995, p. 596). Therefore, failure to take every measure to prevent a person’s suicide is considered malpractice (Martin, 2011; Mishna et al., 2002; Szasz, 1999), one of the top reasons for malpractice suits filed against mental health professionals. Stefan (2016) indicates that healthcare professionals are fearful of being held liable for malpractice when working with suicidal people. Healthcare professionals such as social workers “frequently express worry about [...] legal consequences after a client has died by suicide” (Feldman & Freedenthal, 2006, p. 468). Therefore, we may presume the extent

to which social workers are held responsible for the decisions made when working with suicidal people.

The fear of malpractice impacts social workers' interventions and practices with respect to suicidal people in three ways. First, this fear may lead to dismissing suicidal people and referring them to other healthcare professionals and services. As Stefan (2016) explains, there are "benefits in limiting liability of mental health professionals for the suicide of their [patients, including that] it will reduce existing perverse incentives for mental health professionals to cherry-pick the healthiest and least suicidal [patient]" (p. 276). This statement suggests that social workers often dismiss suicidal people in favour of those who are not perceived to be suicidal and avoid instances where they may be held liable for suicide. Stefan (2016) mentions that suicidal people often describe difficulties in finding mental health professionals to help them, which may be a result of a mental health professional wanting to avoid being accused of malpractice. Also, social workers' fear of liability may lead to "over-hospitalization of people who talk about being suicidal" (Stefan, 2016, p. 274), suggesting that hospitalization protects social workers from being liable if ever the person completed suicide. Second, the fear of malpractice experienced by social workers often results in a failure to provide safe opportunities for suicidal people to express their desire to die. As previously mentioned, suicidal people may know what not to say to prevent coercive interventions (Baril, 2017; Martin, 2011; Stefan, 2016). In order to ensure people's safety and avoid accusations of malpractice, healthcare professionals, such as social workers, must follow policies and procedures that often involve coercive interventions (Martin, 2011; Stefan; 2016). For example, in September 2019, a student seeking help for suicidal thoughts through the University of Toronto's mental health services was handcuffed, institutionalized, and medicalized against her will because healthcare professionals and campus police had to follow university protocol and procedures (King, 2019).

Therefore, as a result of social workers' fear of malpractice, which is guided by policies, suicidal people often practice self-silencing to avoid being handcuffed, institutionalized, and medicalized against their will (Baril, 2020; East, Dorenzenko, & Martin, 2019; Radford, Wishart, & Martin, 2019; Szasz, 1999). Third, fear of malpractice hinders the therapeutic relationship between the social worker and the suicidal individual. Since suicidal people are often fearful of disclosing their desire to die, healthcare professionals are in a position of control (Stefan, 2016). However, when a suicidal individual expresses their desire to die, which is then disclosed without consent, resulting in coercive intervention, they may be more reluctant to seek mental health services in the future (Stefan, 2016). Stefan (2016) suggests "limiting liability of mental health professionals for suicide" (p. 276) to help them engage in suicide-related interventions and practices without fear of malpractice. More specifically, limiting social workers' liability for suicide may help avoid the dismissal of suicidal people, provide them with a safe space to express their suicidal thoughts, and favour a positive therapeutic relationship.

2.3. Social Work Code of Ethics and Ethical Practice

In Canada, registered social workers must abide by the Canadian Association of Social Workers (CASW) code of ethics and guidelines for ethical practice. Social workers' practices are guided by the ethical values and principles espoused by the CASW. Therefore, when working with suicidal people, social workers' decisions and practices are guided by these values and principles, which may make it difficult for social workers to determine the right course of action for suicidal people. At times, social workers' personal values and their desired intervention with suicidal people contradict with the values and guidelines espoused by the CASW.

The CASW code of ethics (2005a) stipulates social workers must "respect [...] the inherent dignity and worth of persons [...] by [upholding] each person's right to self-determination" (p. 4). However, "social workers uphold the right of society to impose limitations

on the self-determination of individuals, when such limitations protect individuals from self-harm and from harming others” (CASW, 2005a, p. 5). On the one hand, social workers must ensure that an individual’s right to self-determination is respected but, on the other hand, they can impose limitations on such a right in case of suicidality. Self-determination may reduce psychologically distressful feelings, increase the desire to live, and motivate willingness for treatment for suicidal people (Britton, Patrick, Wenzel, & Williams, 2011). However, Britton et al. (2011) and Mishna et al. (2002) indicate that, when assessing suicidal behaviours, healthcare professionals, such as social workers, may deprive individuals of the right to self-determination in an attempt to help. Depriving suicidal people of their right to self-determination “conflict[s] with social workers who were trained to give clients full self-determination in making treatment decisions” (Sanders et al., 2008, p. 14).

Also, the CASW code of ethics (2005a) stipulates social workers must respect “confidentiality in professional practice, [which] does not apply when disclosure is necessary to prevent serious, foreseeable imminent harm to a client or others” (p. 7). However, when a person expresses their desire to die, there “are no clear guidelines regarding [social workers’] permission to disclose” (Mishna et al., 2002, p. 273) confidential information. Disclosing confidential information may have a very negative impact on the therapeutic relationship between a social worker and the suicidal person, which may potentially contribute to suicidal people avoiding seeking mental health services in the future (Stefan, 2016). Also, social workers’ disclosing an intent to die without permission often involves reporting it to the police and emergency department, which can be a very traumatic experience for suicidal people (Kumbhare, 2020; Stefan, 2016; Baril, 2020). Therefore, social workers make decisions regarding the limitations of confidentiality based on contradictory guidelines, which may do more harm than good.

Finally, the code of ethics (2005a) stipulates that “social workers respect a client’s right to competent social worker services” (p. 8). Therefore, social workers must determine their level of competence when working with suicidal people (Mishna et al., 2002; Schmitz et al., 2012). Competence is defined by Quineet as a clinician’s capacity to conduct:

...[a] one-to-one assessment/intervention interview between a suicidal respondent in a telephonic or face-to-face setting in which the distressed person is thoroughly interviewed regarding current suicidal desire/ideation, capability, intent, reasons for dying, reasons for living, and especially suicide attempt plans, past attempts and protective factors. The interview leads to a risk stratification decision, risk mitigation intervention and a collaborative risk management/safety plan, inclusive of documentation of the assessment and interventions made and/or recommended. (as cited in Schmitz et al., 2012, p. 294)

In order for social workers to be considered competent when working with suicidal people, they presumably must meet the expectations mentioned above. I use the word *presumably* because this research will review some of the aforementioned interventions. However, evidence has suggested “that there has been negligible progress in improving the competence of mental health professionals [such as social workers] in evaluating, managing, and treating suicidal patients” (Schmitz et al., 2012, p. 296). Social workers’ training on suicide will be reviewed in the next section.

The social work code of ethics (CASW, 2005a) and guidelines for ethical practice (CASW, 2005b) present many contradictions, which make it difficult to determine the right course of action for social workers (Mishna et al., 2002; Kim & Stoner, 2008). Although social workers must follow ethical guidelines by respecting the self-determination of people they work with, Mishna et al. (2002) and Stefan (2016) indicate that healthcare professionals must strip people of that right when they express their desire to die. Stripping suicidal people of their fundamental rights is considered a form of suicidism based on the values anchored in compulsory liveness. Furthermore, Mishna et al. (2002) explain that the circumstances in which social workers can disclose confidential information when individuals express their desire to die are

unclear. Finally, I ask: Is social workers' current level of competence sufficient and adequate when working with suicidal people? Or is more suicide-related social work training required?

2.4. Social Work Training on Suicide

Maple et al. (2017) and Ruth et al. (2012) indicate that social work literature on suicide practices and interventions remains sparse, despite social workers' frequent encounters with suicidal people. What remains limited is "social work research on knowledge that guides and directs social work practices through testing and evaluation of the efficacy of suicide prevention strategies, intervention, and postvention" (Maple et al., 2017, p. 6). Also, Ruth et al. (2012) indicate that "the relative lack of social work literature on suicide occurs in the larger context of suicide prevention and intervention research, which remains underdeveloped across the helping professions" (p. 503). Research about suicide-related clinician education remains largely conducted by psychologists and psychiatrists, but not by social workers (Ruth et al., 2012). Although strong consensus exists among social work field supervisors on the need to teach Master of Social Work (MSW) students about suicide, they often do not feel prepared to teach them (Ruth et al., 2012). Social workers have often expressed needing additional training and education on suicide assessment (Sanders et al., 2002). For example, one social worker shared their experience of assessing their client, explaining, "My client denied suicide intent [while in session] and then left my office and hung himself in a local park" (Sanders et al., 2002, p. 11). Social workers have expressed that it is "critical that they [learn] about not only evaluating the level of lethality in the clients' statements, but also in their behaviors" (Sanders et al., 2002, p. 10). Therefore, the current lack of literature and training related to suicide about and by social workers leads us to believe that social workers are not adequately prepared to work with suicidal people due to the paucity of suicide-related information in their field.

My own experience as an MSW student is an example of this inadequate or lack of suicide-related training and education. In one of my courses, we spent three hours speaking and learning about suicide and the experiences of suicidal people. At times, we had brief conversations about suicide in some of our courses, but it was never the primary subject. Despite feeling unprepared and having had relatively no suicide-related training and education, my placement involved working with people who expressed suicidal thoughts. I have felt much of what has been previously described about suicide and toward suicidal people, such as fear of liability, anxiety, stress, and unpreparedness. I have also felt sad, worried, and incompetent, as well as questioned the effectiveness of my interventions. This next section will review social work students' and social workers' suicide-related training and education, and continuing education.

2.4.1. Social work students and training on suicide

Social work students have described receiving little or no suicide-related training and education (Feldman & Freedman, 2006; Ruth et al., 2012). Also, university professors, directors, and deans agree that students are provided with very few opportunities for suicide-related training and education (Ruth et al., 2012). MSW students receive an average of four hours of suicide-related education throughout their entire MSW program (Ruth et al., 2012). In a study conducted by Feldman and Freedman (2006), social work students described receiving fewer than two hours of suicide-related education during their studies, which for some included at least one of their courses addressing suicide at some point, while some reported receiving no suicide-related training and education at all. Social work students receiving little or no suicide-related training and education is shocking and unacceptable as they will most likely come into contact with suicidal people during their field placements and at their jobs after graduation. Also, MSW students reported receiving between two and seven hours of suicide-related training and

education during their field placements, but “it is unlikely that methods and skills training were thoroughly covered” (Feldman & Freedman, 2006, p. 474). MSW students have described “the amount of suicide education they received in their MSW program to be inadequate” (Feldman & Freedman, 2006, p. 471), also mentioning regretting not having received more suicide-related training. Even when social work students have not encountered a suicidal person, they have described feeling fearful of working with suicidal people (Ruth et al., 2012).

University professors, directors, and deans have expressed similar concerns (Ruth et al., 2012). Although the majority reported that suicide-related education was included in the MSW curriculum, they also indicated that it amounted to around four hours (Ruth et al., 2012). Overall, staff and faculty also ranked MSW students as having “moderately limited [suicide education] preparation” (Ruth et al., 2012, p. 505). Ruth et al. (2012) note, “Professors expressed concerns... [about] first-year field placements” (p. 508) because of student’s potential exposure to suicide during placement. As such, professors acknowledge that MSW students receive little and inadequate suicide-related training and education in the MSW program. However, despite acknowledging the need for more suicide-related training and education, most university professors, directors, and deans had no plan or desire to “increase suicide education in the curriculum” (Ruth et al., 2012, p. 505). When asked about the barriers to increasing suicide-related training and education, university professors, directors, and deans cited a “lack of faculty expertise [...] lack of room in the curriculum [and] other training priorities” (Ruth et al., 2012, p. 505), suggesting, I believe, that people in positions of power find excuses not to increase suicide education in the curriculum because if they truly believed it was important, then they would. Although most staff and faculty members agreed that formal suicide training and education should be explicitly included in the MSW curriculum, issues arose related to

professors' level "of comfort and expertise" (Ruth et al., 2012, p. 510). Even professors feel unprepared when addressing the subject of suicide in their courses or seminars.

With those observations, we may wonder when and where students are provided opportunities to learn about suicide and suicide interventions. One professor explains:

If they are placed in a field setting where they are required to conduct suicide assessments, they will receive some training on this issue. ...The sense that a lot of people have is that [suicide-related training is] something that you kind of pick up. (Ruth et al., 2012, p. 508)

If university professors do not have the expertise to teach MSW students about suicide and suicide intervention, maybe social workers are expected to learn on the fly. Since social workers often come into contact with suicidal people, then the inadequacy of suicide-related training and education they receive is not only unacceptable but should be reviewed, in order to make changes in areas such as, for example, the social work university curriculum. In chapter four, I will elaborate on recommendations regarding suicide-related training and education.

2.4.2. Social workers in the workplace and continuing education on suicide

Social workers are currently the "largest providers of mental health treatment services" (Sanders et al., 2008, p. 2) in North America, which makes adequate preparation of social workers to work with suicidal people and suicide-related issues essential. Providing social workers with continuing education may help prepare them to face the evolving challenges experienced by suicidal people. Continuing education can improve knowledge and skills among healthcare professionals (Nock et al., 2008; Schmitz et al., 2012; Smith, Silva, Covington, & Joiner, 2014). Scientific literature has begun to indicate that continuing suicide-related training and education can "change clinic policy, confidence in risk assessment, and confidence in management of suicidal patients" (Schmitz et al., 2012, p. 296). Among healthcare professionals, continuing education on a number of topics, such as ethics, are mandatory for remaining licensed

in their profession (Schmitz et al., 2012). Mandatory continuing education “ensures that mental health professionals are informed about [...] current issues” (Schmitz et al., 2012, p. 296). However, continuing suicide-specific education is not a requirement for licensure among healthcare professionals (Schmitz et al., 2012). Similar to continuing education on the topic of ethics for healthcare professionals, mandatory for remaining licensed in their profession, continuing suicide-related training and education should be mandatory for the same reasons. In a study conducted by Sanders et al. (2008), social workers reported needing education on “coping with suicide, assessing suicide, debriefing the suicidal behavior, [issues related] to power and control [...], and treatments for suicidal clients” (p. 9), indicating the expressed need to receive continuing suicide-related education. Although social workers often work with suicidal people, they enter the workforce “with little or no education related to suicide” (Feldman & Freeman, 2006, p. 472). Social workers in the workplace have described receiving inadequate suicide-related training and education and regret not having received more (Feldman & Freedman, 2006). Therefore, given this description of a lack of suicide-related training and education, do social workers have the necessary competency when working with suicidal people? Mishna et al. (2002) explain that “the first important guideline is that clinicians must determine their own level of competence to work with high risk clients and must ensure that they have adequate training to manage difficult situations” (p. 272), suggesting that social workers must be provided with adequate suicide-related training and education in order to gain the competence needed when working with suicidal people. Instead of feeling competent when dealing with suicidal people, social workers have described feeling “fearful, frustrated or hopeless” (Bergmans, Rowe, Dineen, & Johnson, 2016, p. 140). Therefore, social workers expressing feelings of inadequacy and a desire for suicide-related training and education indicates that they receive little or no continuing education on suicide.

Clearly, a need for adequate, sufficient, and continuing suicide-related training and education for social workers exists. Social workers and social work students have expressed feeling unprepared to work with suicidal people due to insufficient and inadequate suicide-related training and education. However, determining the ways in which this information can be transmitted is difficult. Many have expressed the need for suicide-related training and education, but nobody wants to take on the responsibility of informing social workers about the subject. Is it because suicide still remains the elephant in the room? And are we still sweeping the subject of suicide under the rug?

2.5. Various Types of Social Work Interventions with Suicidal People

Although social workers may benefit from adequate, sufficient, and continuing suicide-related training and education, they already practice a variety of interventions with suicidal people. Various interventions have been developed for working with suicidal people, including community-based interventions, dialectical behavioural therapy (DBT), cognitive behavioural therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), and Applied Suicide Intervention Skills Training (ASIST). These various interventions are briefly described below.

2.5.1. Community-based interventions

Community-based interventions involve treating and evaluating people in their respective communities and decentralizing services (Murphy, 2014). They include outpatient group programs, peer support groups, collaborative community actions, democracy, empowering individuals, broadening public awareness, and a sense of connection (Kral & Idlout, 2016; Murphy, 2014; Maple et al., 2017; Ruth et al., 2012; Stefan, 2016; Wray, Colen, & Pescosolido, 2011). With regard to suicidal people, community-based intervention “involves a public health style [...] [with] treatment approaches that focus on the suicidality itself, rather than treating the

suicidal person as mentally ill” (Stefan, 2016, p. 415). Indigenous people commonly prefer to address suicide in their community, through community-based interventions that are “built upon the notion that knowledge generation is a collaborative process in which each participant’s diverse experiences and skills are critical to the outcome” (Kral & Idlout, 2016, p. 236). Community-based interventions by Indigenous people have similar notions and approaches to those used by non-Indigenous communities (Murphy, 2014).

2.5.2. Dialectical Behaviour Therapy (DBT)

Dialectical behaviour therapy (DBT) is an evidence-based approach commonly used to treat suicidal people with multiple mental health disorders (Linehan et al., 2015). DBT is a multicomponent treatment, which includes “individual therapy, group skills training, between-session telephone coaching, and a therapist consultation team” (Linehan et al., 2015, p. 476), but is often offered using only a single component, such as, for example, group skills training. DBT is comprised of a combination of elements from cognitive behavioural therapy (CBT) and mindfulness techniques to help individuals “develop skills in emotion regulation, interpersonal effectiveness, and distress tolerance” (D’Anci, Uhl, Giradi, & Martin, 2019). The focus is on the individual’s unique experience rather than treating individual’s psychiatric diagnosis (Stefan, 2016).

2.5.3. Cognitive Behavioural Therapy (CBT)

Cognitive behavioural therapy (CBT) is another evidence-based approach commonly used for emotional and behavioural problems (D’Anci et al., 2019; Stefan, 2016). CBT focuses on problem-solving strategies and “reframing the way an individual conceptualizes his or her problems, and approaches them” (Stefan, 2016, p. 441). Stefan (2016) explains that the core of CBT is “challenging [...] frameworks [...] [of] automatic thoughts [...] conditional assumptions [...] and beliefs [...] and teaching a different way of approaching these situations” (p. 442). CBT

suicide prevention (CBT-SP) focuses on the ways in which suicidal people view their lives and the decisions they need to make (Stefan, 2016). Similar to DBT, the focus of CBT-SP is on the individual's unique experience rather than treating their psychiatric diagnosis (Stefan, 2016).

2.5.4. Collaborative Assessment and Management of Suicidality (CAMS)

Another evidence-based suicidality treatment is Collaborative Assessment and Management of Suicidality (CAMS) (Jobes, 2012; Stefan, 2016). CAMS is a suicide-specific approach and problem-focused treatment, which collects quantitative and qualitative information (Jobes, 2012; Stefan, 2016). Stefan, 2016 explains that with CAMS, “the professional sit[s] side-by-side with the individual while [...] [they] fill [...] out an assessment form (Suicide Status Form, or SSF) [...], which is an assessment and tracking tool and treatment plan on which both the clinician and suicidal person work in collaboration (Jobes, 2012; Stefan, 2016). CAMS includes sections in the assessment forms for the suicidal person to explain their reasons to live, as well as their reasons to die, and sections where they may indicate what they find most painful (Jobes, 2012; Stefan, 2016).

2.5.5. Applied Suicide Intervention Skills Training (ASIST)

Applied Suicide Intervention Skills Training (ASIST) aims at improving “gatekeepers’ general suicide knowledge, suicide risk assessment accuracy, and appropriate responses for suicide prevention” (Silva, Smith, Dodd, Covington, & Joiner, 2016, p. 1240). In this context, gatekeepers are those “who first come into contact with potentially suicidal individuals” (Rimkevičienė, Skruibis, & Padrošytė, 2020, p. 1). Through ASIST, gatekeepers are trained to recognize an individual having suicidal thoughts and together they create a plan to ensure their safety (Canadian Mental Health Association, 2021).

To summarize, the critical literature review regarding social workers’ intervention strategies with suicidal people not only identifies the barriers mentioned above but highlights the

impact they have on suicidal people, which will be further reviewed in the next chapter. Social workers are obliged to abide by the values and principles of their code of ethics and, failing to do so, they may be liable for malpractice, making it difficult to work in the best interests of suicidal people. Social workers must follow guidelines that impose the will to live towards suicidal people even if it might conflict with their values. The CASW code of ethics and guidelines for ethical practices explicitly demand that social workers limit the individual's right to self-determination when considered a threat to themselves, resulting in suicidal people experiencing epistemic violence because they are not considered as credible knowers of their own experience. Social workers describe feelings of fear, stress, anger, and unpreparedness impacting their interactions with suicidal people. Although various interventions may be used with suicidal people, their effectiveness and objectives may be questionable and often lie, as we will see in the next chapter, on presumptions, such as the injunction to live and to futurity and compulsory liveness (Baril, 2020), which reproduce suicidism and epistemic injustices with respect to suicidal people.

CHAPTER 3 - IMPACTS OF INTERVENTIONS ON SUICIDAL PEOPLE

If I die, then I will never have to worry about upsetting my Mom again... It would have been nice today to stick my head in the lawnmower blade. F***, I really did have to hold back the urge. Maybe the next time I will give it a try. Most people are scared to die. It can't be any worse than living a life like mine. Being dead I think would suit me just fine. I wonder when the best time to do it would be. I'm not going to get locked because then I'm back on checks and they will expect me to act up then. I will call my Mom before bed and have one more chat. Somehow I have to let her know that none of this is her fault. I don't know why I'm like I am but I know she didn't do it to me. People say there is nothing wrong with me. Honestly I think they need to F*** off because they don't know what goes on in my head. When I use to try and hang myself I was messing around trying to make them care and pay attention. Now it's different. I want them to f*** off and leave me alone. It's no longer a joke. (Ashley Smith, as cited in *The Fifth Estate*, 2010, paras. 43–44)

This excerpt is from the journal of 19-year-old Ashley Smith, who later completed suicide by self-inflicted strangulation while on suicide watch in 2007. Ashley was imprisoned for various minor offences, including a failure to comply with authorities and the law on a number of counts (*The Fifth Estate*, 2010). She killed herself while guards watched her die, as the warden and ward deputy had instructed them not to enter Ashley's cell if she was still breathing after attempting to strangle herself with ligatures (*The Fifth Estate*, 2010). For four years prior to her death, since the age of 15, Ashley had often spent time segregated in a cell, sometimes as small as 9 by 6 by 7.5 feet, for days at a time, and for as long as 23 hours a day (*The Fifth Estate*, 2010). She was often placed in restraints or a body bag to restrict her movements, made to wear a helmet, hit, tasered, pepper-sprayed, put in shackles, forced down while nurses cut off her clothes, and endure many other inhumane and humiliating treatments (*The Fifth Estate*, 2010). In addition, she eventually was not permitted to write in her journal and was denied "sufficient toilet paper [,] [...] soap in her cell [,] [...] underwear or sufficient sanitary products to meet her hygiene needs" (*The Fifth Estate*, 2010, para. 60). Despite requesting hospitalization and medicine, she never received the treatment she wanted (*The Fifth Estate*, 2010). Instead, she was punished, humiliated, and violated by those who were presumably supposed to look out for her best interests. Despite the

fact that the suicide intervention strategies that Ashley experienced took place while she was in prison, the treatment she received is in some ways similar to those utilized for suicidal people in general in society. In keeping with Ashley's experiences, this chapter will review the impacts of suicide interventions on suicidal people, their expressed and unmet needs, which interventions should be avoided, and which should be prioritized. Also, the interventions reviewed in this chapter are representative of all people who come into contact with suicidal people, which includes social workers. However, in the context of this research, I am particularly interested in the impact of social workers' suicidal intervention strategies on suicidal people.

3.1. The Negative Impacts of Suicide Intervention Strategies on Suicidal People

Suicide intervention strategies have negative impacts on suicidal people in many areas of life, including on personal, emotional, interpersonal, social, educational, professional, economic, and legal levels (Baril, 2018; 2020). The negative impacts resulting from these interventions have important repercussions on suicidal people, to be explored in this chapter.

At the personal and emotional level, suicidal people, as a result of their experiences with suicide intervention strategies, often feel unworthy, powerless, ashamed, distressed, and betrayed (Bergmans, Rowe, Dineen, & Johnson, 2016; Borecky, Thomsen, & Dubov, 2019; Martin, 2011; Stefan, 2016). Often healthcare professionals will consider suicidal people incapable of making choices for their healing and recovery, "placing [them] in a position of powerlessness" (Bergmans et al., 2016, p. 146), which exacerbates their already present feelings of unworthiness. Increased feelings of distress resulting from suicide intervention strategies have also been conveyed by suicidal people (Borecky et al., 2019). In addition, not only is the experience with suicide interventions strategies often "frightening, demoralizing and demeaning" (Borecky et al., 2019, p. 74), but suicidal people have also reported feeling ashamed as a result of their expressed desire to die (Borecky et al., 2019; Stefan, 2016). Finally, Martin (2011) explains

that deceiving suicidal people to keep them alive is often perceived as trickery and contributes to them feeling betrayed, leaving them skeptical of seeking help in the future.

In addition to emotional and personal struggles experienced when expressing suicidal thoughts, suicidal people often face difficulties in their interpersonal relationships. Individuals who have attempted suicide report being discriminated against by family and friends (East et al., 2021). According to East et al. (2021), “the continued focus on people who re-attempt suicide or die by suicide perhaps contributes to viewing people with lived experience of suicide as a risk rather than a resource” (p. 188). Family members and friends often fail to acknowledge suicidal people as knowers and experts of their own experiences, disregarding their expressed needs and instead viewing them as a danger or victims to rescue. In addition to being discriminated against by family and friends, parents expressing suicidal thoughts may lose custody of their children despite doing “a pretty decent job” (Stefan, 2016, p. 447). Their children are often their reason to live, but society considers that “individuals suffering from mental illness cannot successfully parent” (Stefan, 2016, p. 448). The discrimination experienced by suicidal people is rooted in sanist and suicidist systems of oppression (Baril, 2017, 2018, 2020). Suicidal people express the need for compassion and care, but instead they are often discriminated against by their loved ones and even stripped of their loved ones’ presence by society and its laws.

Despite suicide being recognized as a world health issue, it is often stigmatized in general society (Baril, 2020; Bergmans et al., 2016; Borecky et al., 2019; Britton, Patrick, Wenzel, & Williams, 2011; Cover, 2016; Crichton, Carel, & Kidd, 2017; East et al., 2021; Mishna, Antle, & Regehr, 2002; Ruth, Gianino, Muroff, McLaughlin, & Feldman, 2012; Stefan, 2016; Wedlake, 2020). Suicide stigma stems from stereotypes about suicidal people, such as the idea that they are “attention-seeking, selfish, incompetent, emotionally weak, and immoral” (Carpiniello & Pinna, 2017, p. 4). In addition to this stereotypical discourse, in a study conducted

by Ruth et al. (2012), university staff of an MSW program indicated that “stigma was a significant barrier to discussion of the topic.... It [suicide] was a ‘dirty word’” (p. 509). The negative labels attributed to suicidal people and suicide “may lead [healthcare professionals] to unnecessary or inappropriate decision[s]” (Bentley, as cited in Mishna et al., 2002, p. 268). Furthermore, Stefan (2016) believes that suicidal people “fail to seek treatment due to the fear of being labeled and stigmatized” (p. 448). Therefore, not only are suicidal people potentially stigmatized by healthcare professionals when seeking support and by society, but they also often fail to access mental health services in order to avoid being stigmatized. More importantly, stigma increases the risk of suicide attempts, as well as the potential risk of suicide (Carpiniello & Pinna, 2017).

In addition, post-secondary students are often involuntarily hospitalized, evicted from their dorms, forced to take a leave of absence or expelled, sometimes without a tuition refund, because of expressing their desire to die (Baril, 2020; Stefan, 2016). Many students are aware that their institution’s mental health services may force them off campus, which may interfere with their academic journey, making them more reluctant to seek help (Stefan, 2016). While some students may benefit from individual counselling, often post-secondary students who complete suicide had never gone to their local mental health and wellness centres for professional counselling (De Somma, Jaworska, Heck, & MacQueen, 2017; Stefan, 2016). Furthermore, not only has the threat of forcing students out of their institution kept them from seeking help, but Stefan (2016) indicates that it “may have even resulted in increasing student suicides” (p. 392). Therefore, university students often remain silent to avoid the negative impacts of expressing their thoughts, which may themselves potentially lead to suicide.

Professionally and economically, suicidal people may be negatively impacted by suicide intervention strategies. They are often not hired for work, lose their jobs, and their loved

ones are denied life insurance (Baril, 2020; Stefan, 2016). Suicidal people describe being denied a job “because information about suicide is known about [them]” (Stefan, 2016, p. 372), despite the person being qualified for the job. Suicidal people often cannot maintain certain jobs because “they are denied security clearance [and] their licences to practice law and medicine are made contingent on indefinite and nonconfidential therapy” (Stefan, 2016, p. 374). In addition, life insurance companies often apply a suicide exclusion period, stating that if the customer was to die by suicide during that period their inheritors would not receive the inheritance (Yip et al., 2010). Denying inheritors, who are often loved ones, their inheritance may be perceived as punishing people for completing suicide, as well as their relatives. Suicidal people experience many forms of professional and economic oppression and may be punished for their thoughts by not being hired, losing their jobs, or being denied life insurance.

Finally, suicidal people are often stripped of their legal rights when they express their desire to die, such as being unable to refuse treatment, coercively tied to their beds, forcibly medicated, or locked up in a psychiatric hospital (Baril, 2018, 2020; Stefan, 2016; Szasz, 1999). Three months before Ashley died, she filed grievances against the institution in which she was held, reporting that her basic rights were being violated (The Fifth Estate, 2010). When individuals are treated coercively, their risk of dying by suicide increases and, at times, they complete suicide while hospitalized (Stefan, 2016). Even when healthcare professionals prevent people from dying by suicide while hospitalized, many suicidal people re-attempt suicide shortly after being discharged from hospital (Stefan, 2016). Ashley’s attempts to die increased in frequency as she was treated more coercively and as her legal entitlements to basic needs were taken away. Suicide intervention strategies that involve violating people’s legal rights are not only traumatic and inhumane but can also increase the risk of suicide for people who are already experiencing distressful feelings.

3.1.1. Exploring the point of view of suicidal people

Every time they put me in places and cut out that part of my life, that made it a thousand times worse. You're too at risk, in their effort to keep me safe they made me a thousand times more dangerous they took away any chance at meaning and outside positive feedback. It took me a decade to tell myself that I had any value. (Suicidal person, as cited in Stefan, 2016, p. 271)

This testimony illustrates one possible impact of suicide intervention strategies. In this case, the intervention created an even more difficult situation than the person had originally been presented with. In the next section, I will explore suicidal people's points of view on and experiences of suicide intervention strategies.

3.1.1.1. Inhumane treatment

Too often, suicidal people are perceived to be a danger and are criminalized, sometimes resulting in their arrest (Baril, 2018, 2020; Kumbhare, 2020; Stefan, 2016; Szasz, 1999). They may be handcuffed, confined to a room, and punished for their suicidal behaviour on the pretext that these interventions are to take care of them (Baril, 2018, 2020; Stefan, 2016; Szasz, 1999). The treatment of suicidal people as criminals is historically rooted and continues in attempts to prevent them from completing suicide. Szasz (1999) gives the example of family members calling the police for help finding their loved ones at risk of suicide and, when found, they are often handcuffed and put into a police car. Martin (2011) provides the example of suicide crisis line interventions that often fail to provide the limits of confidentiality to suicidal people as they pertain to perceived safety and risk factors, and sometimes dispatch police to the suicidal individual's location without their knowledge, which can be a very traumatic experience for the suicidal person. A participant in Stefan's research, explains, "What we did is not against the law, and our rights are taken away from us, we have fewer rights than prisoners" (2016, p. xvi). Society's perception of suicidal people as criminals may have devastating effects on their well-being. Not only are suicidal people perceived as criminals by society, but society's overall

perception of criminalized people is founded on prejudice, denying that criminalized people are equally deserving of respectful treatment. Society wants to prevent suicide at all costs, even if suicide intervention strategies do more harm than good. Ironically, society is supposed to protect suicidal people from harming themselves. However, being treated as a criminal harms suicidal individuals. Treating suicidal people as if they have committed a crime is a form of suicidism. Additionally, suicidal people's expressions are often not considered credible, an example of the epistemic injustice they experience.

Also, suicidal people are often involuntarily hospitalized and institutionalized when expressing their desire to die (Baril, 2018, 2020; Martin, 2011; Stefan, 2016; Szasz, 1999). Involuntary hospitalization often involves the use of physical and mechanical restraints, forced medicalization, and seclusion (Raboch et al., 2010; Stefan, 2016). In interviews conducted by Stefan with suicidal people, those who experienced being involuntarily hospitalized expressed being "angry, and [...] very badly damaged" (2016, p. 55). One participant in Stefan's research describes their experience of involuntary hospitalization: "After my suicide attempt I was locked in a quiet room...not allowed to bathe or brush my teeth. I was also not allowed to have my eyeglasses" (2016, p. xviii). This person's experience is similar to that of Ashley on suicide watch, stripped of many of her basic needs. Another participant in Stefan's research describes their experience as follows:

It is not helpful to be in a mental ward I know we get locked up for our safety, but being in such a sterile and noisy environment it does not make any of us feel better about our place in life and basically we all do our best to get out as fast as possible. (2016, pp. xviii-xx)

When suicidal people are involuntarily hospitalized, they are subject to inhumane treatments like those mentioned above. Much like criminalization, involuntary hospitalization often harms suicidal people expressing their desire to die.

Finally, suicidal people may often be forced to take medication (Baril, 2018, 2020; Crichton et al., 2017; Stefan, 2016; Szasz, 1999). When individuals display various distressful symptoms associated with mental illness, they may be “detained in hospital and medicated against their will” (Crichton et al., 2017, p. 66). Since suicidal people are often considered delusional, impulsive, irrational, or mentally incompetent, a form of oppression by a sanist system, mental health providers medicalize suicidal people using the justification of acting in their perceived best interests. Raboch et al. (2010) explain that, at times, in order to force suicidal people to take medication, “strong psychological pressure (involving at least three staff members) to administer medication against [...] [their] will” (p. 1013) is required. Under certain circumstances, suicidal people are forced to take medicine in order to continue receiving coverage from their insurance company for hospital treatments (Stefan, 2016). One research participant explains their experience as follows:

I don't take medication, I weaned myself off, I don't want to be on pills. I know that meds are available and I don't want meds to be a crutch. When I act out, 'Oh are you taking your meds? Because you are acting out.' No, I am crazy anyway. [...] If I can live authentic to myself, I can be as real as I was meant to be. [...] I have my faith and that has changed my entire life. When I get super anxious or panicky, when I get the runaway hamster in my head, I get on my knees and pray, give me the strength to get through this. (Stefan, 2016, pp. 270-271)

This person's testimony illustrates that suicidal people may consider treatment other than forced medication to be effective. This statement also illustrates the extent to which suicidal people experience epistemic injustice, as their own understanding of their reality and potential helpful treatments is made illegitimate and not credible. When medication is forced on the suicidal individual, healthcare professionals are imposing treatments that they believe to be in the person's best interests, disregarding them as a knower of their own experience. This constitutes a form of testimonial injustice since the expressed needs of suicidal people are sidelined by those who assume to have better insight into suicidal people's needs and reality.

3.1.1.2. Silencing suicidal people

Suicidal people express the need to be heard, but often they are criminalized, hospitalized, and medicalized against their will for sharing their desire to die (Baril, 2017, 2018, 2020; Stefan, 2016). As a result, some suicidal people have learned to stay quiet (Baril, 2018, 2020; Stefan, 2016). A previously cited statement by a participant in Stefan's research illustrates this lesson: "You sit down, you shut up and you don't act out" (2016, p. 174). The person is aware of how to behave, what to say, and what not to say to avoid the potential risk of being criminalized, hospitalized, and medicalized against their will. This statement leads us to believe that the person needs to express their feelings but refrains from doing so because they are afraid of what might happen. Ashley had similar experiences. She knew that guards would lock her up and strip her of her basic rights and needs if she expressed her desire to die, so she often stayed quiet (The Fifth Estate, 2010).

Suicidal people have also stayed silent to avoid negative suicidist impacts on many areas of their lives, including personal, emotional, interpersonal, social, educational, professional, economic, and legal. Baril (2020) explains that suicidal people avoid expressing their feelings because they fear being "institutionalized and drugged against their will [...] excluded from insurance programs [...] either not hired for new jobs or fired from their current jobs [...] expelled from university campuses, [or] hav[ing] their parenting rights revoked" (n. p.). Stefan explains that many of the participants she interviewed described experiencing "stigma and shame of having attempted suicide" (2016, p. xvii), which may mean that suicidal people's negative experiences of suicide intervention strategies contribute to them avoiding expressing their suicidal thoughts. We can imagine the extent to which parents might avoid disclosing their desire to die. As Stefan (2016) explains, if a suicidal parent is aware they might lose their child, who

might be their only reason to live, then it is likely they will stay quiet about their desire to die.

Society has created obstacles for suicidal people wishing to express their desire to die.

In order to avoid the negative impacts of expressing suicidal thoughts, suicidal people often suffer in silence (Baril, 2017, 2020; Stefan, 2020). Often suicidal people would rather stay quiet and experience their distressful feelings alone because they fear the stigma associated with suicide and the possibility of being subject to inhumane treatments they have not only heard of but also experienced. In Radford, Wishart, and Martin's 2019 study, participants described wanting to be heard but often being disregarded or institutionalized. According to one participant,

everybody told me it's totally voluntary, but it didn't feel like that. It felt like I had to be there. If I'm not feeling safe, then I will hold back a lot of information. I may downplay what's going on. I may leave out, like, a lot of information, especially things around suicide and self-harm. (Radford et al., 2019, p. 21)

Clearly, this suicidal person avoids disclosing what they feel to avoid further repercussions, such as being forced to take medication. Also, the assumption is that the healthcare system must protect suicidal people from harm but, in this statement, the suicidal participant is trying to protect themselves from the healthcare system's suicide intervention strategies. In addition, the suicidal person modifies their statements to be more acceptable and avoid negative reactions from healthcare professionals, which is a form of testimonial smothering, and as a result, is reduced to silence (Dotson, 2011). Another participant explains, "There were times when even though I needed someone to talk to about my suicidal thoughts...those people [clinicians] would be the last people I want to talk to" (Radford et al., 2019, p. 20). This suicidal person expressed the need to reach out and talk to someone but instead must suffer in silence. How long can a person continue suffering in silence? What happens to someone after suffering in silence for a long period of time? Is dying the only way out? Can speaking openly and safely about suicidal thoughts potentially save more lives than not?

Often suicidal people die in silence. Numerous accounts of situations where people who completed suicide never sought help from healthcare services exist (Baril, 2018, 2020; Stefan, 2016). Examples of post-secondary students who completed suicide without having sought institutional services come to mind (De Somma et al., 2017; Stefan, 2016). They lived their pain in silence and eventually completed suicide. This outcome may result from negative impacts associated with expressing suicidal thoughts, such as being expelled and feeling ashamed. We also must consider that if someone truly wants to die, they will. Baril (2020), Stefan (2016), and Szasz (1999) have indicated that suicide cannot always be prevented and the notion of saving lives at all costs can be more harmful than good. Baril (2017; 2020) explains that suicidal people who suffer in silence may use violent means to complete suicide, making it essential to provide compassionate approaches to suicidal people, which will be further discussed later in this chapter.

3.1.1.3. Delegitimizing and marginalizing suicidal people

Often suicidal people's voices are delegitimized by those to whom they express their suicidal thoughts. When suicidal people's voices are delegitimized, they experience a form of testimonial injustice, since they are often perceived as lacking credibility "owing to identity prejudice" (Fricker, 2007, p. 5) associated with suicidality. Suicidal people are often considered irrational, and their knowledge and opinions are excluded from their course of treatment (Baril, 2020; Mishna et al., 2002; Stefan, 2016; Szasz, 1999). Baril (2020) argues that "suicidal people are not considered "legitima[te] [...] knowing subjects [...] [and] not seen as knowledgeable on the topic of suicidality" (n. p.). Also, as reported in a study by Radford et al. (2019), research participants "reported they were misunderstood and considered to lack the capacity to know what they needed" (p. 3). Even suicidal people's family members will often delegitimize what the person expresses, as this testimony illustrates:

My parents used to joke around. They were like, “Oh, we can have the men in white coats come and take you away,” and then one day they were just like, “All right, let’s do that then.” And outright lied on the phone going, “Yeah, they’ve taken an overdose,” and the paramedics get there and my medications are full and it doesn’t matter [...]. That’s what the scary thing was... I was like, “Do I look like I’m in any way overdosing right now?” No. These people are abusive. They’ve threatened this before but that means nothing in this situation. (Radford et al., 2019, p. 20)

I agree with Radford et al. (2019) that this statement indicates that suicidal people “may be assumed to lack credibility when it comes to their own actions and feelings. Regardless of what they say, they are not heard and are instead disempowered and excluded from the decisions made about their well-being” (p. 20), which is a form of epistemic violence that marginalizes suicidal people (Baril, 2020; Crichton et al., 2017; Fricker, 2007). Society in general, professionals, and even family members delegitimize suicidal peoples’ voices and determine what is best for their lives.

Suicidal people are often under surveillance to prevent suicide. Police officers may check on their welfare, they may be persuaded to devise a safety plan, and they may be perceived as a danger rather than a source of knowledge (Baril, 2020; East et al., 2021; Martin, 2011; Radford et al., 2019; Stefan, 2016; Szasz, 1999). As East et al. (2021) explain, suicidal people are perceived as “a risk rather than a resource” (p. 7) and need to be under surveillance because they may be a danger to themselves. In a study conducted by Radford et al. (2019), one participant reports:

I’ve had a few welfare checks. Like a few of my medical professionals, they’ve called the police on me to check on my welfare. I’ve not had good experience with them, especially with one...calling the police on me because I mentioned feeling suicidal. It didn’t end well for me since...suddenly having the police rock up at your house – it can be distressing...like this happened in front of my kids as well...the police didn’t want to listen to me, like even when I tried to explain it to them...I had no plan, there was nothing in the house I could use but I was stilled [sic] cuffed and thrown in the back of a police car and spent a “fantastic” 24 hours locked up for no reason – well, to protect myself. (p. 19)

Therefore, as explored earlier through the concept of compulsory liveness (Baril, 2020), society must prevent the “abnormal” deviation from living at whatever cost and, in order to do so, suicidal people must be under surveillance. If they are suspected of wanting to complete suicide, then family members, healthcare professionals, and police officers are to prevent them, often using coercive treatments.

Often, when suicidal people express distressful feelings and the desire to die, they are invalidated by healthcare professionals, family, and friends. Even public discourse and the media invalidate suicidal people by encouraging them to reach out and talk or to take a pill, which minimizes the complexity of their suicidal experiences (Rector, 2017). Several authors agree that suicidal people’s expressions of emotional distress and suicidal thoughts are invalidated and perceived as irrational (Baril, 2018, 2020; Chamberland, 2011; Szasz, 1999; Wedlake, 2020). Wedlake (2020) explains the invalidation of suicidal people, noting that through “the process of perceiving suicidality as always irrational and a result of mental illness or social injustice, the experiences of suicidal people are invalidated and erased, and their humanity is too” (p. 93). As recounted by Rector (2017), one suicidal person described their experience as follows: “When I told my doctor he actually laughed at me... and said ‘You’re fine’” (p. 38), while another person explained, “I have so many experiences with counsellors where I open my mouth and they’re like ‘Let’s talk about something more productive’” (p. 39). Even when suicidal people are treated coercively, Szasz (1999) explains that the “physician and [...] family insist that they are helping [...] invalidating [their] [...] perception that they are harming [them]” (p. 48). As a result of being invalidated, some suicidal people say that they will “never reach [...] out for help again” (Rector, 2017, p. 40). The invalidation that suicidal people experience by healthcare professionals, family, and friends delegitimizes and marginalizes them. If a person is expressing their desire to die and feels that their feelings are then invalidated, we can imagine the extent to

which they might feel even more lonely, isolated, and distressed than they had initially felt, even before expressing their suicidal thoughts.

Finally, society often perceives suicidal people as a burden, resulting in suicidal individuals feeling like a burden to society and loved ones (Rector, 2017; Stefan, 2016). Stefan describes the burden experienced by suicidal people as the individual feeling “already in doubt about [...] [their] value in the world, already feel[ing] powerless to transform or transcend life’s burdens” (p. 51). Also, during Stefan’s interviews with suicidal people, the interviewees implicitly expressed feeling like a burden, which interfered with the care they desperately needed from others (2016). One participant in Rector’s research explains, “I have to be careful what I express because I have people that do a lot of... things for me” (2017, p. 33), suggesting they are a burden to others as it is, and would therefore disappoint others if they were suicidal. The previous statement leads us to believe that the feeling of being a burden can often be accompanied by feelings of guilt.

3.1.2. Exploring the scientific evidence regarding ineffective suicide prevention practice

Often suicidal people will do everything they can to avoid being hospitalized or reaching out for help. The following statement explicitly illustrates the extent to which suicidal people avoid seeking mental health services: “We’d rather be dead than go there” (Suicidal person, as cited in Radford et al., 2019, p. 6). Radford et al. (2019) describe suicidal people’s experiences with mental health services and their impact as follows: “Dehumanising and punitive experiences were common within mental health services. There is ongoing fear that a voluntary admission would become involuntary, leading to censorship of suicidal thoughts” (p. 6), suggesting that suicide prevention practices are often ineffective. This study is one of many to indicate the ineffectiveness of some suicide prevention practices. This next section will review the inefficacy of forced treatment, the silencing effect of suicide prevention strategies, and the

epistemic injustice experienced by suicidal people through an examination of scientific evidence.

3.1.2.1. The inefficacy of forced treatment and forms of criminalization of suicidal people

Evidence suggests that forcing treatment on suicidal people is not an effective means of preventing suicide (Baril, 2017; 2020; Stefan, 2016; Szasz, 1999). In fact, Szasz (1999) explains that “the term “preventing” conceals the indignity and injuriousness of psychiatric coercion [...] [and] ought to be called ‘coercive psychiatric suicide prevention’” (p. 45). Stripping people of their clothes, holding them down, and forcibly tying them to a bed for their presumed protection not only may not fail to prevent suicide but does more harm than good. Stefan (2016) indicates that forced treatment does not ameliorate a person’s suicidality but might instead lead to their suicide. Szasz (1999) explains that suicidal people may regard coercive psychiatric suicide prevention intervention strategies such as restraints “as a form of unjust and unmerited punishment” (p. 48). Also, despite forced attempts to treat suicidal people to prevent their suicide, as mentioned by Baril (2020), Stefan (2016), and Szasz (1999), if someone truly wants to die, they will.

Evidence suggests that criminalizing and arresting suicidal people, as well as perceiving them to be dangerous, are ineffective approaches and interventions for preventing suicide (Baril, 2020; Martin, 2011; Stefan, 2016; Szasz; 1999). On the contrary, evidence suggests that treating suicidal people like criminals and as a danger often exacerbates their desire to die, creating an even more distressful situation than they had originally presented (Baril, 2020; Martin, 2011; Stefan, 2016). Martin (2011) questions the effectiveness of police intervention and forced treatments with suicidal people:

We must ask whether having them taken into custody by police and treated against their will is likely to do anything to lessen their suffering and oppression. It seems that there is a good possibility that such treatment will simply reinforce it. (pp. 166–167)

It seems counterproductive to arrest a suicidal person in order to prevent their suicide, when they are already in distress. With this approach, similar to the concept of compulsory liveness (Baril, 2020), suicide is to be prevented at all costs, despite interventions that might increase a person's desire to die.

In addition, evidence is lacking to indicate that involuntarily hospitalizing suicidal people might decrease suicide rates (Stefan, 2016; Szasz, 1999). In fact, evidence suggests that involuntary hospitalization might increase suicidal people's desire to die (Martin, 2011; Bergmans et al., 2016; Stefan, 2016; Szasz, 1999). If involuntarily hospitalizing suicidal people is supposed to help prevent suicide, then why is there "a higher risk for death by suicide after discharge from a hospital stay" (Bergmans et al., 2016, p. 148)? Also, suicidal people often complete suicide while in hospital (Borecky et al., 2019; Stefan, 2016), "with the majority of inpatient suicides occurring soon after admission" (Borecky et al., 2019, p. 73). It would seem that suicidal people's experiences of involuntary hospitalization might lead to their suicide rather than preventing suicide.

Finally, evidence suggests that forced medical interventions with suicidal people are often ineffective (Stefan, 2016; Szasz, 1999). Evidence suggests that forced medication may do more harm than good (Stefan, 2016). In Stefan's interviews with suicidal people who had experienced an involuntary hospitalization, when asked about which treatment was most helpful while in hospital, they indicated none, including medication (2016). In fact, Szasz (1999) and Stefan (2016) indicate no significant change in suicide rates despite suicidal people taking psychiatric medicine. Maybe forcing suicidal people to take medication is one of the only approaches healthcare professionals are aware of or feel comfortable to use when treating suicidal people's pain.

3.1.2.2. The silencing effect of suicide prevention strategies

Evidence suggests that suicide prevention practices have often silenced suicidal people (Baril, 2020; Jobes & Joiner, 2019; Stefan, 2016). According to Baril (2017; 2018; 2020), since suicide is perceived in a negative way, and never as an option, suicidal people stay quiet to avoid being judged, discriminated against, criminalized, hospitalized, or medicalized. Suicidal people are reluctant to reach out and speak about their suicidal thoughts because they are often implicitly and explicitly told that dying by suicide is never an option. I agree with Baril (2020) in thinking that the compulsion to live imposed by society on suicidal people has further isolated them and contributes to their silence. Not only are suicidal people silenced because of the stigma often associated with suicide, but suicide also silences non-suicidal people, as Stefan explains: “Our silence about suicide translates into misunderstandings and stereotypes, as well as (perhaps even more potently) fear of liability” (2016, p. 410). In professional contexts, non-suicidal people who work with suicidal people, such as social workers, often do not understand the complexity of suicide, which instills the fear of liability when hearing people express suicidal thoughts. The silencing of suicide by non-suicidal people prevents suicidal people from speaking about their desire to die. In addition, evidence indicates that people who attempt or complete suicide often do not seek or receive mental health services (Lytle, Silenzio, Homan, Schneider, & Caine, 2018; Stefan, 2016; Szasz, 1999). In many of the interviews conducted by Stefan (2016), suicidal participants “did not seek help when they were suicidal because they were afraid of being sent to hospital” (p. 392). Too often the system has failed suicidal people, and they either seek support from friends and family (Lytle et al., 2018) or suffer in silence instead. Since mental health services are often associated with negative impacts on suicidal people (Baril, 2020; East et al., 2019; Stefan, 2016), “cities where suicide prevention services are offered, for example, show a rise and not a fall in suicides... [and] that the services do actually engender pathology” (Szasz,

1999, p. 54), suggesting that suicidal people avoid seeking mental health services. That suicidal people often avoid seeking help might lead us to believe that, not only are they not understood, but they are also not listened to.

3.1.2.3. Epistemic injustice toward suicidal people

Finally, evidence suggests that the ineffectiveness of suicide prevention practices contributes to suicidal people experiencing epistemic injustices (Baril, 2020; Crichton et al., 2017; Wedlake, 2020), especially within the healthcare system. Crichton et al. (2017) describe this experience as follows for people experiencing mental health issues:

The consequence is that patient testimonies and interpretations are not acknowledged as credible, and patients are thus undermined in their capacity as knowers and contributors to the epistemic effort to reach a correct diagnosis and treatment. [...] As a consequence, the patient may be telling the truth, but the doctor deflates the level of credibility which she gives to the patient ('credibility deficit') and thereby does the patient a distinctive kind of injustice, namely epistemic injustice, which undermines the patient specifically in her capacity as a giver of knowledge. (p. 65)

The epistemic injustice experienced by suicidal people is part of a larger framework of suicidism, as Baril (2020) argues, contributing to suicide intervention practices that violate suicidal people's rights, such as the right to have their voices, testimonials, and opinions legitimized, respected, and valued. In addition, evidence indicates that negative impacts are associated with epistemic injustice experienced by suicidal people. Not only does epistemic injustice often exacerbate feelings of isolation and unworthiness but it can also hinder therapeutic relationships and alliances (Bergmans et al., 2016; Kumbhare, 2020; Martin, 2011). When suicidal people's voices are excluded from their course of treatment and they are not included as an active agent of change, the therapeutic alliance may be negatively impacted. In many of the interviews conducted by Stefan (2016), participants, on numerous accounts, mentioned the need to be listened to. However, listening also involves treating the suicidal individual as rational and their expressed feelings as legitimate, and avoiding minimizing what they are communicating. To

favour a therapeutic alliance with suicidal people, healthcare professionals must actively listen to them and refrain from paternalistic approaches, which may reduce the epistemic violence often experienced by suicidal people.

3.2. Alternative Types of Interventions Focused on Respecting Suicidal People

This has been a place where I can talk openly about my suicidal thoughts and actions and ... not feel worried that something bad is going to happen afterwards. I've never had to worry about youse [*sic*] two calling the cops on me. There's been times when I've said things, I feel like I've said things in group that could be misunderstood and there's been times I've been worried, "Oh, no, they might call the police." And a few hours later, "Oh, they didn't." (Suicidal person, as cited in Radford et al., 2019, p. 22)

This statement suggests that suicidal people often feel unsafe about expressing suicidal thoughts and, as a result, they often refrain from expressing their feelings. Also, this suicidal person is implicitly expressing the need to speak safely and be understood, which may be met by some types of interventions, such as those discussed by Radford et al. (2019). This section will review interventions that focus on respecting suicidal people, including specialized mental health services, community-based intervention, peer support intervention, and suicide-affirmative intervention.

3.2.1. Specialized mental health services

Many of the suicidal participants interviewed by Stefan (2016) indicated that dialectical behavioural therapy (DBT) helped them enormously. DBT focuses on the suicidal person's unique experience and "rejects the premise that psychiatric diagnosis serves as the framework to treatment" (Stefan, 2016, p. 439). DBT teaches suicidal people explicit coping and problem-solving skills that can be used over the long term (Stefan, 2016). Unlike DBT, hospitalization and other common suicide intervention strategies are sometimes short-term fixes and are usually practices that do not respect suicidal people. DBT can potentially offer a human

connection with and care for suicidal people, needs often expressed when seeking treatment (Stefan, 2016). However, with DBT, the idea of dying is never an option, and the suicidal person must be persuaded to live by utilizing DBT skills in order to prevent suicide. Despite the benefits of DBT described by suicidal people, this treatment continues to present suicide as abnormal and, as a result, the suicidal person as abnormal as well. DBT's suicide intervention strategies reproduce forms of suicidism and epistemic injustice, since their practices often fail to listen to suicidal people's desires and instill forms of compulsory liveness (Baril, 2020).

Many of the suicidal people interviewed by Stefan (2016) also indicated that cognitive behavioural therapy (CBT) helped them very much. Similar to DBT, CBT focuses on the suicidal person's unique experience (Stefan, 2016), providing a more respectful approach. However, CBT's main focus is on solving problems, which is not always what suicidal people are seeking (Stefan, 2016). Since CBT focuses on problem-solving, it presents suicide as a problem needing to be fixed. Similar to DBT, CBT treatment associates abnormality with suicidal people not wanting to live.

Collaborative Assessment and Management of Suicidality (CAMS) is a suicide-specific treatment to reduce suicide risk (Huh, 2018; Stefan, 2016). With CAMS, the suicidal individual creates both an assessment and tracking tool and treatment plan alongside the clinician (Stefan, 2016). The collaborative nature of CAMS may potentially include respecting, validating, and listening to suicidal people, often centering them as the experts on their experiences. However, similar to DBT and CBT, CAMS treatment presents suicide as a problem and individuals wanting to die as abnormal and needing to be fixed. Although, DBT, CBT, and CAMS have been proven to decrease suicide rates for certain individuals, we must also consider those who complete suicide without ever having consulted mental health services. As Baril (2020), Stefan (2016), and Szasz (1999) argue, if a person truly wants to die by suicide, they will.

3.2.2. Community-based intervention

Community-based interventions often include treatments such as DBT and CBT. McNeish and Tran (2020) explain that community-based interventions are “interdisciplinary programs that involve community partnerships and community members in community settings” (p. 1500). As it pertains to mental health, community-based intervention “can function as a tool to strengthen services of the health care system, prevent the development of mental health problems, advocate for individuals with mental health problems, and promote well-being” (McNeish & Tran, 2020, pp. 1500-1501). Suicidal people often express the need to be close to their loved ones, including their pets, who may be their only reason left to live (Stefan, 2016). When suicidal people are arrested and involuntarily hospitalized, they are kept away from what is sometimes their only reason to live. Many Indigenous people have described their experiences of being institutionalized for being suicidal in regions far away from their homes and families, similar to the experience of being taken away from their families to assimilate and placed in residential schools (Kral & Idlout, 2016). Their experience is an example of the importance of providing interventions that take into consideration the individual in their community. Since community-based programs often involve suicidal people living close to their families and friends, suicidal people may potentially feel more supported than if they were hospitalized. However, community-based interventions that often include DBT and CBT treatments also present suicide as abnormal and living as the only option, making it essential to fix suicidal people. They therefore also reproduce forms of suicidism through the concept of compulsory liveness (Baril, 2020). In addition, if a person presents themselves at a community-based service in crisis and expressing their desire to die, “liability and risk concerns lead to [...] hospitalization” (Stefan, 2016, p. 269), arrest, and/or forced medication, as is the case with so many other suicide prevention approaches.

3.2.3. Peer support intervention

Peer support groups often consist of people sharing “similar experiences [who] can offer each other emotional, appraisal, and informational support and hope” (Castelein et al., 2008). Peer support groups for suicidal people are not perceived by society as an effective suicide prevention strategy because non-suicidal people often assume that if suicidal people intervene with other suicidal people, they may potentially encourage one another to complete suicide. Since society imposes the compulsion to live on suicidal people, few suicide prevention peer support groups exist. However, DISCHARGED is a suicide prevention peer support project in Australia that focuses on “connections and relationship-building” (Radford et al., 2019, p. 9). In addition, the DISCHARGED peer support project offers “a space where people can share openly and authentically about their suicidal thoughts and feelings without fear of a clinical intervention” (Radford et al., 2019, p. 3). DISCHARGED participants describe being accepted and treated without judgment by other participants and peer facilitators. Offering opportunities for suicidal people to express feelings authentically and safely provides a respectful and compassionate environment, potentially destigmatizing suicide and refraining from a discourse that promotes living at all costs. Projects such as DISCHARGED offer suicidal people lived experiences of epistemic justice, since they are put in the position of being experts on their own experience who acquire knowledge about suicide and may potentially help others.

3.2.4. Suicide-affirmative intervention

Suicide-affirmative intervention offers suicidal people a harm reduction approach by providing them with safe spaces to express their desire to die and accompaniment on their journey if they decide to die after much consideration (Baril, 2017, 2018, 2020). In Baril’s writing, he aims to provide strategies for compassionate suicide prevention interventions and

suicide assistance to all individuals who are suicidal regardless their physical or mental state.

Baril (2020) defines suicide-affirmative intervention as follows:

They [suicidal people] would have the opportunity to explore other solutions with professionals in order to determine if suicide is still, after much consideration, their preferred option, to carefully plan their death several weeks or months in advance, to say goodbye to their loved ones and to leave this world using less lonely and violent means than those usually employed in completed suicide. (n. p.)

These interventions do not impose the will to live or promote life at all costs, but rather permit suicidal people to speak openly about their desires to die, without judgment or the fear of being criminalized, hospitalized, forced to take medication, or other coercive treatments. Suicidal people have expressed the need to be listened to and suicide-affirmative interventions may finally offer them the opportunity. According to Baril (2020), this approach can potentially save more lives than not because, through the process of accompaniment, suicidal people may change their mind from wanting to die to wanting to live. Suicide-affirmative interventions are based on anti-oppressive, anti-sanist, anti-ableist and anti-suicidist practices, similar to the interventions practiced with other marginalized groups, based on the notion of informed consent and self-determination.

To summarize, the critical literature review of the impacts of various healthcare professionals on suicidal people, including social workers' intervention strategies, highlights the alarming need for alternative types of strategies focusing on respecting suicidal people. Suicidal people have often been negatively impacted by suicide interventions, which interfere with their lives in a number of areas. Suicidal people's points of view, as well as scientific evidence, clearly indicate the need for effective alternative suicide intervention strategies that respond to the unmet needs of suicidal individuals. Although various interventions may be used with suicidal people,

suicide is often perceived as being a problem needing to be fixed, which contributes to the idea that suicidal people are abnormal. The next chapter will provide recommendations for alternative suicide intervention strategies that respect suicidal people while shedding a different light on suicide.

CHAPTER 4 – RECOMMENDATIONS

[I would like it if] someone [...] like validat[ed] what I was experiencing, like [telling me it] was real and was difficult and for someone to empathize with [me] [...] or just give me credit for making it through. (Suicidal person, as cited in Rector, 2017, p. 45)

I can openly express myself here [refers to the peer-support group]. There's not really those awkward questions, like you don't have to try to make others believe what you are...when you're in a room full of people like you. (Suicidal person, as cited in Radford, Wishart & Martin, 2019, p. 29)

These testimonies indicate the extent to which suicidal people need spaces to speak about their feelings openly and safely. Suicidal people express needing to be validated, to feel that others empathize with them, and desiring a welcoming space in which to speak about their experiences and thoughts. This next chapter will provide recommendations for the field of social work regarding suicide intervention strategies that respect suicidal people and create safer spaces for them to express their thoughts. Recommendations for the federal sector, healthcare sector, community services, and social awareness about suicide will also be provided.

4.1. Recommendations for the Field of Social Work

As previously highlighted in Chapter 2, social workers often come into contact with suicidal people. However, social workers have described feeling unprepared when individuals express suicidal thoughts, highlighting the need for social workers to receive adequate suicide-related training and education. In order to provide suicide intervention strategies that respect suicidal people, many changes need to be made at various levels, including suicide-related training and education for social workers and opportunities for continuing education, but also in terms of the Canadian Association of Social Workers (CASW) code of ethics and the guidelines for ethical practices. The values and principles of both the code and the guidelines present confusing recommendations for social workers. In addition, Mishna, Antle, and Regehr (2002) illustrate the potentially conflicting ethics of social work practice when coming into contact with

individuals expressing suicidal thoughts, noting “in certain situations the social worker may face an ethical choice between respecting a client’s right to choose suicide and intervening to protect the client’s life” (p. 266). This next section will provide recommendations for more training for social work students, as well as continuing education for social work professionals in the workplace, while keeping in mind that the CASW code of ethics and the guidelines of ethical practices need reviewing in order to make these recommendations possible.

4.1.1. Providing more training for social work students

I think sometimes faculty members are anxious because the stakes are so high that they don't want to teach something they don't know very well. Because what if they get it wrong, or get it superficial or say something that a student takes the wrong way? (MSW professor, as cited in Ruth, Gianino, Muroff, McLaughlin, & Feldman, 2012, p. 509)

In order to provide social workers with adequate suicide-related training and education, university professors must first be qualified to teach about suicide. The previous statement indicates the extent to which many professors feel unprepared to do so. Many university professors agree that social work students are provided with very few suicide-related training and education opportunities during their studies, but they also implicitly indicate feeling uncomfortable and having little expertise on teaching about suicide (Ruth et al., 2012). Would it be appropriate for a physiotherapist to teach cardiac surgery to a medical student? Or for a physiotherapist to teach a medical student any kind of intervention to ensure the well-being of their patients? Medical students are taught and educated by doctors specialized in their fields, and we may assume that most students are taught by a professor specializing in the field they teach. Although social workers are the largest providers of mental health treatment services in North America and frequently come into contact with suicidal people, many professors are not trained to teach social work students about suicide intervention strategies. Therefore, I recommend that specific suicide-related training, based on current literature and provided by the Canadian

Association for Social Work Education (CASWE), become mandatory for all new university professors hired by Canadian schools of social work. The specific suicide-related training on teaching university students provided to professors by CASWE should include suicide-related literature and intervention strategies that respect suicidal people based on evidence-based practices, and should be rigorous and ongoing. However, if, for some reason, university social work schools are unable to make suicide-related training mandatory for all professors, at least a percentage of them should be trained and able to teach university students about suicide.

Also, if social workers are to be trained regarding suicide intervention strategies, then field placement supervisors must also have expertise on suicide. Just as I did, social work students may come into contact with suicidal people during their placements. Professors have expressed concern about their students encountering suicidal people during their placements because of the inadequate nature of the suicide-related training and education students receive (Ruth et al., 2012). Often, social workers are expected to learn about suicide intervention strategies during their placements (Ruth et al., 2012), making it crucial that field placement supervisors be trained. Therefore, explicit suicide-related training should be a prerequisite for social work field placement supervisors. However, if explicit suicide-related training cannot be provided to all field placement supervisors, like university professors, a percentage of them should be trained, serving as a point of reference on suicide for social work students. As numerous studies have indicated, social workers often encounter suicidal people and must therefore be trained and educated by professors and field placement supervisors with relevant expertise on suicide.

Since social work students have described receiving little or no suicide-related training and education and feeling unprepared, such training and education should be explicitly included in university social work curricula at both the bachelor and master's level. Two mandatory

undergraduate suicide-related courses should be required, including one theoretical and one practical course. Each course should comprise a total of 45 hours per semester and should be taught once a week for three hours. Master of Social Work (MSW) students should be required to take two mandatory suicide-related courses, also including a theoretical and a practical course, each of which would total 45 hours per semester, once a week for three hours. Courses at the master's level would explore the subject of suicide more thoroughly than the courses required in the BSW program. By the end of the MSW program, students would have completed two full courses on the topic of suicide. In order to make space for suicide-related training and education, university staff members have indicated that the "curriculum could be streamlined [...] to make room for suicide education, eliminating repetition in other areas" (Ruth et al., 2012, p. 511).

Within the theory component, evidence-based interventions should be reviewed, as well as literature on suicide. Emphasis should be placed on avoiding coercive interventions with suicidal people, including dispatching police officers, involuntary hospitalization, forced medicalization, or use of physical and mechanical restraints or seclusion, and rather on interventions indicated by the literature as being helpful for and from suicidal people. In a study by Ruth et al., social work faculty members recommended:

the use of first-person narratives, including the professors' own experiences working with suicidal clients, and the stories of suicide survivors as especially beneficial to student learning [...] Some [...] [cited] the utility of case studies for teaching about suicide across the curriculum. (2012, p. 511)

Also, in studies conducted both by Ruth et al. (2012) and Schmitz et al. (2012), social workers, professors, and the authors suggested students practice suicide intervention strategies through role play and experiential exercises. Students may record these exercises and then complete a reflective assignment. These are just a few examples of how suicide-related training and education could be included in the social work curriculum, beneficial not only to student learning

but also potentially helpful in providing social workers with compassionate suicide intervention strategies that respect suicidal people, an approach suicidal people have described needing.

4.1.2. Providing more continuing education for social work professionals in the workplace

Social workers cited in Sanders et al. suggest the following training is needed:

Training-lots or role-play of how to handle [suicidal behaviours]. Then a discussion of therapists' feelings in dealing with the role-play client. Written material on how other therapists feel about suicide attempts and completions. [...] True stories of suicides and how clinicians and families coped would be helpful in any training. (2012, p. 10)

As mentioned in Chapter 2, social workers in the workplace have also described receiving inadequate suicide-related training and education and feeling unprepared when people express suicidal thoughts. The above statement indicates that social workers feel the need for more suicide-related training and the desire to develop intervention skills to be better prepared when they come into contact with suicidal people, as well as knowing how to work with their families. Similar to psychologists requiring “continuing education in ethics for licensure” and “continuing education in ethics for licensure renewal for addictions counselors” (Schmitz, et al., 2012, p. 296), I recommend that social workers be required to take suicide-specific continuing education offered by a specialist approved by the CASWE, in order to maintain their membership in a provincial social work association. In order to keep up with current evidence-based suicide intervention strategies and ethical issues, social workers should be required to take a suicide-specific workshop every two years, offered by a CASWE-approved specialist. I make this recommendation because I was required, at my previous place of employment, to complete recertification for intervention strategies with children with behavioural difficulties every three years. My recertification comprised of keeping up with current evidence-based intervention strategies with children with behavioural difficulties, including both a theoretical and practical component. Like many of my colleagues, I felt I needed retraining sooner than every three years.

Intervals of two years may allow trainers time to integrate, modify, and change suicide intervention strategies, based on research and evidence provided to social workers through CASWE-approved specialist training. I recommend a day-long, six-hour, suicide-specific workshop every two years. Similar to what should be required for social work students, half of the suicide-specific workshop content should be theoretical and the other half practical, to keep up with social work students' suicide-related training and education. The material covered in the suicide-specific workshop should focus more on the articulated and unmet needs of suicidal people and less on healthcare professionals' opinions and should address alternative suicide intervention strategies rather than coercive ones. Also, I agree with the recommendation by Schmitz et al. (2012) that "individuals without appropriate graduate or professional training and supervised experience should not be entrusted with the assessment and management of suicidal patients" (p. 300). Therefore, if social workers do not receive the biennial suicide-specific workshop offered by a CASWE-approved specialist, their provincial social work association should give them up to two years to complete the required training. Failing to complete this training within two years, the social worker should not only be stripped of their registered membership in a provincial social work association but should also be prevented from working with potentially suicidal people. Given that they often come into contact with suicidal people, making training in adequate suicide intervention strategies an inevitable part of social workers' jobs is crucial.

In addition, I recommend that employers provide mandatory, paid professional development (PD) days, of which at least an hour and a half are dedicated to suicide-related topics. During my last two placements, the institutions where I worked were very different but both held mandatory, paid full-day retreats for social workers about every six weeks. They covered both familiar and new subjects, and were very helpful. Often the time allocated for

sharing our experiences and discussing important topics was not sufficient. Therefore, I suggest monthly PD days to allow sufficient time dedicated to suicide-related topics and other important topics that employers want to cover, providing opportunities for social workers to debrief about their experiences with suicidal behaviours. In a study conducted by Sanders, Jacobson, and Ting (2008), social workers expressed feeling:

that having a specific training module on coping was crucial. The main area that [...] [they] felt should be addressed was coping with the various personal and professional reactions that stemmed from the suicidal behavior, including material on secondary trauma, feelings of professional failure, levels of professional responsibility, as well as the need for self-care and the care of others. (p. 9)

Although social workers described needing specific training for coping in various areas, an hour and a half per training day dedicated to coping related to suicide topics may be beneficial in keeping up-to-date with evidence-based suicide intervention strategies, as well as providing continuing education on suicide for social work professionals in the workplace. Providing this allotted monthly time to suicide-related topics may save social workers a lot of time and energy in the long run. If they are constantly supported and provided with continuing education, social workers may feel more competent and, thus, be more productive. I agree with Sander et al.

(2008) that “without sufficient education and training on coping with the impact of client suicide completions or attempts, social workers are at higher risk for compassion fatigue and burnout, along with other personal and professional reactions” (p. 14). The previous statement may also apply to general education and training on suicide-related topics, making PD days with at least an hour and half dedicated to suicide-related topics crucial for social workers’ continuing education. Also, suicidal people’s needs may potentially be better met by social workers’ continuing education on suicide, as workers will have better knowledge and understanding of suicidal people’s experiences, be informed about evidence-based practices, and feel confident in their work.

4.2. Recommendations for Other Sectors

Listen [...] Listen to we who have traveled that path and lived to talk about what helped.

DON'T put someone in a ward full of other people in emotional distress, treat them as if they are annoying and difficult, and pump them full of drugs. LISTEN for God's sake.

Don't come from a place of preventing – come from a place of connecting... Most importantly be present and LISTEN.

Listen, listen, listen. Listen with your whole being.

Be kind. Be understanding, listen with your heart.

- Suicidal people, as cited in Stefan, 2016, p. xxvi

These statements from suicidal people were meant to address the question of what suicide prevention policymakers and mental health professionals can do for them. This next section will provide recommendations for provincial suicide-related policies, hospitals and healthcare professionals, community organizations, and general recommendations for social awareness regarding suicide, all of which are based on the critical literature review provided herein.

4.2.1. Government: Federal policies

Popular campaigns, such as Bell's "Let's talk," often feature quotes describing mental health as mattering just as much as physical health, when in fact they are treated differently by the government and society. The difference in treatment of mental and physical health is apparent when we speak of pain, suffering, and medical assistance in dying. The Canadian government clearly states that if a person has a mental illness as their "only medical condition," they are "not eligible to seek medical assistance in dying" (2021, n. p.). However, a person is eligible to seek medical assistance in dying if they have:

a serious illness, disease or disability (excluding mental illness [...]) [,] be in advanced state of decline that cannot be reversed [and] experience unbearable physical or mental suffering from [...] [their] illness, disease, disability or state of decline that cannot be relieved under condition that [...] [they] consider acceptable. (Government of Canada, 2021, n. p.)

Even if a person doesn't have a fatal or terminal condition, they are permitted to seek medical assistance in dying when their pain and suffering becomes unbearable (Government of Canada, 2021). However, if pain and suffering are solely psychological, people are currently denied medical assistance in dying. Many authors have indicated that psychological pain and suffering are often just as severe as physical pain and suffering, arguing that medical assistance in dying should also be available to people who suffer psychologically (Baril, 2017; Bayliss, 2016; Kious & Battin, 2019; Maier-Clayton, 2016; Scully, 2020). Baril (2017, 2020) proposes that medical assistance in dying should be available to all people, including suicidal people. Baril (2020) explains that making medical assistance in dying an option available to suicidal people not only provides them with companionship and may prevent them from using violent means to end their lives but may also result in them deciding that they do not want to die. Therefore, if the Canadian government was to make people with mental illness and suicidal people eligible to seek medical assistance in dying, this change would potentially help treat mental health as equal to physical health, to destigmatize suicidal people, and provide a more compassionate approach than coercive treatments such as arrest or involuntarily hospitalization.

In Chapter 2, I indicated that healthcare professionals, such as social workers, fear being liable for the treatment of suicidal people. I agree with Stefan (2016) when she recommends "immunizing outpatient providers from liability for the suicide of patients unless they act intentionally or recklessly to cause the suicide" (p. 275). Limiting healthcare professionals' liability when working with suicidal people may decrease the latter's involuntary hospitalization, avoid the dispatching of police officers, and enable healthcare professionals "to listen more freely" (Stefan, 2016, p. 275). Eliminating liability for suicide may potentially reduce healthcare professionals' fear of malpractice, allowing them to provide suicide intervention

strategies that respect suicidal people. Also, eliminating healthcare professionals' liability for suicide may highlight the extent to which people who truly want to die will do so, despite the treatments that exist (Stefan, 2016). Most importantly, the benefits mentioned above may potentially save more lives than not, since suicidal people will be able to express their thoughts and receive the treatment and care they are seeking without the fear of being criminalized, hospitalized, or medicalized against their will.

4.2.2. Health sector: Hospitals and clinics

Sometimes, people will die by suicide while in hospital or in a clinical setting (Schmitz et al., 2012; Stefan, 2016). Therefore, we may ask ourselves if healthcare professionals are adequately trained to work with people expressing suicidal thoughts. Schmitz et al. (2012) indicate that healthcare professionals working in hospitals and other emergency clinical settings are inadequately trained to screen and assess suicide. Stefan (2016) explains that people often have lethal means at their disposal while in hospital, making suicide and suicide attempts possible. Similar to my recommendations for social work professors, supervisors, and students, I believe all staff working with suicidal people, such as social workers, nurses, and doctors, should receive suicide-related training and education. More specifically, I agree with the recommendations by Schmitz et al. (2012) that “accreditation and certification bodies for hospitals and emergency department settings must verify that staff members have the requisite training in assessment and management of suicidal patients” (p. 300) and, without appropriate training, they should not work with suicidal people. Also, in order to ensure that staff receive training, Schmitz et al. (2012) recommend that hospitals and other emergency clinical settings document the training that staff receive, which “could easily be reviewed as part of regularly conducted accreditation inspections” (p. 300). If healthcare professionals were adequately trained, employing coercive interventions would be seen as inappropriate. No evidence suggests

that involuntary hospitalization prevents suicide but rather it often increases the risk of suicide, and no change in suicide rates has taken place despite the forced use of psychiatric medicine (Stefan, 2016; Szasz, 1999). Providing this kind of information to healthcare professionals through suicide-related training and education may potentially prevent them from employing coercive interventions, and rather offer interventions that respect suicidal people. I also recommend that healthcare professionals refrain from any kind of coercive interventions with suicidal people. As previously mentioned, if a person truly wants to die, they will. Therefore, employing interventions without their consent will do nothing more than make them feel even more unworthy and in distress than they originally felt.

4.2.3. Community services

Often community services such as crisis centres will dispatch police to the location of a person expressing their desire to die, without their consent or knowledge (Martin, 2011). Suicidal people call crisis centres as their last resort in trying to alleviate their pain and suffering (Martin, 2011). However, when police officers storm into someone's home, forcefully dragging them out, handcuffing them, and putting them into a police car within the view of the public, these tactics cannot possibly make them less suicidal. Also, incidents of "suicide by cop," a term that refers to the killing of a suicidal person by police officers, occur too often (Martin, 2011; Stefan, 2016). This term often also refers to a suicidal individual acting violently toward a police officer because they want the officer to kill them (Stefan, 2016). However, suicidal individuals are often killed by police officers while they are:

locking door[s] or barricading them (which are broken down by police with battering rams), hiding in bathrooms and basements, or behind bushes in their own backyards, refusing to come out and confront the police who are throwing blinding grenades into their houses or cutting off their electricity. (Stefan, 2016, pp. 366–67)

Often, suicidal people are attempting to get away from police officers and are killed in the process. This is particularly true for people with mental illness, people of color and poor people. Therefore, I recommend that community services refrain from using police interventions to prevent suicide, at least without the consent of the suicidal person. Instead, listen to suicidal people and validate what they are expressing. Too often, people in distress are perceived as dangerous and a threat when they are not.

Although suicidal people have conveyed finding DBT and CBT helpful, these therapies implicitly fail to present suicide as an option and portray suicidal people as abnormal. For suicidal people to feel worthy and have their pain and suffering validated, like Baril (2020), I recommend that they be provided with a space to express their feelings safely and openly, including their desire to die. The suicide-affirmative approach suggested by Baril (2020) creates a space where suicidal people can speak about suicide without someone imposing the will to live. A suicide-affirmative approach steers away from a toxic positive discourse about living and instead validates what the suicidal person is expressing, centering them as the expert of their experience. I also recommend that community organizations encourage peer support groups, similar to DISCHARGE, which create a space where suicidal people can share their experiences, and facilitators guide conversations and refrain from explicitly preventing suicide. Such peer support groups may potentially empower suicidal people and create opportunities for people to experience control and self-determination, experiences of which suicidal people are often stripped.

4.3. General Recommendations for Social Workers' Social Awareness about Suicide

While they might not always agree with people wanting to die by suicide, social workers need to legitimize and validate suicidal peoples' feelings and opinions. Social workers need to be empathetic and try to see life from the perspectives of suicidal people, rather than from

their own. Many suicidal people describe feeling unbearable pain, after experiencing years of failed treatment, and yet their pain is often invalidated and delegitimized. Many people might enjoy life but, for reasons that might be unknown to some social workers, reality is not the same for suicidal people. Therefore, when coming into contact with suicidal people, social workers need to be aware that they are the experts of their experience, rather than the social workers. Social workers need to be active listeners and not the passive listeners suicidal people often encounter when seeking help.

Despite suicide being a major cause of death in Canada (Navaneelan, 2012), society often avoids discussing it. For example, a participant in Rector's study describes when a healthcare professional brushes aside the subject in favour of more "productive subjects" (2017, p. 39). Stefan (2016) also mentions that healthcare professionals will favour clients at least risk of suicide. Even the word "suicide" evokes uncomfortable feelings, and many people try to avoid discussing it (Chapple, Ziebland, & Hawton, 2015). Suicide is a taboo subject, defined by Chapple et al. (2015) as a "danger to the social order" (p. 622), one of the factors contributing to the highly stigmatized nature of suicide. Therefore, I recommend that social workers speak openly about suicide, explicitly using the word "suicide" when speaking about the subject. Using the word "suicide," which society has constructed as an abnormality, rendering suicidal people abnormal, may contribute to destigmatizing suicide.

Finally, similar to the perceived abnormality of suicide and suicidal people, social workers need to refrain from discourse that promotes living at all costs, denies dying as ever being an option, or describing suicidal people as a problem that needs fixing. The subject of suicide and the word "suicide" need to be positively reclaimed, in order to destigmatize suicide and suicidal people, which may be achieved by refraining from discourse suggesting that staying alive is the ultimate goal in life; that if you do not want to live, we need to fix you; or that you do

not know what is best for you but society and healthcare professionals do. Once social workers start refraining from treating suicide as an abnormality and stop using a paternalistic approach toward suicidal people, not only will suicidal people potentially be less resistant to reaching out, but society as a whole may be encouraged to listen to and respect suicidal people.

CONCLUSION

Chapter 1 provided a historical overview of suicide and its conceptualizations, and a justification as to why theoretical frameworks of epistemic injustice and suicidism are well-suited to describe the various forms of oppressions experienced by suicidal people. The concepts of hermeneutical marginalization and testimonial smothering, from the theoretical framework of epistemic injustice, as well as the concepts of silencing suicidal people and compulsory liveness, from the theoretical framework of suicidism, describe not only the oppression to which suicidal people are subjected but the discrimination they experience, acting as barriers preventing suicidal people from accessing respectful interventions. These theoretical frameworks provided an understanding of the treatment of suicidal people and its impacts and guide the critical literature review of this research. **Chapter 2** explored the experiences of social workers when they encounter suicidal people. Ultimately, social workers describe being unprepared when coming into contact with suicidal people, since they are provided with little or no suicide-related training and education in their university studies or the workplace. Also, this chapter explained that it is essential social workers be provided with continuing suicide-related education. The social work code of ethics clearly serves as guidelines for suicide intervention strategies and impacts social workers' interventions with suicidal people. This chapter also explored various suicide intervention strategies employed by social workers, such as community-based interventions, dialectical behaviour therapy (DBT), cognitive behavioural therapy (CBT), Collaborative Assessment and Management of Suicidality (CAMS), and Applied Suicide Intervention Skills Training (ASIST). In **Chapter 3**, various testimonies by suicidal people provided a better understanding of the impacts of many suicide intervention strategies. This chapter highlighted the inhumane practices of being criminalized, involuntarily hospitalized, or forcibly medicalized often experienced by suicidal people, and their impacts on suicidal individuals. Scientific

evidence was presented in this chapter to demonstrate the ineffectiveness of many suicide intervention strategies employed by healthcare professionals, including social workers. Finally, **chapter 4** provided recommendations for alternative suicide intervention strategies based on the research explored through the critical review. Essentially, suicide intervention strategies should respect suicidal people's needs and avoid treating people coercively or without their consent. The concepts raised in the theoretical frameworks of epistemic injustice and suicidism indicate that most suicide intervention strategies implicitly or explicitly associate suicide with abnormality and suicidal people with needing to be fixed. Ultimately, this critical literature review indicated that interventions providing suicidal people with a safe space to express their suicidal thoughts and be listened to should be made a priority and coercive treatment of suicidal people be avoided.

Ashley Smith was regularly subject to coercive treatment to prevent her suicide. After enduring years of coercive treatment by guards who were presumably supposed to ensure her safety, she completed suicide. We could imagine what would have happened to Ashley if she had been treated with compassion and respect. Would she have chosen to live and eventually been released from prison? Or would she have completed suicide regardless? In keeping with considering whether Ashley would have chosen to live or die if subject to respectful suicide intervention strategies by prison guards, research on providing suicidal people with a safe space to express their suicidal thoughts, rather than treating them coercively, remains limited. Specific to this text, research is sparse regarding social workers' experiences when encountering suicidal people. In addition to limited general research on alternative suicide interventions strategies or on social workers' experiences when coming into contact with suicidal people, my research has certain limitations as well. First, data regarding social workers' experiences when encountering suicidal people was gathered by analyzing existing literature, which is limited. In-person interviews with social workers could have potentially led to different results than the critical

literature review conducted here. However, current restrictions related to the pandemic created some barriers to conducting in-person interviews, important for obtaining results. Second, data regarding suicidal people's experiences with suicide intervention strategies was also gathered by analyzing existing literature, which is also limited. However, given the complexity of suicide and the significant stigma associated with suicide and suicidal individuals, participants would have been difficult to find within the limited timeframe of this research. Much like interviewing social workers, current pandemic restrictions also created a barrier to conducting in-person interviews, which could have potentially provided different results than the critical literature review conducted here.

While this critical literature review briefly mentions society and non-suicidal people perceiving peer support groups as a place where suicidal people may encourage one another to complete suicide, future research related to suicidality should include an exploration of suicide triggers. The critical review indicates that suicidal people need to be listened to and express their feelings but if they were to do so in a space with other suicidal people, would suicide attempts and suicide rates increase? At the University of Ottawa, when a person dies of suicide, an email is sent to all students explaining that we have lost somebody in the community, without mentioning suicide. Does speaking about suicide make others suicidal? Do we avoid mentioning a person's suicide to avoid suicidal feelings in others or do we avoid speaking of suicide because of social taboos? Future research on what acts as triggers for suicide attempts and suicide is needed to have a better understanding of the expression of suicidal thoughts and whether it does or does not in fact trigger suicidal behaviour.

REFERENCES

- Alonso, Y. (2004). The biopsychosocial model in medical research: The evolution of the health concept over the last two decades. *Patient Education and Counseling*, 53(2), 239–244. [https://doi.org/10.1016/S0738-3991\(03\)00146-0](https://doi.org/10.1016/S0738-3991(03)00146-0)
- Bal, B. S. (2009). An introduction to medical malpractice in the United States. *Clinical Orthopaedics and Related Research*, 467(2), 339–347. <https://doi.org/10.1007/s11999-008-0636-2>
- Baril, A. (2017). The somatechnologies of Canada’s medical assistance in dying law: LGBTQ discourses on suicide and the injunction to live. *Somatechnics*, 7(2), 201–217. <https://doi.org/10.3366/soma.2017.0218>
- Baril, A. (2018). Les personnes suicidaires peuvent-elles parler? Théoriser l’oppression suicidiste à partir d’un modèle sociosubjectif du handicap. *Criminologie*, 51(2), 189–212. <https://doi.org/10.7202/1054240ar>
- Baril, A. (2020). Suicidism: A new theoretical framework to conceptualize suicide from an anti-oppressive perspective. *Disability Studies Quarterly*, 40(3). <https://doi.org/10.18061/dsq.v40i3.7053>
- Bayliss, G. (2016). It doesn’t get better. Canada's assisted-suicide law fails the mentally ill. *The Walrus*. <https://thewalrus.ca/suicide-is-not-painless/>
- Bergmans, Y., Rowe, A., Dineen, M., & Johnson, D. (2016). When despair and hope meet the stigma of “manipulation” and “ambivalence.” In J. White, I. Marsh, M. J. Kral, & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for the 21st century* (pp. 133–153). Vancouver: University of British Columbia Press.
- Bogart, K. R., & Dunn, D. S. (2019). Ableism special issue introduction. *Journal of Social Issues*, 75(3), 650–664. <https://doi.org/10.1111/josi.12354>

- Borecky, A., Thomsen, C., & Dubov, A. (2019). Reweighing the ethical tradeoffs in the involuntary hospitalization of suicidal patients. *American Journal of Bioethics*, 19(10), 71–83. <https://doi.org/10.1080/15265161.2019.1654557>
- Britton, P. C., Patrick, H., Wenzel, A., & Williams, G. C. (2011). Integrating motivational interviewing and self-determination theory with cognitive behavioral therapy to prevent suicide. *Cognitive and Behavioral Practice*, 18(1), 16–27. <https://doi.org/10.1016/j.cbpra.2009.06.004>
- Canadian Association of Social Work (CASW). (2005a). *Code of Ethics*. https://www.casw-acts.ca/files/documents/casw_code_of_ethics.pdf
- Canadian Association of Social Work (CASW). (2005b). *Guidelines for Ethical Practice*. https://www.casw-acts.ca/files/documents/casw_guidelines_for_ethical_practice.pdf
- Canadian Association of Social Work (CASW). (n.d.) What social workers do. <https://www.casw-acts.ca/en/what-social-work/what-social-workers-do>
- Canadian Association of Social Work Education (CASWE). (2021). *Field resources*. <https://caswe-acfts.ca/home/>
- Canadian Mental Health Association. (2021). ASIST (Applied Suicide Intervention Skills Training). <https://cmhaww.ca/events/asist-applied-suicide-intervention-skills-training-39/>
- Carpiniello, B. & Pinna, F. (2017). The reciprocal relationship between suicidality and stigma. *Frontiers in Psychiatry*, 8(35). <https://doi.org/10.3389/fpsy.2017.00035>
- Castelein, S., Bruggeman, R., van Busschbach, J. T., van der Gaag, M., Stant, A. D., Knegtering, H., & Wiersma, D. (2008). The effectiveness of peer support groups in psychosis: A randomized controlled trial. *Acta Psychiatrica Scandinavica*, 118(1). 64-72. <https://doi.org/10.1111/j.1600-0447.2008.01216.x>

- Chamberland, V. (2011). L'euthanasie et l'aide au suicide: Enquête sur la position des travailleurs sociaux au Québec. *Frontières*, 24(1–2), 36–44.
<https://doi.org/10.7202/1013083ar>
- Chapple, A., Ziebland, S., & Hawton, K. (2015). Taboo and the different death? Perceptions of those bereaved by suicide or other traumatic death. *Sociology of Health & Illness*, 37(4), 610–625. <https://doi.org/10.1111/1467-9566.12224>
- Corrigan, P. (2004). How stigma interferes with mental health care. *The American Psychologist*, 59(7), 614–625. <https://doi.org/10.1037/0003-066X.59.7.614>
- Crichton, P., Carel, H., & Kidd, I. J. (2017). Epistemic injustice in psychiatry. *BJPsych Bulletin*, 41(2), 65–70. <https://doi.org/10.1192/pb.bp.115.050682>
- D'Anci, K. E., Uhl, S., Giradi, G., & Martin, C. (2019). Treatments for the prevention and management of suicide: A systematic review. *Annals of Internal Medicine*, 171(5), 334–342. <https://doi.org/10.7326/M19-0869>
- De Somma, E., Jaworska, N., Heck, E., & MacQueen, G. M. (2017). Campus mental health policies across Canadian regions: Need for a national comprehensive strategy. *Canadian Psychology/Psychologie canadienne*, 58(2), 161–167. <https://doi.org/10.1037/cap0000089>
- Dean, H. (2007). Marginalization, outsiders. In G. Ritzer (Ed.), *Blackwell encyclopedia of sociology*. <https://doi-org.proxy.bib.uottawa.ca/10.1002/9781405165518.wbeosm026>
- Dewsbury, G., Clarke, K., Randall, D., Rouncefield, M., & Sommerville, I. (2004). The anti-social model of disability. *Disability & Society*, 19(2), 145–158.
<https://doi.org/10.1080/0968759042000181776>
- Dotson, K. (2011). Tracking epistemic violence, tracking practices of silencing. *Hypatia*, 26(2), 236–257. <https://doi.org/10.1111/j.1527-2001.2011.01177.x>

- East, L., Dorozenko, K. P., & Martin, R. (2021). The construction of people in suicide prevention documents. *Death Studies, 45*(3), 182–190.
<https://doi.org/10.1080/07481187.2019.1626938>
- Feldman, B. N., & Freedenthal, S. (2006). Social work education in suicide intervention and prevention: An unmet need? *Suicide & Life-Threatening Behavior, 36*(4), 467–480.
<https://doi.org/10.1521/suli.2006.36.4.467>
- Flood, C. M., & Thomas, B. (2011). Canadian medical malpractice law in 2011: Missing the mark on patient safety. *Chicago-Kent Law Review, 86*(3), 1053–1092.
- Fricker, M. (2006). Powerlessness and social interpretation. *Epistemic: A Journal of Social Epistemology, 3*(1), 96–108. <https://doi.org/10.1353/epi.0.0004>
- Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.
- Fricker, M., & Jenkins, K. (2017). Epistemic injustice, ignorance and trans experiences. In A. Garry, S. J. Khader, & A. Stone (Eds.), *Routledge companion to feminist philosophy* (pp. 268-278). New York: Routledge.
- Gearing, R. E., & Lizardi, D. (2009). Religion and suicide. *Journal of Religion and Health, 48*(3), 332–341. <https://doi.org/10.1007/s10943-008-9181-2>
- Government of Canada. (2021). Medical assistance in dying. <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a2>
- Huh, D., Jobs, D. A., Comtois, K. A., Kerbrat, A. H., Chalker, S. A., Gutierrez, P. M., & Jennings, K. W. (2018). The collaborative assessment and management of suicidality (CAMS) versus enhanced care as usual (E-CAU) with suicidal soldiers: Moderator analyses from a randomized controlled trial. *Military Psychology, 30*(6), 495–506.
<https://doi.org/10.1080/08995605.2018.1503001>

- Inwood, M. (1998). Hermeneutics. *Routledge encyclopedia of philosophy*. Retrieved April 10, 2021, from <https://www.rep.routledge.com/articles/thematic/hermeneutics/v-1>.
- Jenkins, R., & Kovess, V. (2002). Evaluation of suicide prevention: A European approach. *International Review of Psychiatry, 14*(1), 34–41.
<https://doi.org/10.1080/09540260120114041>
- Jobes, D. A. (2012). The Collaborative Assessment and Management of Suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide & Life-Threatening Behavior, 42*(6), 640–653. <https://doi.org/10.1111/j.1943-278X.2012.00119.x>
- Jobes, D. A., & Joiner, T. E. (2019). Reflections on suicidal ideation. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 40*(4), 227–230. <https://doi.org/10.1027/0227-5910/a000615>
- Joe, S., & Niedermeier, D. (2008). Preventing suicide: A neglected social work research agenda. *The British Journal of Social Work, 38*(3), 507–530.
<https://doi.org/10.1093/bjsw/bcl353>
- Kious, B. M., & Battin, M. (Peggy). (2019). Physician aid-in-dying and suicide prevention in psychiatry: A moral crisis? *American Journal of Bioethics, 19*(10), 29–39.
<https://doi.org/10.1080/15265161.2019.1653397>
- Kral, M. J. & Idlout, L. (2016). Indigenous best practices: Community-based suicide prevention in Nunavut, Canada. In J. White, I. Marsh, M. J. Kral, & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for the 21st century*, (pp. 229–243). Vancouver: University of British Columbia Press.
- Kim, H., & Stoner, M. (2008). Burnout and turnover intention among social workers: Effects of role stress, job autonomy and social support. *Administration in Social Work, 32*(3), 5–25.
<https://doi.org/10.1080/03643100801922357>

- King, A. (2019, November 13). How a student seeking mental-health treatment got handcuffed by U of T police. *CBC News*. Retrieved April 20, 2021, from <https://www.cbc.ca/news/canada/toronto/u-of-t-student-handcuffed-while-seeking-mental-health-treatment-1.5357296>
- Kumbhare, S. (2020). A reconceptualization of suicide and social workers' duty to report. *OMEGA: Journal of Death and Dying*, 1–17.
<https://doi.org/10.1177/0030222820963773>
- Linehan, M. M., Korlund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., McDavid, J., Comtois, K. A., & Murray-Gregory, A. M. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *JAMA Psychiatry*, 72(5), 475–482.
<https://doi.org/10.1001/jamapsychiatry.2014.3039>
- Lytle, M. C., Silenzio, V. M. B., Homan, C. M., Schneider, P., & Caine, E. D. (2018). Suicidal and help-seeking behaviors among youth in an online lesbian, gay, bisexual, transgender, queer, and questioning social network. *Journal of Homosexuality*, 65(13), 1916–1933.
<https://doi.org/10.1080/00918369.2017.1391552>
- Maier-Clayton, A. (2016, May 8). As a person with mental illness, here's why I support medically assisted death. *The Globe and Mail*.
<https://www.theglobeandmail.com/life/health-and-fitness/health/as-a-person-with-mental-illness-heres-why-i-support-medically-assisted-death/article29912835/>
- Malebranche, M., Morisod, K., & Bodenmann, P. (2020). Deaf culture and health care. *Canadian Medical Association Journal (CMAJ)*, 192(50), E1809.
<https://doi.org/10.1503/cmaj.200772>

- Martin, N. (2011). Preserving trust, maintaining care, and saving lives: Competing feminist values in suicide prevention. *International Journal of Feminist Approaches to Bioethics*, 4(1), 164–187. <https://doi.org/10.2979/intjfemappbio.4.1.164>
- McNeish, R., & Tran, Q. (2020). Leadership that promotes successful implementation of community-based mental health interventions. *Journal of Community Psychology*, 48(5), 1500–1511. <https://doi.org/10.1002/jcop.22343>
- Mello, M. M., Frakes, M. D., Blumenkranz, E., & Studdert, D. M. (2020). Malpractice liability and health care quality: A review. *JAMA: The Journal of the American Medical Association*, 323(4), 352–366. <https://doi.org/10.1001/jama.2019.21411>
- Mishna, F., Antle, B. J., & Regehr, C. (2002). Social work with clients contemplating suicide: Complexity and ambiguity in the clinical, ethical, and legal considerations. *Clinical Social Work Journal*, 30(3), 265–280. <https://doi.org/10.1023/A:1016045431637>
- Murphy, J. (2014). *Community-based interventions: Philosophy and action* (1st ed.). New York: Springer.
- Maple, M., Pearce, T., Sanford, R. L., & Cerel, J. (2017). The role of social work in suicide prevention, intervention, and postvention: A scoping review. *Australian Social Work*, 70(3), 289–301. <https://doi.org/10.1080/0312407X.2016.1213871>
- Navaneelan, T. (2012). Suicide rates: An overview. *Statistics Canada Catalogue 82-624-X*. <https://www150.statcan.gc.ca/n1/pub/82-624-x/2012001/article/11696-eng.htm>
- Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic Reviews*, 30(1), 133–154. <https://doi.org/10.1093/epirev/mxn002>
- Raboch, J., Kalisova, L., Kjellin, L., Priebe, S., Kallert, T. W., Nawka, A., Kitlerove, E., Onchev, G., Karastergiou, A., Magliano, L., Dembinskas, A., Kiejna, A., & Torrs-Gonzales, F.

- (2010). Use of coercive measures during involuntary hospitalization: Findings from ten european countries. *Psychiatric Services*, *61*(10), 1012–1017.
<https://doi.org/10.1176/appi.ps.61.10.1012>
- Radford, K., Wishart, E., & Martin, R. (2019). “*All I need is someone to talk to*”: *Evaluating DISCHARGED suicide peer support*. <https://www.recoverymatters.com.au/wp-content/uploads/2020/12/Evaluating-DISCHARGED-Suicide-Peer-Support.pdf>
- Reamer, F. G. (1995). Malpractice claims against social workers: First facts. *Social Work*, *40*(5), 595–601. <https://doi.org/10.1093/sw/40.5.595>
- Rector, A. (2017). “*Because life is shitty*”: *Reconsidering suicidal distress and imagining humanizing responses*. (Unpublished Master’s thesis). McMaster University, Hamilton.
https://macsphere.mcmaster.ca/bitstream/11375/22148/2/Rector_Amy_FinalSubmission2017September_MSW.pdf
- Rich, A. C. (2003). Compulsory heterosexuality and lesbian existence (1980). *Journal of Women’s History*, *15*(3), 11–48. <https://doi.org/10.1353/jowh.2003.0079>
- Rimkevičienė, J., Skruibis, P., & Padroštytė, G. (2020). Effectiveness of applied suicide intervention skills training (ASIST) in Lithuania. *Death Studies*, 1–7.
<https://doi.org/10.1080/07481187.2020.1867254>
- Ruth, B. J., Gianino, M., Muroff, J., McLaughlin, D., & Feldman, B. N. (2012). You can’t recover from suicide: Perspectives on suicide education in MSW programs. *Journal of Social Work Education*, *48*(3), 501–516. <https://doi.org/10.5175/JSWE.2012.201000095>
- Sanders, S., Jacobson, J. M., & Ting, L. (2008). Preparing for the inevitable: Training social workers to cope with client suicide. *Journal of Teaching in Social Work*, *28*(1-2), 1–18.
<https://doi.org/10.1080/08841230802178821>

- Schmitz Jr., W. M., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., Quinnett, P., & Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: An American association of suicidology task force report addressing serious gaps in U.S. mental health training. *Suicide & Life-Threatening Behavior*, 42(3), 292–304. <https://doi.org/10.1111/j.1943-278X.2012.00090.x>
- Scully, J. (2020, February 27). Why medical assistance in dying must treat mental and physical illness equally. *CBC News*. <https://www.cbc.ca/news/opinion/opinion-assisted-dying-aid-legislation-mental-health-1.5474025>
- Shyman, E. (2016). The reinforcement of ableism: Normality, the medical model of disability, and humanism in applied behavior analysis and ASD. *Intellectual and Developmental Disabilities*, 54(5), 366–376. <https://doi.org/10.1352/1934-9556-54.5.366>
- Silva, C., Smith, A. R., Dodd, D. R., Covington, D. W., & Joiner, T. E. (2016). Suicide-related knowledge and confidence among behavioral health care staff in seven states. *Psychiatric Services*, 67(11), 1240–1245. <https://doi.org/10.1176/appi.ps.201500271>
- Smith, A. R., Silva, C., Covington, D. W., & Joiner, T. E. (2014). An assessment of suicide-related knowledge and skills among health professionals. *Health Psychology*, 33(2), 110–119. <https://doi.org/10.1037/a0031062>
- Stefan, S. (2016). *Rational suicide, irrational laws: Examining current approaches to suicide in policy and law*. Oxford University Press.
- Szasz, T. (1999). *Fatal freedom: The ethics and politics of suicide*. Westport: Praeger Publishers.
- The Fifth Estate. (2010, November 12). Timeline: The life and death of Ashley Smith. *CBC*. <https://www.cbc.ca/fifth/blog/the-life-and-death-of-ashley-smith>

- Ting, L., Jacobson, J. M., & Sanders, S. (2011). Current levels of perceived stress among mental health social workers who work with suicidal clients. *Social Work, 56*(4), 327–336.
<https://doi.org/10.1093/sw/56.4.327>
- Wade, D. T., & Halligan, P. W. (2017). The biopsychosocial model of illness: A model whose time has come. *Clinical Rehabilitation, 31*(8), 995–1004.
<https://doi.org/10.1177/0269215517709890>
- Wedlake, G. (2020). Complicating theory through practice: Affirming the right to die for suicidal people. *Canadian Journal of Disability Studies, 9*(4), 89–110.
<https://doi.org/10.15353/cjds.v9i4.670>
- Wray, M., Colen, C., & Pescosolido, B. (2011). The sociology of suicide. *Annual Review of Sociology, 37*(1), 505–528. <https://doi.org/10.1146/annurev-soc-081309-150058>
- Yip, P., Pitt, D., Wang, Y., Wu, X., Watson, R., Huggins, R., & Xu, Y. (2010). Assessing the impact of suicide exclusion periods on life insurance. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 31*(4), 217–223. <https://doi.org/10.1027/0227-5910/a000023>