# Suicide Prevention in Occupational Therapy

CAOT Role Paper

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Canadian Association of Occupational Therapists
Association canadienne des ergothérapeutes

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## DISCLAIMER

This is a proposal to extend a standard occupational therapy practice into an emerging role. Roles and recommendations proposed in this document do not preclude the possibility that other approaches or practices are valid and relevant. Occupational therapists and occupational therapist assistants must use their clinical judgment and consider factors such as clients' preferences and resource availability when applying these recommendations. Any provincial regulations related to occupational therapy practice and those of occupational therapist assistants should be followed.

To ensure the readability of the text, the term "occupational therapists" is used throughout. As most of the roles and recommendations proposed here are also relevant to occupational therapist assistants, we hope this document will support the practice of both occupational therapists and occupational therapist assistants.

Recommendations presented in this document are based on the best information available. Should new information become available and modifications to the recommendations be warranted, the Canadian Association of Occupational Therapists (CAOT) reserves the right to update and issue a new version of this role paper at any time.

Concerns or questions related to the content of this role paper should be addressed to Julie Lapointe, CAOT Director of Knowledge Translation Programs at practice@caot.ca or at 1(800) 434-2268, ext. 260.

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## PREFACE

The Canadian Association of Occupational Therapists (CAOT) is honoured to have Dr. Catherine Backman author the preface of our inaugural role paper, Suicide Prevention in Occupational Therapy. Dr. Backman is an engaged and dedicated member of the CAOT community, a noted educator in the Department of Occupational Science & Occupational Therapy at The University of British Columbia (UBC), and Senior Scientist with Arthritis Research Canada.

Catherine has, and continues to make, significant contributions to the evolving body of occupational therapy knowledge in Canada through her teaching, research and volunteer commitments. She has served in multiple volunteer positions over the course of many years for the benefit of CAOT, including the role of President from 2018 and 2020. She has also been selected for the prestigious Muriel Driver Memorial Lectureship Award (2003), became a CAOT Fellow (2004) and received a CAOT Award of Merit (2014). As professor and scientist, Catherine has led an impressive body of research work aiming to get a better understanding of the occupational disruptions of people living with chronic illnesses such as arthritis. She has also examined the perceptions and integration of occupational balance in sustaining health and well-being.

## SUICIDE PREVENTION IS A PUBLIC HEALTH IMPERATIVE.

Occupational therapy is concerned with helping people of all ages and abilities to participate in the tasks, activities, and occupations that matter to them. Being deprived of occupations due to illness, personal crisis, environmental barriers, or life circumstances is a contributing factor to suicide. This role paper outlines how occupational therapists and occupational therapy assistants can identify clients at risk of suicide and take steps to prevent suicide. Importantly, reducing the risk of suicide is not limited to mental health settings but is relevant to all practice settings.

A key question for people at risk of suicide discussed in this paper is *Do you want to stop living, or stop living like this?* Occupational therapy plays a critical role in ensuring people can realize their potential to do what matters and re-establish or discover new occupations that give their life meaning.

For example, this paper introduces Martha, whose ability to care for her grandchildren was disrupted by a stroke, then a fractured hip, contributing to depression and an observed risk for suicide. Once a safety plan is in place, an occupational therapist finds ways to help Martha address her feelings, gather resources, and develop skills to engage with her grandchildren in the context of her current situation. Readily embedded within a suicide prevention framework when indicated, occupational therapy supports others to do their job, succeed at school, socialize with peers, and otherwise engage in the rhythm of daily life.

This role paper integrates expertise from CAOT's *Suicide and OT Practice Network* with findings from the literature and national documents on suicide prevention. As a professional development tool, it offers specific practice suggestions and provokes reflection on suicide prevention. This is an important first step to advance practice, alleviate suffering, and contribute to resolving a societal crisis, because every death by suicide is heartbreaking.

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## EXECUTIVE SUMMARY

This Canadian Association of Occupational Therapists (CAOT) role paper seeks to support Canadian occupational therapists and occupational therapist assistants working with clients who are suffering and who may be considering suicide, and offer specific and practical recommendations. Suffering is a central issue in referrals to occupational therapy. Looking at suicide exclusively within practice settings oriented toward mental health is not a best practice. This paper is relevant to practice throughout the continuum of occupational therapy services across diverse practice areas in health, education, and social service sectors.

The first section provides a background and rationale for a why a role paper on occupational therapy and suicide prevention is needed. This section is followed by a presentation of the methods chosen to complete this work. A rapid review of the literature pertaining to the role of occupational therapy in suicide prevention was conducted, occupational therapists working in the field were consulted, and CAOT members invited to comment on draft recommendations. The main part, the section on the role of occupational therapists, presents evidence as well as expert consensus and opinion on the contribution of occupational therapists in this context. The document concludes with a discussion and provides a vision of the future of suicide prevention related to occupational therapy.

Occupational therapists need to consider the mental health status of their clients and recognize that suicidal ideation is a significant occupational barrier in every practice setting. Our hope is that occupational therapists and occupational therapist assistants are equipped with adequate knowledge and training to address suicide and recognized as essential partners in public health initiatives related to suicide.

## BACKGROUND AND RATIONALE

"Every 40 seconds a person dies by suicide somewhere in the world and many more attempt suicide" (WHO, 2014, p.3). In Canada, suicide is one of the top ten causes of death (Mental Health Commission of Canada [MHCC], 2019), with an annual death rate of 11.5 people per 100 000 (Navaneelan, 2009). The consequences of suicide extend beyond the individuals who die, with a ripple effect affecting a total of 6 to 28 people (American Association of Suicidology, 2010; Knieper, 1999). For instance, losing a co-worker to suicide has been reported to take a toll on individual team members, which can be devastating and affect overall team performance (Lynn, 2008).

The World Health Organization (2014) provides guidance on how society can address this epidemic. "The burden of suicide does not weigh solely on the health sector; it has multiple impacts on many sectors and on society as a whole" (WHO, 2014, p.2). Nations are advised to develop and use a multi-level comprehensive and contextual approach to suicide prevention that involves a range of systems and stakeholders.

The response within the Canadian context has reached a groundswell. In 2012, Bill C-300 became law and obliged the Canadian government to engage stakeholders in developing a federal framework to help resolve this national dilemma (Government of Canada, 2014). In 2016, the *Federal Framework for Suicide Prevention* was released identifying three main objectives: to address stigma and raise public awareness, connect Canadians with information and resources, and accelerate knowledge transfer and implementation of suicide prevention measures (Public Health Agency of Canada, 2016). The framework also identified groups at high risk for suicide and highlighted the need to concert efforts to decrease deaths by suicide in these populations (2016). Key government initiatives make suicide a priority. With *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, the Mental Health Commission of Canada made suicide prevention one of its six key pillars (MHCC, 2019). The National Aboriginal Youth Suicide Prevention Strategy Program Framework (Government of Canada, 2013) and the National Inuit Suicide Prevention Strategy (Inuit Tapiriit Kanatami, 2016) developed specific suicide prevention strategies to address elevated suicide risk.

Because suicide has been identified as a top priority by different governments, all sectors of society are called upon to do their part to address the public health crisis. As part of the healthcare sector, occupational therapists are responsible for contributing their knowledge and skillset in preventing and managing the impact of suicide within Canada.

Although no formal guidelines have governed suicide prevention, addressing suicide in practice is not new to occupational therapists. A 2014 survey of Canadian occupational therapists revealed that suicide was a concern and a reality across all practice settings (Collins, Vrbanac, & Hewitt, 2014). Furthermore, over 88% of occupational therapists reported providing some suicide intervention over the course of their career (Collins, Vrbanac, & Hewitt, 2014). These statistics should come as no surprise as clients come to occupational therapists when they have a problem that impedes their ability to participate fully in activities they need and want to do. In these situations, they are likely suffering. Equipping clients to respond effectively in such situations is one of the goals of our profession (Egan, 2007, p. 300):

"Relief of suffering seems to be the tacit goal of both the practice and theory of our profession.

Attention to suffering, action to alleviate remediable suffering, avoidance of infliction of further suffering, continuing development of equanimity and compassion in the face of irremediable suffering, provision of safe spaces for our patients and explication and discussion of the values and beliefs that guide our responses to suffering will further help make this tacit goal explicit."

Occupational therapists must be made aware of the societal context around suicide prevention in Canada. The report entitled *World Health Organization's Preventing Suicide: A Global Imperative* (WHO, 2014) states explicitly that a public health approach to suicide prevention is key. The skill of approaching suicide with a broad, multidimensional perspective aligns with Canadian occupational therapists' competencies outlined in the Profile of Occupational Therapists in Canada, where occupational therapy "interventions are directed at the individual, group, community and population level in order to address barriers effectively that interfere with occupational engagement and/or performance" (CAOT, 2012, p. 1).

Looking at suicide within mental health-oriented practice settings only is not a best practice. A public health approach to suicide prevention is recommended (MHCC, 2019; Public Health Agency of Canada, 2016; WHO, 2014). Adopting a public health approach as a best practice challenges occupational therapists, including those in research and academia, to be aware of high-risk groups and to be open to consider suicide ideation as a barrier to engagement in life in any practice setting (Collins, Vrbanac, & Hewitt, 2014; Gutman, 2005). Similarly, according to Milner and colleagues' (2015) systematic review, workplace suicide prevention programs are most effective when they adopt a multi-faceted, comprehensive and community-based approach. Finally, the landmark document *Working Together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention* (Public Health Agency of Canada, 2016) calls for a national, consolidated response across professional practice areas.

Occupational therapy models already implicitly mandate suicide prevention. The Canadian Model of Occupational Performance and Engagement (CMOP-E) addresses suicide, provides hope, and allows clients to pursue and find meaning (Polatajko, Townsend, & Craik, 2007). Concretely, occupational therapists identify the occupations that make life meaningful. They support their clients in planning, initiating and tracking short- and long-term goals that enable participation in activities. They address possible risk factors for suicide, connect clients with networks of community resources and help clients structure and organize their daily life to balance what they want, need or are expected to do.

Written for occupational therapists and occupational therapist assistants, this CAOT role paper aims to support Canadian therapists working with clients who are suffering. It offers specific, practical evidence-based recommendations as well as expert consensus and opinion to support clients whose suffering evolves into suicidal ideation.

[1]These associations were the American Occupational Therapy Association, the Royal College of Occupational Therapists, Occupational Therapy Australia, the Canadian Alliance of Mental Illness and Mental Health, and the World Federation of Occupational Therapists.

## METHODOLOGY

A rapid scoping review was completed to examine and summarize publications that looked at the role of occupational therapists in suicide prevention and to inform the development and selection of practice recommendations. A scoping review framework was used because it helped the review team formulate a broad research question and examine a wide range of publications and design (Arksey & O'Malley, 2005). The process made it possible to identify gaps in current evidence and lay the groundwork for recommendations in the future. A rapid review is a recognized approach to synthesize evidence in a short time-frame (Ganann, Ciliska, & Thomas, 2010). Choices made to keep the scoping review within a manageable timeframe are described below.

**Identification of the research question**

The overarching question that guided this search for publications was: "What is the role of occupational therapists in suicide prevention?"

**Identification of relevant publications and selection**

One person was responsible for the identification and selection of publications. Publications were identified in the following electronic databases: PubMed, Embase, PsychInfo and the Cochrane Library. The CDC Information Database, National Institute for Health and Care Excellence (NICE) and National Guideline Clearinghouse were also consulted.

For the first wave of identified publications, documents had to contain the term "occupation" or "occupational therap*" and the term "suicide" or "suicide prevention" (Table 1). Because these parameters led to few results, a second wave of publications were identified. For the second wave, the term "recommendations" or "guidelines" AND "suicide prevention" were used (Table 1). General searches on Google Scholar using terms such as "role of occupational therapy in suicide prevention," "occupational therapy" and "suicide prevention" produced a list of publications that helped to inform the final choice of keywords used in the database searches. Reference lists of relevant publications and websites of occupational therapy associations were also consulted to identify relevant publications. The websites of CAOT and other renowned occupational therapy associations were searched with the key words "suicide prevention." Finally, occupational therapist members of the CAOT Practice Network called *Suicide and OT Practice Network* were invited to submit relevant publications and resources for consideration. The identification of publications took place from March to April 2017.

*Table 1. Keywords used to identify publications*

| First wave of publication searches | | |
|---|---|---|
| Occupational therap* | AND | Suicide prevention |
| Occupation | | Suicide |
| | | Suicid* |
| | | Suicide risk management |
| **Second wave of publication searches** | | |
| Recommendations | AND | Suicide prevention |
| Guidelines | | |

**Selection criteria**
To be selected, publications had to contain information about the role of an occupational therapist related to suicide prevention or recommendations that could be used in or transferred to an occupational therapy practice. Publications had to be written in English. There was no limit placed on the year of publication. Publication design types were limited to reviews or knowledge transfer tools (i.e., guidelines for practice, position statements and expert consensus). All primary research studies were excluded because they were unlikely to propose clear recommendations for practice without advising that more research be conducted to confirm them. The only exception was the inclusion of case reports if they were meant to illustrate recommendations for practice. See Appendix B for the algorithm of the identification and selection process.

In parallel, two people appraised all publications that met inclusion criteria using the Evidence Rating Model of the Association of periOperative Registered Nurses (AORN; 2017). Numerical scores were compared and if a global score differed by 20% or more, a consensus meeting was held. The raters agreed on the ratings of 23/27 publications (85%) and after discussion, an agreement was reached related to the four publications with the divergent scores.

**Organizing the data**
Data from selected publications were extracted and featured in a table that included: author, year, title of publication, source of publication, design, specific occupational therapist roles, methodology described (yes/no), quality appraisal score, number of references cited in the publication and insights reviewers had while extracting the information.

**Generating the recommendations**
In July 2017, CAOT selected and trained a group of three volunteer authors, one as a lead author and two as secondary authors. Selection of volunteer authors was based on their level of expertise and availability. Enlisted volunteer authors had to be CAOT members. Their main role consisted of writing the recommendations and proposing a rating of level of evidence for each recommendation according to the following scale:

| | |
|---|---|
| EBR | An Evidence-based Recommendation (EBR) is formulated from a scientific publication (i.e., literature review, meta-analysis or practice guidelines based on a literature review) |
| CBR | A Consensus-based Recommendation (CBR) is formulated in absence of evidence but when authoritative associations or recognized experts in the fields have proposed and published best practice recommendations. |
| PP | A Practice Point (PP) is formulated in absence of evidence or consensus but based on expert opinion of volunteer authors. |

It is important to highlight that the recommendations within this role paper outline roles and responsibilities shared by healthcare providers as well as those unique to occupational therapy practice.

## Frames of reference

A total of three frames of reference or conceptual models inspired the writing of the recommendations. First, the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend, & Craik, 2007) was used as the occupational therapy theory that underpins this paper (see Figure 1). Application of the model clarifies occupational therapists' unique contribution to suicide prevention. Specifically, the CMOP-E (Polatajko, Townsend, & Craik, 2007) was chosen because it features spirituality at its centre, highlighting how people engage in occupations.

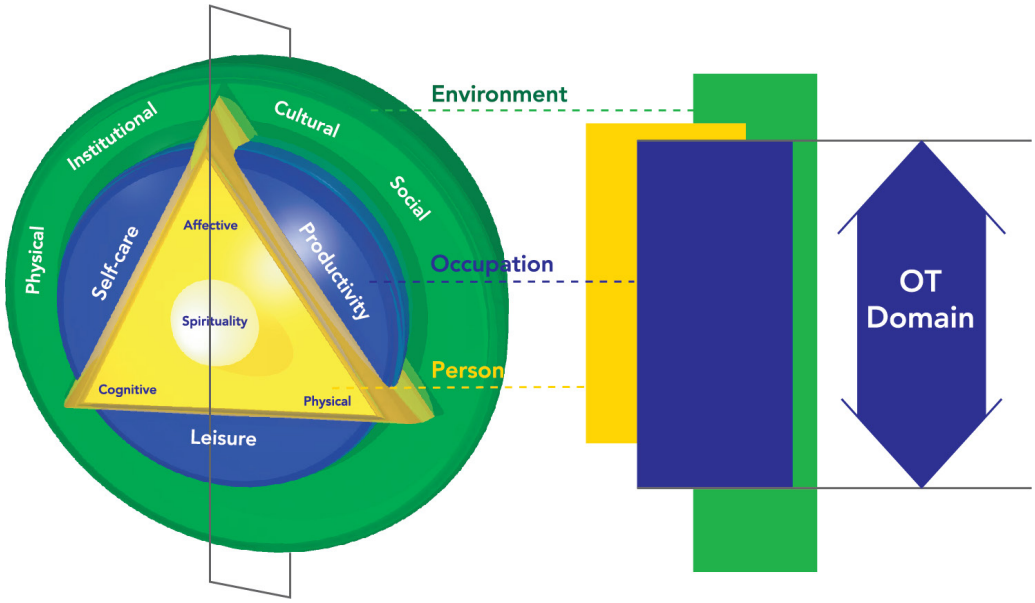



**Figure 1. The Canadian Model of Occupational Performance and Engagement (CMOP-E)**

Second, the Canadian Practice Process Framework (CPPF; Polatajko, Craik, Davis, & Townsend, 2007) was used to structure the recommendations into sub-sections reflecting occupational therapy at various stages of practice. The CPPF was chosen to represent delivery of occupational therapy services across various roles and populations. Figure 2 illustrates the CPPF and its sub-sections.

Third, the Ways of Preventing Suicide Continuum (LivingWorks, 2014a) depicted by the waterfall diagram in Figure 3 was chosen to represent the phases of suicide ideation and the corresponding range of suicide prevention activities, from suicide prevention to intervention to postvention. These phases guided the drafting of the recommendations. In the context of occupational therapy, the phases also reflect the day-to-day work practitioners do to enable meaningful occupations.

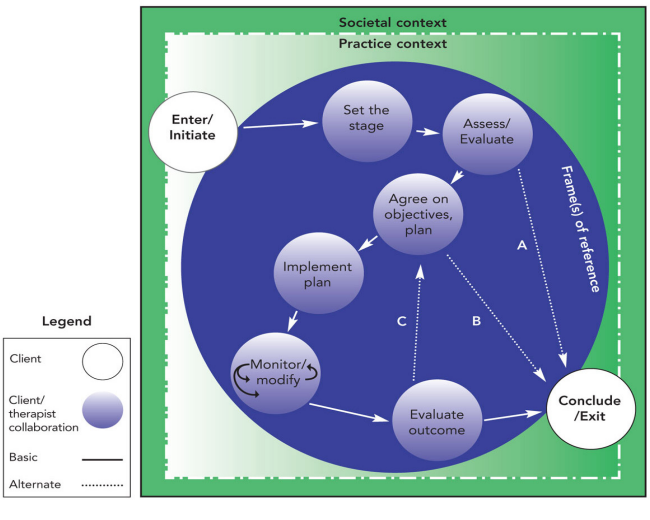



**Figure 2. The Canadian Practice Process Framework (CPPF)**

In the prevention stage, it is understood that everyone will suffer at some point. The dam represents the support most people have while dealing with their suffering, given that most people's suffering does not turn into suicide. Efforts to prevent suicide are illustrated prior to the dam. Once suffering pushes past the dam and someone is considering suicide, the work of suicide intervention begins. Finally, the representation shows that if suicidal ideation shifts into action resulting in either injury or death, the practitioner would work within the postvention phase.

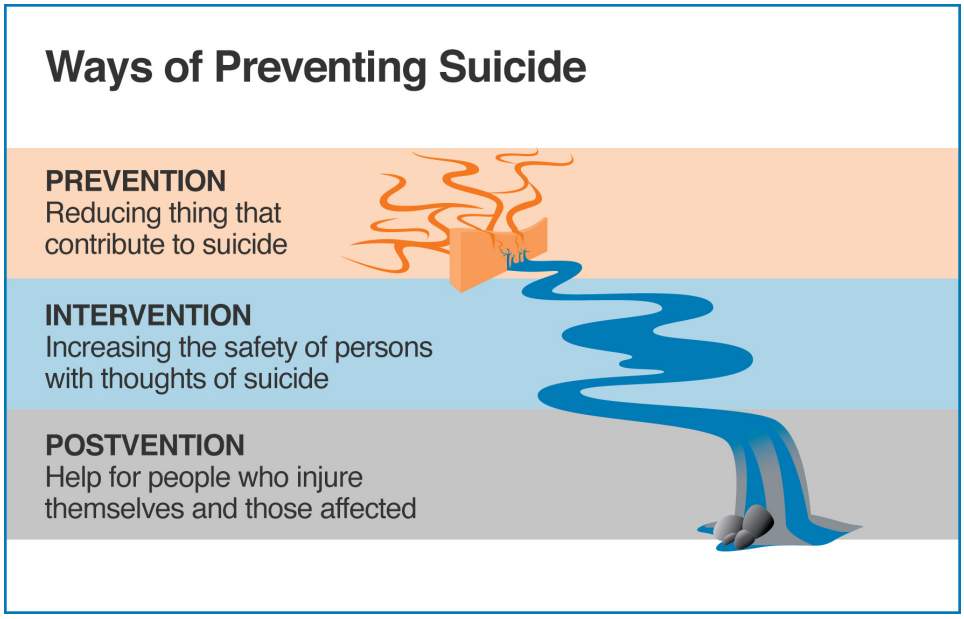



**Figure 3. Suicide Continuum Phases (This image has been reproduced with kind permission of LivingWorks, Inc.)**

### Consultation and revision

A one-month member consultation took place in March 2018 and provided all CAOT members with the opportunity to read and comment on a first draft of recommendations. Comments received from CAOT members and members of the CAOT Practice Network, *Suicide and OT Practice Network*, informed the writing of a second draft. The second draft was sent to selected external stakeholders chosen to represent a wide range of service users and decision-makers. The final revision was coordinated by an appointed CAOT staff member who consulted voluntary authors and experts when needed until the document reached its current form.

### Vignettes

Five vignettes of experiences occupational therapists have had addressing suicide in practice are provided to illustrate possible implementations of recommendations into clinical practice. These vignettes were written by five Canadian occupational therapists and cases were selected to demonstrate how suicidal ideation presents itself across the lifespan. They also demonstrate the theoretical underpinnings, including the various shapes suicide can take within the Canadian Practice Process Framework (Polatajko, Craik, Davis, & Townsend, 2007) and the Ways of Preventing Suicide Continuum (LivingWorks, 2014a). The full story of each vignette can be found in Appendix C. Appendix D presents a guide to support reflection and action planning in suicide prevention.

## OCCUPATIONAL THERAPISTS' ROLE IN SUICIDE PREVENTION PRACTICE RECOMMENDATIONS

Note: EBR = Evidence-based recommendation; CBR = Consensus-based recommendation; PP = Practice point. See page 12 for definitions.

**Canadian Practice Process Framework: Societal Context**
**Suicide Continuum Phase: Prevention**

EBR Seek to gain a greater understanding of what contributes to position certain groups at a high risk of suicide (Hawton & Heeringen, 2009; Public Health Agency of Canada, 2016).

EBR Be knowledgeable about suicide's known risk factors, and be vigilant, particularly when the risk factors are compounded:

| **Some of the known risk factors for suicide[2,3] (in alphabetical order)** |
|---|
| • Addiction (e.g., substances and gambling) |
| • Availability of means |
| • Early traumatic life events |
| • Exposure to suicidal role models |
| • Facing significant life stressors (e.g., trauma, war, victimization and marginalization) |
| • Genetic predisposition |
| • History of family violence (e.g., child abuse and neglect) |
| • Limited problem-solving or coping mechanisms |
| • Mental illness (e.g., depression) |
| • Neurobiological disturbances (e.g., serotonin dysfunction and hypothalamic-pituitary axis hyperactivity) |
| • Perception of being alone or a burden to others |
| • Personal characteristics (e.g., impulsivity and aggressivity) |
| • Physical disorder |
| • Poor physical health |
| • Prior suicide attempt |
| • Psychiatric disorder |
| • Psychosocial crisis |
| • Recent loss |
| • Restricted fetal growth and perinatal circumstances |
| • Self-harming behaviour |

(Hawton & Heeringen, 2009; Public Health Agency of Canada, 2016)

[2]The list presented here is not exhaustive. Readers are encouraged to refer to the latest evidence specific to the population they serve.

[3]Different methods to categorize or profile risk factors have been proposed in reference documents and training programs. We chose not to present any particular method, as no consensus has been reached at the time of production of this document.

CBR Be knowledgeable about known protective factors.

| **Some of the known protective factors for suicide[2] (in alphabetical order)** |
|---|
| • Adaptive coping and problem-solving skills<br>• Cultural identity<br>• Healthy relationships (e.g., familial and social connections)<br>• Responsible media reporting and public awareness<br>• Strong self-esteem |

(Public Health Agency of Canada, 2016)

CBR Use knowledge of high-risk groups to develop prevention strategies at the population or community level (ASIST, 2010).

CBR Become oriented and familiar with key documents that guide suicide prevention strategies in Canada such as *Working Together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention* (Public Health Agency of Canada, 2016); the *National Aboriginal Youth Suicide Prevention Strategy Program Framework* (Government of Canada, 2013), *the National Inuit Suicide Prevention Strategy* (Inuit Tapiriit Kanatami, 2016) and the *Prévention du suicide – Guide de bonnes pratiques à l'intention des intervenants des centres de santé et de services sociaux* (MSSS, 2010).

## Canadian Practice Process Framework: Practice Context Phase within the Suicide Continuum: Prevention

PP Evaluate whether a practice setting is serving clients at high risk for suicide and whether appropriate prevention, identification, response and communication/ documentation measures are in place and understood by all members of the team.

EBR Consider advocating for implementation of community-integrated suicide prevention strategies, efficient crisis management, early identification and response and the appointment of a team member to be trained in and manage the implementation of these strategies in your practice setting (Hewitt, 2014; Isaac, 2009, Robinson et al., 2013).

CBR Communicate the full scope of occupational therapy practice with relevant decision-makers and stakeholders and advocate that occupational therapists take part in suicide prevention initiatives (Petryk, 2014).

CBR Consider suicide prevention training like and as important as cardiopulmonary resuscitation (CPR) training in that being able to respond in a life-or-death crisis is essential (LivingWorks, 2014b).

EBR Acquire the skills to become competent in suicide prevention, including early identification and response (Hawton, 2009; Registered Nurses Association of Ontario [RNAO], 2009; Tryssenaar, 2003).

PP Consider getting trained as a gatekeeper in order to be able to detect suicidal tendencies and provide access to relevant services.

PP Select a gatekeeper-training program that integrates core occupational therapy values such as those related to enablement (Patel & Degagne, 2017).

CBR Know how to evaluate and document suicide risk (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

PP Create and implement processes to aid team communication of suicide risk.

PP When part of a multi-disciplinary team, be knowledgeable about other professions' core values and competencies related to suicide prevention and response.

CBR Invite all relevant stakeholders to get involved in suicide prevention initiatives and advocate for the application of recommendations made in key documents (CAOT, n.d.-a).

CBR Consider using an algorithm or decision aid to determine the response to clients at risk for suicide in different practice settings (Department of Veterans Affairs & Department of Defense, 2013).

CBR Ensure high-risk groups are provided with multi-dimensional suicide prevention services that go beyond medication and include supportive therapy and psychotherapy (Maris, 1995).

EBR Continuously reflect on the emotional impacts of helping clients who are suffering and seek out supervision and support for yourself when needed (RNAO, 2009; Stefanowski-Harding, 1990).

**Canadian Practice Process Framework: Frame of Reference and Enter/initiate**
**Suicide Continuum Phase: Prevention**

CBR Acquire knowledge and skills to be able to recognize when suicidal ideation is present (Centre for Addiction and Mental Health [CAMH], 2011).

EBR Take all indications of suicide seriously, whether explicit or implicit (RNAO, 2009; Fowler, 2012).

EBR Routinely screen clients from a high-risk group for suicidal ideation (Hawton & van Heeringen, 2009; Robinson et al., 2013; Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

CBR Use screening tools to assist the identification of suicidal ideation when an indication of suicide risk is detected (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

CBR Intervene and communicate with clients about suicide in a culturally safe and competent manner (RNAO, 2009).

CBR Acknowledge negative attitudes that may arise when working with a person who has attempted suicide and demonstrate respect and understanding (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

PP If a suicide risk exists, assess the relevance of the referral to occupational therapy services, reprioritize services if needed to address clients' issues and determine whether additional resources are required. Refer a client to a colleague who has gained gatekeeper training and/or advanced knowledge in addressing suicide risk.

PP Use an occupational therapy frame of reference tool such as the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend, & Craik, 2007) to develop and implement suicide prevention strategies within the scope of occupational therapy practice.

**Canadian Practice Process Framework: Setting the stage**
**Suicide Continuum Phase: Prevention**

CBR Support the values of client-centred practice by clarifying values, beliefs, assumptions, expectations and desires of clients and their families (CAOT, n.d.-b).

CBR Demonstrate warmth and empathy when asking about suicide and suicide ideation (Tryssenaar, 2003; Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

CBR Communicate clearly and make every effort to collaborate with clients being assessed for suicide (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

PP Identify a client's occupational issues and whether the reason for referral is appropriate or needs to be revised in the light of more pressing issues, when suffering is great.

PP Use occupation as an engagement tool to build rapport and foster clients' readiness to proceed with suicide prevention strategies.

**Canadian Practice Process Framework: Assess/evaluate**
**Suicide Continuum Phase: Prevention**

EBR When asking about suicide, use clear and direct language such as "Are you thinking about killing yourself?" and "Are you thinking about suicide?". Questions such as, "Are you thinking of harming yourself?" and "Are you thinking about heaven?" will not provide an accurate clinical picture. Clarification of suicidal ideation is essential before determining what steps need to be taken and when (LivingWorks, 2014b).

CBR Engage clients contemplating suicide in an open discussion to better understand their story (CAMH, 2011; LivingWorks, 2014b; Tryssenaar, 2003).

EBR When suicidal ideation is present, do an in-depth assessment, to understand relevant risk factors and assess whether a clear plan exists, the imminence of the plan (when they intend to put it into action), and the degree of hopelessness present Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012; Hawton & van Heeringen, 2009).

CBR Consider the following key elements when assessing clients' suicide risk and ideation:

**General elements:**
- Previous suicide attempts
- Substance abuse
- Mental health concerns, specifically symptoms such as hopelessness, anxiety, agitation and recurrent suicidal thoughts
- Stressful events
- Availability of means to put the suicide plan into action
- Risk factors connected to: physical illness, pain, disability, social and environmental factors, a family history of suicide or suicides in the environment
- (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

**Elements specific to children:**
- Being socially inappropriate
- Being physically and verbally abusive
- Past trauma (physical, emotional, sexual)
- (Stewart & Hirdes, 2015)
- Family history of depression or substance addiction
- Death by suicide of a close family member or friend
- Witness to violence and abuse
- Severe and/or early family instability

(Bridges, Murji, Hodgson, & McLeod, 2011).

CBR Explore clients' perception of the crisis to determine the interplay of static versus modifiable risk factors for suicide. Consider what protective factors are present (CAMH, 2011; RNAO, 2009; Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012). For protective factors, see the table in the section, Suicide Continuum Phase: Prevention.

CBR When assessing clients who have made multiple suicide attempts, consider each past attempt separately and seek to understand what led to each (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

PP Use an occupational therapy frame of reference such as the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend, & Craik, 2007) to help understand the meaning connected to the suffering.

CBR Consult other stakeholders, including family, friends and other healthcare professionals to complete a client's clinical assessment and when determining the level of risk (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

**Canadian Practice Process Framework: Agree on objectives and plan**
**Suicide Continuum Phase: Intervention**

CBR Consider interventions addressing occupational issues as part of the safety plan (Hewitt, 2014).

PP If suicidal ideation is disclosed, create a safety plan even if the danger appears low or non-imminent. This is an important measure, since risk assessment does not always accurately predict suicide risk (Large et al., 2016).

CBR Collaborate with clients and their families to formulate and document a safety plan and ensure the recommended responses correspond with levels of risk (CAMH, 2011; LivingWorks, 2014b; RNAO, 2009).

CBR Advocate for the inclusion of the following elements in a client's safety plan:

- Heightened support from family and/or friends
- Referral to mental health services
- Restricted access to lethal means
- Role of family and caregivers in monitoring safe use of medication
- Safe amounts of medication in person's possession

(Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

PP Use your unique expertise as an occupational therapist to determine which environment would best help the client, enhance health and support balance and recovery. Occupational therapists are professionals trained to consider the environment when applying their professional frame of reference.

CBR Create a sense of control, autonomy and hope by collaborating with clients to plan, initiate and track realistic long- and short-term goals that enable engagement in occupation (CAOT, n.d.-b; Magill, 1977).

CBR Call emergency services or first responders if a client is injured or at imminent risk of injury from suicidal behaviour (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

CBR Collaborate fully with emergency services involved in supporting a person at risk of suicide (Canadian Association of Occupational Therapists [CAOT], n.d.-b; Hawton & van Heeringen, 2009).

**Canadian Practice Process Framework: Implement plan**
**Suicide Continuum Phase: Intervention**

CBR Using a strength-based approach, identify opportunities for clients to engage in health-enhancing activities and assist them in dealing with everyday problems in a positive, healthy way. (College of Occupational Therapists [COT], 2012).

CBR Educate clients on cognitive strategies that help reduce suicidal ideation (CAOT, n.d.-b).

CBR Address and circumvent helplessness by cultivating clients' sense of control and personal choice over their environment while providing hope and recognizing the clients' dignity (Hewitt, 2014, Magill, 1977).

CBR Ensure that the care environment maximizes clients' safety while being as least restrictive as possible (Department of Veterans Affairs & Department of Defense, 2013; LivingWorks, 2014b).

CBR Provide recommendations, guidance and other expertise on increasing coping and problem-solving skills during high-risk transitional times (COT, 2012).

EBR Ensure clients understand the importance of their mental health treatment plan in mitigating risk of suicide (Gutman, 2005).

EBR Educate clients, their family and any other relevant stakeholders about potential fluctuations in mood and function, what to expect in terms of relapse and how to reach out immediately, prior to a psychological crisis (Gutman, 2005).

CBR Support clients who are regaining control by helping them structure and organize their daily lives, so that they can balance what they need to do with what they want to do (CAOT, n.d.-b).

PP Support clients in improving self-image and stress and time management, as well as problem-solving, coping and social skills.

PP Help clients focussed on suicide ideation rediscover meaning and explore new occupations, new ways of enjoying life and new environments.

CBR Provide family members and caregivers with information on crisis safety plans and how to manage a crisis with a loved one (National Health and Medical Research Council, 2012).

CBR Connect clients with existing community services and networks that provide support and resources (CAOT, n.d.-b).

EBR Advocate that clients be provided with appropriate supports and resources (RNAO, 2009), such as access to psychotherapy, as elements of their suicide intervention plan (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

**Canadian Practice Process Framework: Monitor and modify**
**Suicide Continuum Phase: Intervention and Postvention**

CBR Include the client's healthcare team, friends and family when reviewing the safety plan (CAMH, 2011).

CBR Facilitate the transition from hospital or prison to community by monitoring and modifying occupational objectives and social participation (COT, 2012).

CBR Following a suicide attempt, complete a social assessment to identify the aspects of the treatment plan that need to be modified. Consider new approaches to care (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

CBR Following a suicide attempt, engage with clients to rebuild a trusting, therapeutic alliance (Ramsay, 2005).

CBR Following suicidal behaviour, communicate with all involved healthcare providers (Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior, 2012).

EBR Following a death by suicide, implement a concerted postvention strategy to heighten awareness and ensure quick responses to avoid a cluster of suicides. Be attentive to emerging risk factors in high-risk groups following a suicide, such as poor social functioning and poor school adjustment in youth (Cox et al., 2012).

**Canadian Practice Process Framework: Evaluate outcome**
**Suicide Continuum Phase: Postvention**

PP Select and use age-appropriate outcome measures to assess engagement in roles and occupations specific to the setting and population being served.

EBR Evaluate the status of community suicide preparedness and whether key community stakeholders have received adequate suicide prevention training (Cox et al., 2012).

PP Consider collecting program process outcomes during debriefing sessions with family members, caregivers and/or key stakeholders. Ensure that the facilitator of these sessions has received adequate orientation and training, and is not too close to the person who died by suicide.

**Canadian Practice Process Framework: Conclude/exit**
**Suicide Continuum Phase: Postvention**

EBR Consider implementing a community suicide preparedness strategy and/or advocating that community stakeholders and gatekeepers receive suicide prevention training (Cox et al., 2012).

EBR Following a person's death by suicide, engage in postvention activities, such as providing information and 1:1 support sessions for peers, family and staff (Robinson et al., 2013).

PP Offer individual- or group-based services to support suicide survivors' health and well-being while moving through the grief process.

CBR Understand that each person will grieve in unique ways depending on their past, relationship with the person who has died and context (DeRanieri et al., 2002).

CBR Hold regular in-service training to engage all stakeholders in a continual improvement of suicide prevention strategies (Lynn, 2008).

EBR Coach people from the media, if communicating with them, to report sensitively on suicide-related issues to minimize triggering emotional distress among suicide survivors (Lynn, 2008; Mindset, 2014).

## VISION FOR THE FUTURE

Asking about suicide and addressing suicide risk can be uncomfortable. By implementing the recommendations in this role paper, occupational therapists and occupational therapist assistants can demonstrate competency in addressing suicide risk and leading the way with optimal suicide prevention strategies. Our hope is that occupational therapists and occupational therapist assistants will be recognized as essential partners in public health initiatives to address suicide.

*Vision for the occupational therapy profession:*

- The occupational therapy profession acknowledges that occupational therapists are well-placed to discern suicidal ideation and that they have a responsibility to address suicide within their clinical practice, and in research and educational settings.
- Since mental health issues and safety are explicit and embedded in all occupational therapy practice frameworks and conceptual models, occupational therapists need to consider and monitor baseline mental health status and recognize suicidal ideation as a significant occupational barrier, in every practice setting.
- The occupational therapy profession advocates for a workplace culture whereby all occupational therapists consistently take all indications of suicide seriously and ask questions about suicide directly.
- All occupational therapists are equipped with at least elements of gatekeeper training to facilitate an emerging, profession-wide competence in suicide prevention.

*Vision for the individual occupational therapist:*

- Occupational therapists become oriented to and familiar with key documents that guide suicide prevention for Canadians, such as *Working Together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention* (Public Health Agency of Canada, 2016).
- Occupational therapists take all indications of suicide seriously and ask directly about suicide.
- Occupational therapists consider suffering itself as an occupational barrier and look for ways to mitigate suffering.
- Occupational therapists consider how current occupational therapy models can be used to address suicidal ideation.
- Occupational therapists engage in self-care. This includes reflecting on how helping clients who are suffering affects their own emotional health and seeking out supervision and support when needed.

All occupational therapists can become competent in suicide prevention. Ultimately, the vision is that occupational therapists develop the capacity to articulate their role effectively and take action to address suffering and suicide in their practice and their community. Occupational therapists can help their clients overcome the suffering that may have led to suicidal ideation by facilitating clients' engagement in meaningful occupations.

Despite shocking statistics and disturbing stories of suffering and suicide, there is hope. Suicide prevention initiatives exist at both the national and international levels. Increasingly, occupational therapists are recognizing that it is their professional responsibility to respond to suffering and suicide in the context of public health. Indeed, some occupational therapists have already described and advocated for the role of occupational therapy in suicide prevention

(Magill, 1977; Hewitt, 2014; Petryk, 2014; Tryssenaar, 2003). Professional associations are getting involved. Initiatives exist, such as the Canadian Association of Occupational Therapists Professional (CAOT) issue forum on suicide prevention hosted in 2014 (CAOT, 2014), the CAOT *Suicide and OT Practice Network* and, of course, this role paper.

# REFERENCES

*References with an asterisk were retrieved and selected through the rapid scoping review.


American Association of Suicidology. (2010). *Survivors of suicide fact sheet – 2010*. Retrieved from http://www.suicidology.org/Portals/14/docs/Survivors/Loss%20Survivors/Survivors-of-Suicide-Fact-Sheet_2010.pdf?ver=2014-05-07-161555-730

Association of periOperative Registered Nurses (AORN). (2017). *Evidence rating*. Retrieved from http://www.aorn.org/guidelines/about-aorn-guidelines/evidence-rating

*Applied Suicide Intervention Skills Training (ASIST). (2010). *Cross-site evaluation of the Garrett-Lee Smith suicide prevention and early intervention program: Supporting statement.* Retrieved from https://www.reginfo.gov/public/do/DownloadDocument?objectID=41775603

Bridges, L., Murji, R., Hodgson, K., & McLeod, S. (2011). *Tattered teddies: Preventing suicide in children* (2nd Ed.). Calgary, AB: Centre for Suicide Prevention.

Canadian Association of Occupational Therapists (CAOT). (2012). *Profile of practice of occupational therapists in Canada 2012*. Retrieved from https://caot.in1touch.org/document/3653/2012otprofile.pdf

*Canadian Association of Occupational Therapists (CAOT). (n.d.-a). *Getting to know CAOT occupational therapy works!: Impact on mental illness & youth.* Retrieved from https://www.caot.ca/document/4059/Mental%20Health%20-%20Fact%20Sheet.pdf

*Canadian Association of Occupational Therapists (CAOT). (n.d.-b). *Occupational therapy and suicide prevention.* Retrieved from https://www.caot.ca/document/6124/SuicidePrevention_fact%20sheet.pdf

*Canadian Association of Occupational Therapists (CAOT). (2014). *Report of the professional issue forum on suicide prevention and the role of occupational therapy.* Retrieved from https://www.caot.ca/document/3742/2014%20Suicide%20Prevention%20and%20the%20Role%20of%20OT.pdf

Canadian Patient Safety Institute. (2017). *Mental health care: Preventing suicide and self-harm.* Retrieved from http://www.patientsafetyinstitute.ca/en/education/patientsafetyeducationprogram/patientsafetyeducationcurriculum/mentalhealthmodules/pages/mental-health-care-preventing-suicide-and-self-harm.aspx

Cassell, E. J. (1991). *The nature of suffering and the goals of medicine*. New York, NY: Oxford University Press.

*Centre for Addiction and Mental Health (CAMH). (2011). *CAMH suicide prevention and assessment handbook.* Retrieved from http://otgateway.com/articles/sp_handbook_final_feb_2011.pdf

*College of Occupational Therapists (COT). (2012). *Scottish prison service: Women in custody – a consultation response from the College of Occupational Therapists*. London, UK: The author.

Collins, R., Vrbanac, H., & Hewitt, K. (2014). *Addressing the gap of suicide in occupational therapy practice.* Paper presented at Canadian Association of Occupational Therapists Annual Conference '14: Reflection on occupation: Enabling health communities, New Brunswick, Canada.

*Cox, G. R., Robinson, J., Williamson, M., Lockley, A., Cheung, Y. T. D., & Pirkis, J. (2012). Suicide clusters in young people: Evidence for the effectiveness of postvention strategies. *Crisis, 33*(4), 208-214. doi: 10.1027/0227-5910/a000144

Crosby, A. E., Ortega, L., & Melanson, C. (2011). *Self-directed violence surveillance: Uniform definitions and recommended data elements.* Atlanta, GA: Centers for Disease Control and Prevention.

*Custer, V. L., & Wassink, K. E. (1991). Case report: Occupational therapy intervention for an adult with depression and suicidal tendencies. *American Journal of Occupational Therapy, 45*(9), 845-848. doi: 10.5014/ajot.45.9.845

*Department of Veterans Affairs & Department of Defense. (2013). *VA/DoD Clinical practice guideline for assessment and management of patients at risk for suicide.* Retrieved from https://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf

DeRanieri, J. T., Clements, P. T., & Henry, G. C. (2002). When catastrophe happens: Assessment and intervention after sudden traumatic death. *Journal of Psychosocial Nursing and Mental Health Services, 40*(4), 30-37.

Egan, M. (2007). Speaking of suffering and occupational therapy. *Canadian Journal of Occupational Therapy, 74*(3), 293-301. doi: 10.1177/000841740707400310

Fowler, J. C. (2012). Suicide risk assessment in clinical practice: Pragmatic guidelines for imperfect assessments. *Psychotherapy 49*(1): 81-90. doi: 10.1037/a0026148

Ganann, R., Ciliska, D., & Thomas, H. (2010). *Expediting systematic reviews: Methods and implications of rapid reviews. Implementation Science, 5*(1), 56-10. doi: 10.1186/1748-5908-5-56

Government of Canada. (2013). *National Aboriginal youth suicide prevention strategy (NAYSPS) program framework.* Retrieved from https://www.canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/health-promotion/national-aboriginal-youth-suicide-prevention-strategy-program-framework.html

Government of Canada. (2014). *Working together to prevent suicide in Canada: The federal framework for suicide prevention.* Retrieve from: https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-prevention-framework.html

*Gutman, S. A. (2005). Understanding suicide: What therapists should know. *Occupational Therapy in Mental Health, 21*(2), 55-77. doi: 10.1300/J004v21n02_04

*Hawton, K., & van Heeringen, K. (2009). Suicide. *The Lancet, 373*, 1372-1381. doi: 10.1016/S0140-6736(09)60372-X

*Hewitt, K., Boniface, G., & Belagamage, L. (2014). CAOT professional issue forum: Suicide prevention and the role of occupational therapy. *Occupational Therapy Now, 16*(4), 13-15.

Inuit Tapiriit Kanatami. (2016). *National Inuit suicide prevention strategy.* Retrieved from https://www.itk.ca/wp-content/uploads/2016/07/ITK-National-Inuit-Suicide-Prevention-Strategy-2016.pdf

*Isaac, M., Elias, B., Katz, L. Y., Belik, S. L., Deane, F. P., Enns, M. W.,... The Swampy Cree Suicide Prevention Team. (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. *Canadian Journal of Psychiatry, 54*(4), 260-268. doi: 10.1177/070674370905400407

Knieper, A. J. (1999). The survivor's grief and recovery. *Suicide and Life-Threatening Behaviour, 29*(4), 353-364. doi: 10.1111/j.1943-278X.1999.tb00530.x

Large, M., Kaneson, M., Myles, N., Myles, H., Gunaratne, P., & Ryan, C. (2016). Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: Heterogeneity in results and lack of improvement over time. *PLoS One, 11*(6), e0156322. doi: 10.1371/journal.pone.0156322

Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The person-environment-occupational model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*(1), 9-23. doi: 10.1177/000841749606300103

LivingWorks (2014a). ASIST *(Applied Suicide Intervention Skills Training) 11.1: Participant workbook,* 1B11.1EN2501. Calgary, AB: LivingWorks Education Inc.

LivingWorks (2014b). ASIST *(Applied Suicide Intervention Skills Training) 11.1: Trainer manual,* 1EN1011.1. Calgary, AB: LivingWorks Education Inc.

*Lynn, C. W. (2008). When a coworker completes suicide. *American Association of Occupational Health Nurses Journal, 56*(11), 459-467. doi: 10.3928/08910162-20081101-02

*Magill, J., & Vargo, J. W. (1977). Helplessness, hope and the occupational therapist. *Canadian Journal of Occupational Therapy, 44*(2), 65-69. doi: 10.1177/000841747704400203

*Maris, R. W. (1995). Suicide prevention in adults (age 30-65). *Suicide and Life-Threatening Behavior, 25*(1), 171-179. doi: 1995-40689-001

Mental Health Commission of Canada (MHCC). (2019). *Suicide Prevention.* Retrieved from http://www.mentalhealthcommission.ca/English/focus-areas/suicide-prevention

*Milner, A., Page, K., Spencer-Thomas, S., & Lamontagne, A. D. (2014). Workplace suicide prevention: A systematic review of published and unpublished activities. *Health Promotion International, 30*(1), 29-37. doi: 10.1093/heapro/dau085

Ministère de la Santé et des Services sociaux du Québec (MSSS). (2010). *Prévention du suicide – Guide des bonnes pratiques à l'intention des intervenants des centres de santé et de services sociaux. Québec, Canada: Gouvernement du Québec.* Retrieved from http://publications.msss.gouv.qc.ca/msss/fichiers/2010/10-247-02.pdf

*National Health and Medical Research Council (2012). *Clinical practice guideline for the management of borderline personality disorder.* Melbourne, Australia: Unknown.

Navaneelan, T. (2009). *Suicide rates: An overview. Ottawa, Canada: Statistics Canada.* Retrieved from https://www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm

Olson, R. (n.d.). *Suicide contagion and suicide clusters. Centre for Suicide Prevention.* Retrieved from https://www.suicideinfo.ca/resource/suicidecontagion/

Patel, M., & Degagne, C. (2017). *Supporting occupational therapist in practice: A review of suicide intervention training.* Retrieved from: https://caot.ca/uploaded/web/Practice%20Networks/Supporting%20OTs%20in%20Practice%20-%20A%20Review%20of%20Suicide%20Intervention%20Training%20(Last%20updated%202017-06-21).pdf

*Petryk, A. L. (2014). An occupational perspective on child and youth mental health: Reflections from a school-based occupational therapist. *Occupational Therapy Now, 16*(3), 16-18.

Polatajko, H. J., Craik, J., Davis, J., & Townsend, E. A. (2007). Canadian practice process framework. In E. Townsend and H. J. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, and justice through occupation.* Ottawa, Canada: CAOT Publications.

Polatajko, H. J., Townsend, E. A., Craik. J. (2007). Canadian Model of Occupational Performance and Engagement (CMOP-E). In E. A. Townsend and H. J. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, and justice through occupation* (p. 22-36). Ottawa, Canada: CAOT Publications.

Public Health Agency of Canada (2016). *Working together to prevent suicide in Canada: The federal framework for suicide prevention.* Retrieved from https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-prevention-framework.html?_ga=1.196695468.1213892812.1480081835

*Ramsay, J. R., & Newman, C. F. (2005). After the attempt: Maintaining the therapeutic alliance following a patient's suicide attempt. *Suicide and Life-Threatening Behavior, 35*(4), 413-424.

*Registered Nurses Association of Ontario (RNAO). (2009). *Nursing best practice guideline: Assessment and care of adults at risk for suicidal ideation and behaviour. Toronto, Canada.* Retrieved from https://rnao.ca/bpg/guidelines/assessment-and-care-adults-risk-suicidal-ideation-and-behaviour I added Toronto because a print copy is available, but I doubt there's an official publisher.

*Robinson, J., Cox, G., Malone, A., Williamson, M., Baldwin, G., Fletcher, K., & O'Brien, M. (2013). A systematic review of school-based intervention aimed at preventing, treating, and responding to suicide-related behavior in young people. *Crisis, 34*(3), 164-182. doi: 10.1027/0227-5910/a000168

*Stefanowski-Harding, S. (1990). Child suicide: A review of the literature and implications for school counselors. *The School Counselor, 37*(5), 328-336.

Stewart, S. L., Falah Hassani, K., Poss, J. & Hirdes, J. P. (2017). The determinants of service complexity in children with intellectual disabilities. *Journal of Intellectual Disability Research, 61*(11), 1055-1068. doi: 10.1111/jir.12423

Stewart, S. L., & Hirdes, J. P. (2015). Identifying mental health symptoms in children and youth in residential and in-patient care settings. *In Healthcare management forum* (Vol. 28, No. 4, pp. 150-156). Los Angeles, CA: SAGE Publications. doi: 10.1177/0840470415581240

Townsend, E. A., Polatajko, H. J., Craik, J., & Davis, J. (2007). Canadian Model of Client-Centred Enablement. In E. A. Townsend and H. J. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, and justice through occupation*. Ottawa, Canada: CAOT Publications.

*Tryssenaar, J. (2003). Suicide: What occupational therapists need to consider regarding the risk of suicide among their clients. *Occupational Therapy Now*, May issue.

*Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behavior. (2012). *Clinical practice guideline for the prevention and treatment of suicidal behaviour.* Madrid, Spain: Ministry of Health, Social Policy and Equality National Health System Quality Plan.

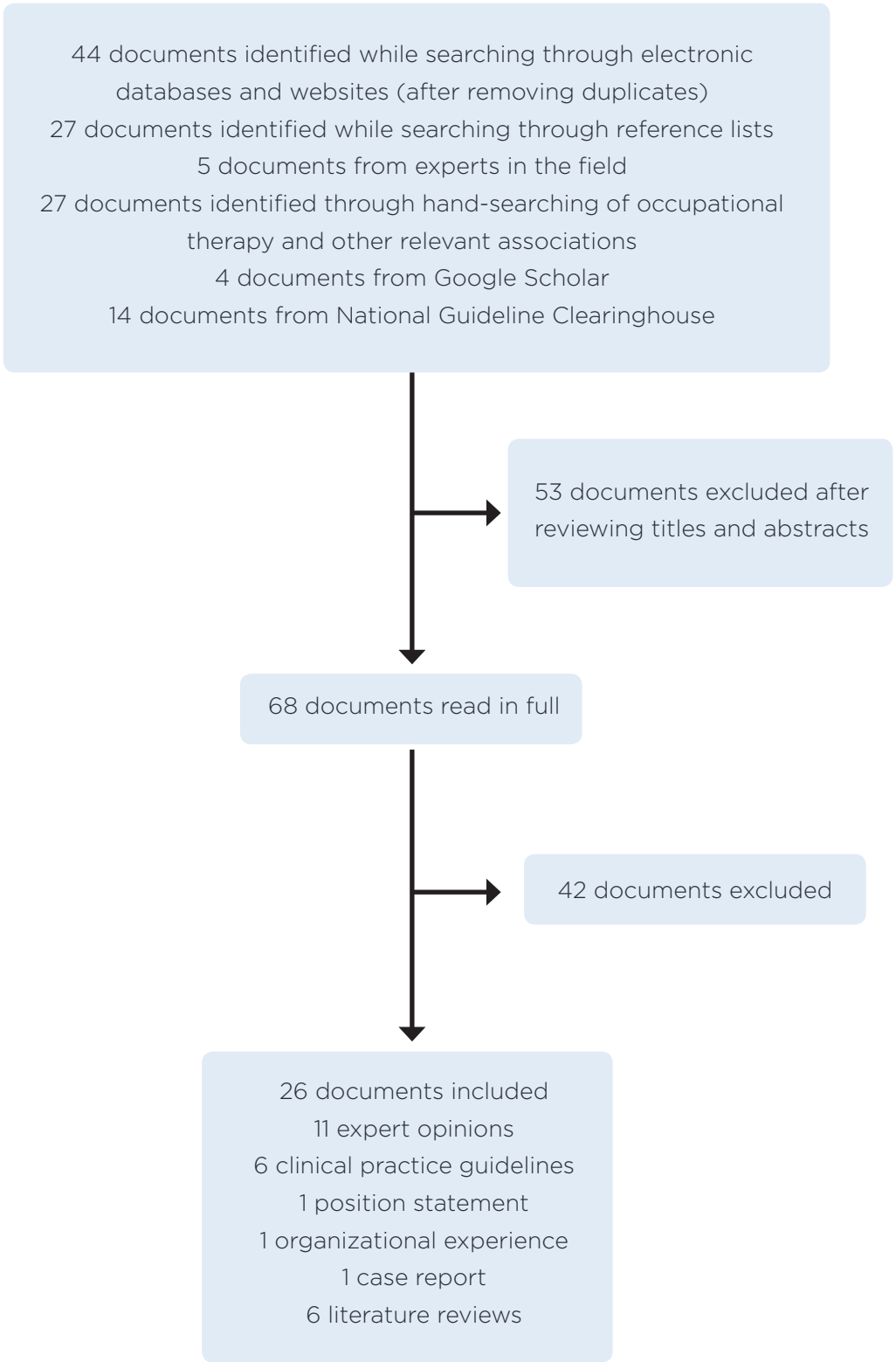
World Health Organization (2014). *Preventing suicide: A global imperative.* Retrieved from http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

# APPENDIX A: DEFINITIONS (GLOSSARY)

## APPENDIX B: ALGORITHM OF THE IDENTIFICATION AND

| Terms | Definition |
|---|---|
| Gatekeeper | "...individuals in communities that come into contact with those at risk and are in a position to 'open the gate to help' (e.g., health professionals, family members, teachers or others in the community)" (Public Health Agency of Canada, 2016) |
| Suffering | Eric Cassell (1991) defined suffering as: "a state of severe distress associated with events that threaten the intactness of the person" (p. 33). |
| Suicide cluster | A suicide cluster is defined as multiple suicidal behaviours or suicides that fall within an accelerated time frame and sometimes within a defined geographical area (Olson, n.d.). |
| Suicidal ideation | "Thinking about, considering or planning for suicide" (Crosby, Ortega, & Melanson, 2011) |
| Suicide Intervention | "Intervention works to address risk of suicide. It focuses on how best to respond early when someone has thoughts of suicide or suicide-related behaviours." (Public Health Agency of Canada, 2016) |
| Suicide postvention | "Postvention works to help support those affected after the loss or experience of suicide, as well as providing follow-up education / prevention to reduce the risk of future crises." (Public Health Agency of Canada, 2016) |
| Suicide prevention | "Prevention works to build protective factors and promote mental health and well-being and reduce risk factors that could lead to suicide." (Public Health Agency of Canada, 2016) |
| Suicide prevention continuum | The continuum of care that can be provided from suicide prevention to intervention to postvention (Public Health Agency of Canada, 2016) |

## SELECTION PROCESS OF RELEVANT PUBLICATIONS APPENDIX C: VIGNETTES



*Italics = stories depicting Canadian occupational therapy practice*

Plain text = rationale and links with the recommendations from this role paper

**THE STORY OF MILOS**

*"After having missed several appointments, Milos arrived in a state of agitation at the community mental health office. He began pacing back and forth in the waiting room. When he sat down with me, his legs were jittery and he was speaking very rapidly and loudly. Milos said, 'I can't take it anymore, I don't feel like anyone understands what's wrong with me or listens when I try to explain what I need. I feel like I'm going around in circles with doctors and counsellors, and nothing is working. I'm tired of suffering and losing people I care about.' I took a chance and asked Milos directly 'Are you thinking of suicide?' Modelling a calm demeanor and a quiet tone, I reminded Milos that suicide was serious, and that we should talk about it. Milos began to explain a series of recent events including a break-up with his best friend, a new girlfriend who didn't understand him, and the recent passing away of his only confidant, his grandmother."*

The occupational therapist working with Milos had had gatekeeper training, and could recognize that the mounting pressures Milos was experiencing were inhibiting coping and could lead to contemplation of suicide. Using the Person-Environment-Occupation (PEO) model to understand what was going on (Law et al., 1996), the occupational therapist was able to recognize the lack of balance between Milos' lack of control (spirituality) and lack of progress in his treatment. The occupational therapist also recognized the risk associated with the level of grief Milos was experiencing paired with his diminished social support. By asking clearly and directly about suicide, the occupational therapist initiated a conversation about suffering and how it related to the client's daily life.

*"He grew more relaxed as he shared how these stressors were piling up on top of ongoing problems like having no place of his own to live, not being able to hold down a job because of his paranoia and anxiety, and constantly having voices screaming in his head."*

The occupational therapist probed to better understand the story that had led Milos's thoughts about suicide.

*"I asked Milos about the voices in his head and from there we discussed different options for managing his mental health, including a referral to a specialized agency for psychosis. It was clear that having someone truly listen to the meaning behind his words made a difference."*

Using the CMOP-E as a framework (Polatajko, Townsend, & Craik, 2007), the occupational therapist began to address Milos' feelings of being overwhelmed and helpless (spirituality). Given the opportunity to express his dissatisfaction and be heard, Milos had some space and could organize his thoughts and regain control. The occupational therapist applied the PEO model to look at where potential imbalances were, and recognized there was a gap between symptoms and the services he was receiving. Providing Milos with information about services, including a referral to the services he needed the most, was another way in which control was increased.

*"Milos expressed hope that things would change and agreed to meet with me again the next day for more information about other service options."*

The occupational therapist demonstrated accountability and commitment by making plans to meet with Milos the following day to put a safety plan into action.

**Key relevance to occupational therapy and suicide prevention**
Young adult
Mental health setting
Missed appointments, high level of stressors
Asking about suicide directly
Intervention
Spirituality, meaning, purpose and occupation

**THE STORY OF NANCY**

*"The parents of Lillie, a four-year-old non-verbal girl with autism spectrum disorder, participated in a paediatric day hospital intervention program to reduce Lillie's problematic behaviours and facilitate her social communication. The toddler presented with incessant agitation and an inability to calm or organize herself. Lillie also exhibited self-harming behaviour. Nancy, Lillie's mother, 28 years old, was the main care-giver, while Lillie's father was the bread-winner. When performing the occupational therapy initial assessment and interviewing Lillie's parents about their daily routine, I noticed Nancy was pale, kept her answers short and general, and shared very little about their home experience. She looked tired. Lillie's father deferred to Nancy to give the answers."*

*"A few days later, when following up with Nancy about one or two strategies I'd given her to try with Lillie at home, Nancy admitted that she had not yet had a chance to try them. She promised to try at least one later. When I followed up with her a second time, she said the same thing."*

Applying the PEO model (Law et al., 1996), the occupational therapist could consider the family as a unit in the social environment. The occupational therapist was struck by Lillie's parents' incongruous level of engagement in service and appointments and the lack of follow-through they had putting the recommendations for Lillie's care into practice.

*"I spoke with our team social worker about my concerns, and she asked that I bring them up at team rounds. During the weekly multidisciplinary team meeting with the psychiatrist, psychologist, social worker, nurse and early educator, I was expected to report on the child's behaviour, social communication and daily living competencies (i.e., Lillie's occupational performance). I did this. I added, 'I'm concerned about Lillie's heightened anxiety, and her inability to calm herself or self-organize. I've tried different approaches, but Lillie is still making little to no progress. It's exhausting to watch her! Her mom keeps promising to try a new strategy, and doesn't. Something is strange… it's not adding up. I'm concerned about the home environment.' I mentioned that the father was relatively absent, while Nancy stayed home to care for her daughter. I shared that I suspected something was being hidden, abuse or neglect of some kind, which might explain Lillie's agitation. After sharing my concerns with the team, I discovered that they, too, were concerned."*

The occupational therapist brought her unease forward to the healthcare team and engaged them in a comprehensive discussion about Lillie. The inconsistency between the investment in and concern for Lillie's well-being and the lack of follow-through on recommendations was striking.

*"A meeting alone with Nancy and our social worker led us to learn that Lillie had not slept a full night in the four years since she was born. Nancy opened up to our social worker; she was ashamed of not being able to handle this situation with her daughter. Nancy was spent, and at a loss. She felt she had run out of options. She said "I want to drive my car into a tree with Lillie in it!"*

Further assessment revealed Nancy's long struggle to manage a range of stressors. The suffering in Nancy's story was palpable. It raised the question: "Do you want to die, or not want to live like this?"

*"Lillie and Nancy were temporarily discharged from the day program and admitted to the crisis intervention program, where they got rest. By the time they returned to the paediatric day program, Lillie had made important gains in her self-regulation, independence in sleeping, toileting, playing ball, and interacting with peers and other adults. Nancy was able to integrate strategies and recommendations at home with Lillie, and was sleeping nights again."*

The ability to recognize the impact of Nancy's suffering was crucial. Nancy could access supports and services that enabled her to fulfill her role as the main caregiver in Lillie's environment. The original intervention plan was halted temporarily when the occupational therapist brought her concerns and observations to the interdisciplinary team.

**Key relevance to occupational therapy and suicide prevention**
Occupational therapy offers unique solutions
Shared role in intervention
Recognizing limitations of one's own expertise
Consulting and collaborating with healthcare team
Referring to experts

**THE STORY OF KYLAH**

*"I ran a small group with clients who were recently discharged from hospital and who were transitioning back into the community. It was an opportunity for clients to check in on a weekly basis, talk about challenges they were facing, work on strategies, and practice skills. Peer support was a big part of the weekly group. I noted that Kylah was becoming more withdrawn. It was increasingly difficult to engage her in discussion and she had missed several sessions. Kylah was in her mid-40s, a single mom, with many psychosocial stressors and poor coping skills."*

*"When she returned to group one time, she requested to speak with me after the meeting. Initially she was vague and not very forthcoming. However, with some prompting and encouragement, Kylah indicated that she was struggling and had been increasingly suicidal."*

Kylah had developed enough meaningful rapport with the occupational therapist to request a meeting. An effective communicator, the occupational therapist created a safe environment for Kylah to open up about her thoughts about suicide.

*"For a moment, which at that point seemed endless, I tried to gather my own thoughts as to what I was going to do with what had been disclosed. I remembered something one of my university professors had said in a class on mental health. 'Talking about suicide is not going to give them ideas; they have already thought about it.' I decided to stick to that and started asking questions, trying to be understanding and supportive of Kylah in this difficult situation."*

The occupational therapist remembered that talking about suicide does not put the person at greater risk. Rather, it provides an opportunity to do something about the situation. The occupational therapist began to get more information about the person's suicide story to determine how to move forward. While facilitating Kylah's sharing of her story, the occupational therapist gathered information that contributed to a comprehensive assessment by the interdisciplinary team.

*"We spoke about recent events that had contributed to her current situation. We talked about a plan and means. Although Kylah continued to be vague in this regard, I got a better understanding of where she was at in her contemplation of suicide. As we continued speaking, I became increasingly concerned that she had very limited support in the community."*

The occupational therapist took the time to explore Kylah's potential plans for suicide, including access to any means, and her lack of social support. After considering the physical and social environment, the occupational therapist removed the means and ensured Kylah was connected to formal and informal supports in her community, contributing to the safety plan and complementing other professional disciplines' approaches.

*"Since I had limited experience at that time dealing with clients in crisis, I suggested we walk over to the emergency room. This took some convincing, as Kylah felt that her last hospital admission had been of little help, but she eventually agreed. We walked to the emergency room together. At the registration desk, with Kylah's permission, I shared with the nurse some of my concerns. I was relieved when the nurse indicated that they would take over at that point."*

The occupational therapist was aware of what she did not know, and acknowledged more help was required. She knew to reach out to other healthcare service providers, who could offer the care Kylah needed.

*"I realized how little I knew about the mental health supports in my new workplace and community. I made a point of seeking out that information. I spoke about my experience with my co-workers, initially, to share what had happened and for my own support throughout the events; however, I also wanted to gain a better understanding of the system I was working in."*

The occupational therapist demonstrated strong reflective practice by reviewing the interactions with Kylah and where improvements could be made. Important follow-up pieces included accessing supports and debriefing with her colleagues and increasing awareness of workplace resources.

Additional steps may have included completing suicide prevention gatekeeper training, as recommended in the Practice Context Section of this paper.

**Key relevance to occupational therapy and suicide prevention**
Importance of knowing community resources in your area
Reaching out to other team members
Intervention

**THE STORY OF JACQUES**

*"Jacques was a gentleman in his 60s who had been diagnosed with Alzheimer's disease. He was admitted to our unit for severe depression. A referral was sent to occupational therapy. Once the cognitive assessment was completed, it was used, along with other professionals' input, to determine that he was unsafe to remain at home with his wife."*
*"Jacques was waiting to go to a nursing home. A nursing home was unacceptable to Jacques, an outdoorsman who had spent most of his days walking in the woods or doing chores outside. His future seemed bleak."*

The occupational therapist recognized that nature and independence were core values of Jacques' and integral to his spirituality. The CMOP-E (Polatajko, Townsend, & Craik, 2007) was used to conceptualize and predict how limiting nature and independence in Jacques' life might affect him. The PEO (Law et al., 1996) helped to determine the imbalance of the transition from independent living to a nursing home. By using the CMOP-E and the PEO model, the occupational therapist became aware of the increased risk for suffering and of the potential areas to be addressed (i.e. how institutional policies, including the rules and routine of the nursing home, would affect him and his chosen occupation). Once the occupational therapist identified the lack of fit, assessment and problem-solving began.

*"One would assume that as an occupational therapist working in mental health, I deal with suicidal clients on a regular basis. However, it has not been the case. Most clients I have worked with, whether on the inpatient unit or in the community, have been willing participants in their recovery and wanted to move forward. So it was with sadness that, three years or so after starting work in mental health, I had to cope with a patient dying by suicide while on a weekend pass from the inpatient unit… Jacques could not bear the thought of spending the rest of his life inside a building, waiting for his wife to come visit him and take him out."*

The occupational therapists' courage to reflect upon Jacques' situation and the service provided was important postvention work.

*"Following the incident, there was a debriefing session at the hospital. His wife joined us. She told us not to feel sad, as Jacques had left on his own terms. She thanked us for all we did, pointing out the crafts he had made in one of the occupational therapy groups and how he had enjoyed working with his hands. She did not blame the staff and was thankful for all that had been tried to pull Jacques out of his depression."*

Once the initial grief work was done, the occupational therapist could reflect on the efforts that had been made, review what could have been done differently and what could be learned from the loss. The occupational therapist could reflect on the case on his or her own and in a team setting. If the client had been in a group, it would also have been important to offer support to other clients who were affected by the loss.

*"This story always makes me sad. It made me realize that quality of life is not only affected by physical pain and suffering, that there is also mental pain and suffering. As an occupational therapist, I continue to strive to help my clients who are depressed and help them see the world through a different, more positive lens; I explore with them what could make their life worth living. But despite our best efforts, they may still die by suicide and this is a choice we have to respect."*

Losing a client to suicide is a profound experience and requires much self-care. Engaging in formal and informal self-care is important.

**Key relevance to occupational therapy and suicide prevention**
Postvention
Family support
Asking about suicide
Application of CMOP-E

**THE STORY OF MARTHA**

*"Martha is a 68-year-old First Nations woman living with her husband in a rural Yukon community. She had a very challenging year related to her health, starting with a stroke that kept her in hospital for six months. When she was functioning well enough to have her first day-pass to visit her family, she fell and fractured her hip. Her hospital stay was prolonged for an additional three months."*

*"The physiotherapist and I, the occupational therapist, received a referral to assess how Martha was functioning at home after the hip replacement. During the visit, Martha's husband pretended to putter around in the kitchen. The physiotherapist inquired how she was doing with her exercises. Martha commented, 'I have not been doing them.' Martha denied pain, and said that she was feeling frustrated that she couldn't interact with or take care of her grandchildren normally because of her hip. The physiotherapist was not getting far in sorting out why Martha was not compliant with her exercises or recovering as fast as she would like. Martha's short responses and lack of engagement prompted me to inquire about her mood."*

Awareness that Martha belonged to a group at high risk for suicidal ideation alerted the occupational therapist to the need to assess her emotional well-being. The occupational therapist considered her risk factors, her background and challenges as an Indigenous person, several changes in physical function, ongoing physical pain, and being somewhat isolated. The occupational therapist believed these factors might contribute to her low mood. This prompted the occupational therapist to do an in-depth assessment.

The occupational therapist recognized that the reason for the referral (i.e., recovery from a fractured hip) was not the pressing issue.

*"I asked Martha directly, "Are you depressed?" and she responded yes. Her husband then came into the room and said, 'Just yesterday she climbed to the top of those stairs and was about to throw herself over the edge. It's a good thing I was here…'"*

Martha opened up about how she was feeling and her husband was able to share a salient

piece of information about Martha's recovery (albeit not what the healthcare team was expecting that day). The next step was to clarify with Martha the meaning of climbing to the top of the stairs. Getting collateral information from significant others was important.

*"I provided Martha with some reassurance that it made sense that she would be feeling this way after all the health challenges she had had that year, and that depression was a treatable medical condition, so she would not have to feel like this forever. Martha provided permission to call her doctor at the health centre and inform him or her that she was experiencing depression. As the occupational therapist, I sprang into action to provide her with the supports she needed."*

The occupational therapist provided psychoeducation to Martha about the course of recovery, including psychosocial impacts and acknowledged and validated her emotional pain. As part of the safety plan, the occupational therapist got in touch with other healthcare providers involved in the client's care, and committed to supporting Martha. The occupational therapist considered the value of community resources (both formal and informal) and worked with the client to ensure she was got the support she needed.

**Key relevance to occupational therapy and suicide prevention**

Martha was a First Nations woman living in a rural Yukon community
Holistic approach
Interdisciplinary team
Referral does not dictate approach
CMOP-E was used to consider other areas of questioning
Intervention

# APPENDIX D: GUIDE FOR REFLECTION

| | |
|---|---|
| **Describe the situation in your practice causing you concern.** | |
| **Identify the elements you believe require attention.** | |
| **Identify stage(s) of Canadian Practice Process Framework (CPPF) the situation relates to.** | |
| **Identify phase of Suicide Prevention Continuum the situation relates to.** | |
| **Identify the potential roles and contributions of an occupational therapist.** | |
| **Identify your next possible actions.** | |