CAOT Role Paper

Occupational Therapists and Occupational Therapy Assistants Address Suicide (provisional title)

The following recommendations will constitute the heart of a larger document that will propose and describe the role of occupational therapists and occupational therapy assistants in addressing suicide prevention. These recommendations have been drafted by a group of CAOT members selected for their knowledge and vision related to this area. Recommendations are based on best scientific evidence, positions of authoritative organizations and/or expert opinions. For the consultation phase, they are presented in themes in order to facilitate your assessment of **completeness** and **conciseness**. They have however been written according to the Canadian Practice Process Framework (CPPF) (Polatajko, Craik, Davis & Townsend, 2007) and their final order will respect this framework. More information about the process of developing the CAOT Role Papers is available in the Appendix of this document.

Your feedback is important as we want this role paper to be useful and supported by members. Apart from the criteria of completeness and conciseness, we are interested in receiving input on the accuracy of the recommendations below. Do you see any omissions or mistakes? Does this language resonate and help in understanding best practices of occupational therapy in suicide prevention?

Please note that this is a working document. The presentation format (i.e. layout) of the following recommendations are **not** final and numbers are attributed to help the communications during the consultation phase. Do not hesitate to send any suggestions and comments through email to Julie Lapointe, CAOT Director of Knowledge Translation Programs at practice@caot.ca Please include the term "Role Paper" in your subject line and indicate the recommendation numbers in your comments.

Prevention

1 Suicide prevention should be considered akin to CPR training in that it is a foundational skill to be able to respond in a life or death crisis (LivingWorks, 2014b). The Canadian Patient Safety Institute (2017) recognizes preventing suicide as a safety issue requiring specific attention.

Knowledge

1 Seek to gain a greater understanding of what contributes to positioning certain groups of people as high-risk groups to suicide (Hawton & Heeringen, 2009; Public Health Agency of Canada, 2016).

2 Be knowledgeable of the known risk factors for suicide presented in the chart below :

Risk Factors for Suicide	
Distal - Genetic loading - Personal characteristics (impulsivity, aggression) - Restricted fetal growth and perinatal circumstances - Early traumatic life events - Neurobiological disturbances (e.g. Serotonin dysfunction, and hypothalamic-pituitary axis hyperactivity)	Proximal - Psychiatric disorder - Physical disorder - Psychosocial crisis - Availability of means - Exposure to models

(Hawton & Heeringen, 2009)

3 Be knowledgeable of other potential risk factors that make an individual more vulnerable to suicide. The table below provides another account of risk factors and offers protective factors:

Risk and Protective Factors for Suicide	
Risk Factors - Mental illness (e.g., depression) - Prior suicide attempt - Recent loss - Poor physical health - Addiction (e.g., substances or gambling, etc.) - History of family violence (e.g., child abuse or neglect) - Self-harming behaviour - Limited problem-solving and coping mechanisms - Feeling as though one is alone or a burden to others - Facing significant life stressors i.e. trauma, war, victimization, marginalization	Protective Factors - Strong self-esteem - Healthy relationships (e.g., familial and social connections) - Cultural identity - Adaptive coping and problem-solving skills - Responsible media reporting and public awareness

(Public Health Agency of Canada, 2016).

4 Use the knowledge related to high-risk group at a prevention level only (ASIST, 2010).

5 Become oriented 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).

6 Knowing who the high-risk groups for suicide are (Cox, 2012; Maris, 1995; Milner 2015; Tryssenaar, 2003), evaluate whether a practice setting is servicing individuals at high-risk for suicide, and if not typically servicing high-risk groups, recognize groups in case there is need to refer for specialized support.

Interactions and collaborations with clients, team members and stakeholders

1 Healthcare providers interacting with persons at risk for suicide should be adequately trained to evaluate and document suicide risk (Working Group of the Clinical Practice Guideline for the Prevention, 2012).

2 From a health promotion perspective, occupational therapists and occupational therapy assistants should engage and be engaged to create interactive and youth friendly approaches that will: support youth, as a high-risk group for suicide; recognize contributors to suicide such as signs of depression, substance abuse; and identify ways youth can get help for themselves and friends (CAOT Impact on Mental Illness and Youth)

3 To fully participate as interdisciplinary team members, occupational therapists and occupational therapy assistants should be knowledgeable of other professions' core value related to suicide prevention such as the nursing professions' value and consideration of suicide prevention as a core competency (RNAO, 2009).

4 Advocacy groups, including occupational therapists and occupational therapy assistants, should actively engage in systems level work, such as with the provinces, when implementing and evaluating suicide treatment strategies (CAOT Impact on Mental Illness and Youth).

5 Engage in reflective practice to evaluate whether full breadth of scope is being accessed. Respond to gaps, engage in research, and network with important initiatives to position occupational therapy as part of the solution both on a local and national level (Petryk, 2014).

6 Communicate to other stakeholders within the practice setting (i.e. team members, managers) the full breadth of the occupational therapy scope and that occupational therapists and occupational therapy assistants have a role in suicide prevention (Petryk, 2014).

7 Engage clients in a culturally safe and culturally competent manner (Polatajko, Townsend & Craik, 2007; RNAO, 2009).

8 Continuously reflect on emotional impact of helping those who are suffering, and seek out supervision and support (RNAO, 2009; Stefanowski-Harding, 1990).

9 Engage all efforts possible to clearly communicate and collaborate with individuals being assessed for suicide (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

10 Acknowledge negative attitudes that may arise towards a person who has attempted suicide more than once. Respect and understanding are essential for supporting a person to overcome suicidal ideation (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

11 Establishing rapport is critical to create a platform on which to engage in meaningful and sensitive work, such as when addressing suicide (Tryssenaar, 2003; RNA0, 2009).

12 With a key role as communicator described in the Profile of Occupational Therapists in Canada (CAOT, 2012) and the Practice Profile for Support Personnel in Occupational Therapy (CAOT, 2009), occupational therapists and occupational therapy assistants are equipped to provide clear

communication and collaboration, and can apply these as necessary skills when addressing suicide within their practice (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

13 Implement values of client-centred practice, and collaborate with clients and families to understand the meaning behind their occupational issues (CAOT Factsheet on suicide prevention). For example, when a client indicates they would like support with making friends, the occupational therapist looks to understand the meaning behind the lack of social network, and often uncovers pain that might be attached.

14 Provide family members and carers with education on crisis plans, and how to manage in a crisis with a loved one (National Health and Medical Research Council, 2012).

15 Dispel the myth that asking about suicide could increase the risk of suicide (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012). A warm and empathetic demeanor is an important quality when asking about suicide (Tryssenaar, 2003; Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

16 Engage other stakeholders, including family, friends, and other healthcare professionals, in formulating the clinical picture and determining risk level (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

17 Assess occupational therapist's role to determine if referral to a suicide prevention expert is most optimal or if ongoing involvement is indicated.

18 Advocate for client to be engaged with supports and resources (RNAO, 2009)

19 Communicate with all healthcare providers following suicidal behaviour (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

20 Ensure best outcomes possible by putting in place wrap-around support that goes beyond medication and includes supportive psychotherapy to individuals at risk for suicide (Maris, 1995; Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012). Within provinces and territories where occupational therapists are able to practice psychotherapy, the occupational therapist is among professionals who provide psychotherapy interventions.

21 Following a suicide attempt, promote the input of an occupational therapist in the hospital as a way to reduce the number of clients who leave against advice, and increases engagement in hospital care (COT/NICE, 2012).

22 When communicating with the media, coach media to report sensitively on suicide-related issues to minimize triggering effects (Lynn, 2008; Mindset, 2014).

23 Address grief immediately. Offer supports to maintain suicide survivors' health, and guidance to move through the grief process (2008). Depending on role and relationship with the person lost, the occupational therapist may be engaged to offer coaching through these steps.

24 Engage individuals in their grief from a variable lens (Lynn, 2008). 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).

25 Hold regular in-services to engage those in leadership roles on high-risk emergencies, and ways to respond immediately (Lynn, 2008).

26 Provide individual and group support to suicide survivors (Lynn, 2008).

27 Model and teach important coping skills recommended by Lynn (2008) such as problem-solving, conflict resolution, and assertive communication.

28 Work with suicide survivors to offer guidance and support as they adapt to new roles as identified in their recovery process.

Intervention plan

1 Take all indications of suicide seriously whether the indications are explicit or implicit (RNAO, 2009).

2 Use occupation as an engagement tool in suicide prevention (Hewitt, 2014).

3 Educate clients in the management of diagnoses associated with high-risk for suicide. Elements of education may include: variable course of treatment, what to look for in terms of relapse, and how to reach out immediately, prior to a psychological crisis (Gutman, 2005).

4 Support clients to understand the pros and cons of medication compliance in mitigating suicidality (Gutman, 2005).

5 Connect clients with a network of supports and resources (CAOT FACTSHEET…)

6 Create a sense of control, autonomy, and hope by helping clients to plan, initiate, and track long and short term goals that enable occupation (CAOT Factsheet on suicide prevention; Magill, 1977)

7 Identify occupational issues and address suffering and suicidal ideation in priority. As suffering is an inherent part of occupational therapists' work, occupational therapists and occupational therapy assistants must be prepared that the original reason for referral may not be the most pressing issue when suffering becomes too great.

8 Competently recognize when suicidal ideation is present (CAMH Suicide Prevention Ax Handbook, 2015). The interRAI, for example, may be one such tool to support suicidal ideation recognition.

9 Facilitate the implementation of a wrap-around approach to suicide prevention interventions that include, but extends beyond medication (Maris, 1995).

10 Facilitate opportunities for health enhancing activities and assist clients to systematically deal with everyday problems (COT, 2012).

11 When asking about suicide, language needs to be clear and direct, i.e. "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?" do not clarify the clinical picture, which is vital in determining the immediate next steps (LivingWorks, 2014b).

12 When suicidal ideation is present, a more fulsome assessment should be completed, including understanding relevant risk factors, assessing imminence of actions and whether a clear plan is present, and degree of hopelessness present (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012; Hawton & van Heeringen, 2009).

13 When assessing clients with multiple suicide attempts, it is important to consider each past attempt separately, and understand what led to each attempt to inform current assessment (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012). For example, being aware of whether a client is implementing a past suicide plan or enhancing a current plan based on gaps in a past plan.

14 Engage clients in open discussion to better understand their suicide story (CAMH, 2015; LivingWorks, 2014; Tryssenaar, 2003)

15 Collaborate with clients to determine static versus modifiable risk factors of suicide risk. Consider what protective factors are present (CAMH, 2015; RNAO, 2009; Working Group of the Clinical

Practice Guideline for the Prevention and Treatment, 2012). Examples of a static risk factors may include: a client with past suicide attempt and/or a high-risk related diagnosis. Examples of modifiable risk factors may include: limited sleep and/ or the current use of substances.

16

Key elements to consider when assessing risk:

1) Previous suicide attempts
2) Substance abuse
3) Mental health concerns, specifically including symptoms such as hopelessness, anxiety, agitation, and recurrent suicidal thoughts
4) Stressful events
5) Availability of means to enact suicide plan
6) Risk factors connected to: repetition, physical illness, chronicity, pain, disability, family history of suicide, social and environmental factors, and a history of suicide in the environment

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

Key considerations to consider when assessing risk in children:

1) Being socially inappropriate
2) Physically and verbally abusive
3) Past trauma (physical, emotional, sexual)
   (Stewart & Hirdes, 2015)
4) Family history of depression or substance addiction
5) Death by suicide by a close family member
6) Witness to violence and abuse
7) Severe and/or early family instability
   (Bridges, Murji, Hodgson, & McLeod, 2011).

17 When estimating risk, consider the following three elements:

1) Gather information related to the client's intent to engage in suicide-related behaviour
2) Consider factors that elevate or reduce risk of acting on that intent
3) Integrate all information available to determine level of risk, and appropriate environment to provide appropriate care

   (VA/DoD, 2013)

18 Collaborate with clients at risk for suicide by exploring their perception of the crisis, focusing on the problem leading up to the suicidal intent, and building an action plan to keep them safe (Tryssenaar, 2003).

19 Select the most appropriate care environment, one that balances optimal safety while being the least restrictive (Department of Veterans Affairs Department of Defense, 2013; LivingWorks, 2014b).

20 Use your unique expertise as occupational therapists and occupational therapy assistants to determine the most helpful and balanced environment. Occupational therapists and occupational therapy assistants are a valuable resource in determining which environment would be most suited to facilitate a person's recovery, as per skills in applying the Person-Environment-Occupation model (Law, Cooper, Strong, Stewart, Rigby, & Letts, 1996).

21 Provide psychotherapy on a weekly basis in the beginning of intervention stage. If not trained in psychotherapy, refer to a professional who is qualified (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

22 Support clients to regain control by helping to structure and organize their daily lives, so that they can balance what they need with what they want to do (CAOT factsheet…).

23 Identify person-factors, such as cognition, as potentially contributing to suicidal ideation. Design and educate regarding cognitive strategies to reduce suicidal ideation (CAOT FACTSHEET…).

24 Address and circumvent helplessness (Magill, 1977). Key interventions cited by Magill to address helplessness: "establish a sense of control over the environment and the opportunity for personal choice, interaction with someone in power, interaction with a hopeful person who recognizes the dignity and value of the patient, a total push with forced exposure to the effectiveness of their responding, interaction with other patients, increasing cognitive and motor skills so they can cope with their environment and immunization" (Magill, 1977, p. 67).

25 Collaborate with clients to set realistic, meaningful goals, and break those goals down into manageable steps. Educate clients to improve skills such as: time management, stress management, self-image, social skills, and problem-solving.

26 Collaborate with clients who have been stuck on suicide to rediscover new meanings and discover new occupations, new ways of enjoying occupations, and new environments (Tryssenaar, caotyr?).

27 Promote principles of hope and self-efficacy, which can support the transformation from despair into meaningful living (Hewitt, 2014).

28 Assess the context, including environmental factors.

29 Engage with clients to rebuild a trusting, therapeutic alliance following a client's suicide attempt (Ramsay, 2005).

30 Follow age-appropriate guidelines as defined by the practice setting you are working in, i.e. within school practice settings, the support role is often guided by the school psychologist or social worker.

31 Following a suicide attempt, it is recommended to complete a social assessment looking at contextual factors (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012). Completion of a social assessment at the postvention stage would support identification of where to modify the treatment plan and consider new approaches to care.

Gatekeeper training

1 As healthcare providers, it is imperative to be sensitive and competent with suicide prevention skills (Hawton, 2009; RNAO, 2009; Tryssenaar, 2003). Gatekeeper training is a promising method for improving suicide prevention skills and could be used by occupational therapists and occupational therapy assistants (Robinson et al., 2013). Healthcare providers with experience in hearing about suicide found gatekeeper programs that include intervention elements or advices to be more valuable (Applied Suicide Intervention Skills Training, 2010). Gatekeeper training offers essential crisis intervention skills for occupational therapists and occupational therapy assistants (Hewitt, 2014; Isaac, 2009).

2 When selecting a gatekeeper training program, it is important for each occupational therapist to select a program (by considering the methods and components of the training) that meets their responsibility, personal style, and professional values such as the ones related to enablement.

3 Consider community suicide preparedness and advocate for community stakeholders and gatekeepers to receive suicide prevention training (Cox et al., 2012)

Algorithms

1 Utilize algorithms in practice to determine flow of action in response to persons at risk for suicide in different practice settings and facilitate consistency of interventions and support clinical decision making (Department of Veterans Affairs Department of Defense, 2013).

2 There are many algorithms available to guide practice on assessing suicide risk, i.e. Health Canada is implementing an education program about the interRAI suites across Canada, and Ontario has adopted its use province-wide, with the trend of other provinces anticipated to follow suit. Research indicates the interRAI to support a “responsive, coordinated approach to care that allows for early identification of mental health problems, improved service planning, resource allocation and application of best practice initiatives from childhood into adulthood” (Stewart & Hirdes, 2015, p.6).

Screening tools

1 Screen high-risk individuals for suicidal ideation using one of the evidence-based screening scales available (Hawton & van Heeringen, 2009; Robinson et al., 2013; Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012). Example of screening tools that could assist in the identification of suicidal ideation are: Beck's Hopelessness Scale or the Hamilton Rating Scale for Depression (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

Transition points

1 Provide areas of expertise with regards to increasing coping and problem-solving skills during transitional times (COT, 2012). Transition points pose a high-risk for suicide for high-risk groups, support is key (COT, 2012; COT and Nice 2012).

2 Following a suicide attempt, in a transition from hospital to community, occupational therapy can support the setting and achievement of goals to maintain/support community participation (COT/NICE, 2012, p. 16/17).

Safety plan

1 Collaborate to formulate a safety plan with the client that aligns response with risk level (CAMH, 2015; LivingWorks, 2014; RNAO, 2009). Advocate for the following components in a safety plan: safe amounts of medication in person's possession, use of containers such as blister packs and provision of one week of medicine at a time to limit overdose, role of family in medication monitoring, heightened support from family and/or friends, restricted access to lethal means, and referral to mental health services (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

2 Consider occupational issues and specific interventions as part of the safety plan (Hewitt, 2014).

3 Thoroughly document safety plan, consult with team, family, and supports (CAMH, 2015).

4 Engage with others on client's healthcare team, friends, and family to review safety plan (CAMH, 2015).

First responders

1 Collaborate with emergency services and advocate for increased access to first responders if acute suicidal ideation is present (Hawton & van Heeringen, 2009)

2 Connection to first responders should be made if a client is injured from suicidal behaviour. (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).

Postvention

1 Following a suicide, hold one of the important postvention activities with the team to heightened awareness for cluster deaths. Stay attuned 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).

2 Contribute to the team decisions and organization of a postvention debriefing session to support the grieving process. It is important that proximity to the loss is considered and engagement in is not only determined by a practitioner's role i.e. the psychologist may be in the role to guide the postvention activities, though if too close to person who died by suicide another support person may be considered.

3 Adapt the postvention debriefing session to the specific setting. To support the grieving process in preschoolers, elementary school age children or high school students respectively, look distinctly different than in healthcare centres.

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

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APPENDIX (not for comment)

The Canadian Association of Occupational Therapists (CAOT) is constantly growing the number and quality of resources offered to its members. In 2016, CAOT Board supported the transition and enhancement of several of the Position Statement used in advocacy activities into Role Papers, a format better suited to support the daily practice of occupational therapists. After a research and development phase, CAOT has designed a sustainable process that involve members at several touch points (see Table 1 below).

Table 1. Outline of steps involved in the development of CAOT Role Papers

1	Selection of the topic by CAOT direction through input from the Board, Staff and Members
2	CAOT conduct a rapid scoping review and appraisal of knowledge synthesis tools
3	Volunteers authors* are selected and trained
4	Volunteers authors are producing a 1st draft of the recommendation for the practice in collaboration with designated CAOT staff
5	The 1st draft is released for CAOT members to provide input
6	CAOT staff produce a 2nd version and consult with volunteer authors as needed
7	The second draft is sent to selected external stakeholders for input
8	CAOT staff produce a 3rd version and consult with volunteer authors as needed
9	The 3rd version enters the production phase (copy edit, translation and layout)
10	The final role paper is released, posted on CAOT website and promoted to CAOT members

*Volunteer authors need to be CAOT members and undergo a selection process.

The recommendations are based on best evidence available and the method used to gather these evidence is detailed below.

Methodology

A scoping review framework was used to chart a broad research question, and examine a wide range of literature and design types (Arksey& O'Malley, 2005). Charting of the existing evidence is a comprehensive and flexible approach to organizing data. The charting process allows for the identification of gaps in current evidence, and the making of recommendation for future work.

Identification of the Research Question

The overarching question which guided this work was: What is the role of occupational therapists in suicide prevention?

Identification of Relevant Studies and Study Selection

One person (CAOT DKTP) was responsible for the identification and selection of publications. Publications were identified through the following electronic databases: PubMed, Embase, PsychInfo and the Cochrane Library. CDC Information Database, NICE and National Guideline Clearinghouse were also searched.

For the first wave of publications identification, documents had to contain the term "occupation" or "occupational therap**" and the term "suicide" or "suicide prevention". Because these parameters lead to few results, a second wave of publications identification took place. For the second wave, the term

"recommendations" or "guidelines" AND "suicide prevention" were used. 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 which helped to inform the final choice of keywords for the searches in the databases. The reference lists of relevant publications and websites of occupational therapy associations were also consulted for the identification of relevant publications. The websites of CAOT and other renowned occupational therapy associations[1] were searched with the key word "suicide prevention". Finally, occupational therapists, members of the CAOT suicide prevention practice network, were invited to submit relevant publications and resources for consideration.

The identification of publications took place on March and April 2017 using the keywords presented in Table 1.

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 it had to contain recommendations that could be employed/transferrable to the practice of occupational therapy. Publications had to be published in English. There was no limit placed on the study year of publication, however design types were limited to reviews or knowledge transfer tools (i.e. guidelines for practice, position statements, expert opinions). All primary research studies were excluded because of the limited resources available to conduct this review, and because they seldom propose clear recommendations for practice without advising that more research be conducted to confirm. The only exception was the inclusion of case reports if the use of such case was meant to illustrate a recommendation to practice. See Appendix C for the algorithm of the identification and selection process.

In parallel, two people appraised all publications that met inclusion criteria using the Association of periOperative Registered Nurses (AORN) Evidence Rating Model (Association of periOperative Registered Nurses (AORN), 2017). Results of the appraisal were then compared and discussed until consensus was reached. Two persons appraised the selected publications independently according to the original AORN scale, as well as according to a numeric system (2 for "High", 1 for "Good" and 0 for "Low") that allowed to more precisely quantify the quality of the work. Numerical scores were compared, and if a global score differed by 20% or more, a consensus meeting was held. The raters agreed for the rating of 23/28 publications (82%), and an agreement was reached for the five divergent scores after a discussion.

Charting the Data

[1] These associations were the American Occupational Therapy Association, the College of Occupational Therapists, Occupational Therapy Australia and the World Federation of Occupational Therapists.

The extraction table included: author, year, title of publication, source of publication, study design, specific occupational therapist roles, methodology described (yes/no), quality appraisal score, number of references, and insights from reviewers.

Theories and models

The Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend, & Craik, 2007) and the Person-Environment-Occupation (PEO) model (Law, Cooper, Strong, Stewart, Rigby & Letts, 1996) are used as the occupational therapy specific theoretical underpinnings of this paper. Application of both models clarifies occupational therapists' unique contribution to suicide prevention. Specifically, the CMOP-E (2007) was chosen as it highlights the way humans engage in occupations as a core value, and holds spirituality at its centre. The PEO (1996) was selected as it depicts the interconnectedness between the person, environment, and occupation, and how overall performance is impacted by such interactions. The Canadian Practice Process Framework (CPPF) (Polatajko, Craik, Davis & Townsend, 2007) sub-sections are used within the Occupational Therapist Role(s) section in this paper to highlight occupational therapy practice at the various stages of engagement in service. The CPPF was chosen as it presents a universal engagement process for all occupational therapists across various roles and populations. Within each CPPF sub-section, from frames of reference to enter/initiate through to concluding/exiting service, various roles an occupational therapist can play to address suicide are identified.

Formulating the recommendations

Using evidence provided by CAOT as well as evidence known by the authors, the lead volunteer author's role is to complete a first draft (approximately 15 pages) of a Role Paper, describing the role of occupational therapists in suicide prevention. Once the Lead Volunteer Author has completed an initial draft, they will work collaboratively with 2 secondary volunteer authors as well as with designated CAOT staff, who will provide feedback and revisions for the lead volunteer author to incorporate.

Coding the recommendations

Once in their final version, each recommendation is coded according to the level of evidence and consensus described in this chart:

EBR	Evidence-based recommendation	Recommendation supported by quality evidence
CBR	Consensus based recommendation	Recommendation formulated in the absence of quality evidence but supported by authoritative organizations
PP	Practice point recommendation	Recommendation based on experts and members' opinion