Suicide intervention: A guide to using resources

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DISCLAIMER: This document contains an overview of tool vetting and practice related to suicide prevention, intervention and postvention. 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 personal knowledge and skill related to suicide assessment and intervention, clients' preferences and resource availability when applying these recommendations. These documents are meant to support practice but are not a substitute for gatekeeper training. 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 Addressing Suicide in OT Practice Network will make every effort to update and issue a new version of this guide at any time. Concerns or questions related to this document can be directed to the Tool Vetting Committee Chair Theresa Straathof (tstraathof@toh.ca) and/or the Network Chair Kim Hewitt-McVicker (khewitt@cmhaww.ca). Within this document, there is reference to two publications: Coping Strategies to Promote Occupational Engagement and Recovery (McNamara & Straathof, 2017) and Coping Strategies to Promote Mental Health (Straathof, 2022). Theresa Straathof (network member) is the author of these publications and may receive royalties from sales.

This document was created in the spirit of being a complimentary document to the Addressing Suicide Prevention in Occupational Therapy Role Paper. The best practice recommendations were pulled from the role paper and tailored to each section in this document. Role Paper Best Practice Recommendations in this document are not an exhaustive list. Please refer to the Suicide Prevention in Occuapational Therapy CAOT Role Paper document for a full list of recommendations.

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Suicide Continuum Phase: Intervention

Gatekeeper Training

Gatekeeper training sessions are designed to teach lay people and professionals about warning signs related to suicide crisis and response strategies. These sessions often provide a structured process to follow related to assessing risk, questioning, providing support and getting assistance to the individual in crisis. There may be a cost associated with training as well as a time commitment to complete the training. Gatekeeper training is often recommended as best practice for those working with populations at high risk for suicide. Gatekeeper training is beyond the scope of this document.

For the Gatekeeper Training Inventory document, please visit the CAOT website or click here

For the Gatekeeper Training Decision Making Tool, visit the CAOT website or click here

Suicide Continuum Phase: Intervention

Suicide interventions address the risk of suicide, focusing on how best to respond early when someone has thoughts of suicide or suicide related behaviours (Public Health of Canada, 2016). If suicide screening/assessment indicates that there is a risk of suicide, intervention is needed. The nature of intervention will depend on the current level of risk, the clinician's personal comfort and skill level of intervention, and needs to be monitored and modified based on changing levels of risk.

Occupational therapists may have varying degrees of training, comfort and competence in providing suicide intervention. Part of providing best practice is acknowledging expertise and referring to others when appropriate. Clinical judgment is important in determining action. It is important to know that there is no conclusive evidence to support the effectiveness of a "no suicide contract" in preventing a client from acting on suicide. In other words, it is not enough for the person to say they will not kill themselves, when other risk factors or warning signs are present. Once suicide risk is identified, consider triaging the client or providing interventions, even if the client says they will "stay safe for now" and agrees not to act on suicide ideation. Remember that a suicide threat or attempt is a medical emergency requiring professional help as soon as possible. A breakdown of interventions related to general guidelines, level of risk, lethal means restriction, safety planning, and connection to community support/follow up is outlined.

General guidelines

- Take all expressions of suicide seriously
- Assist the client in crisis in a calm, compassionate and genuine manner
- Ask questions without fear or judgement
- Use the client's name
- Express your gratitude that the client has voiced their concerns
- Reassure the client that you can provide help
- Ask questions about protective factors or highlight them if revealed in the conversation

- Whenever possible, instill the help of team members (e.g. a colleague may be able to call 911 or the poison control centre)
- Ensure you know the location of your client before you inform them that you are calling 911
- If they have acted on a suicide plan, try to find out extent of injury such as how many pills they have taken or where have they cut themselves
- Consider factors to reduce cognitive effort of the client as they may be experiencing physical (e.g. rapid heart rate, shallow breathing) and emotional distress (e.g. fear with difficulty in reasoning, concentrating and problem solving). Provide repetition, concrete cues, simple choices, etc.

Adapted from Treatment Advocacy Centre (2018)

CPPF: Agree on Objectives and Plan

Role Paper Best Practice

- Consensus Based Recommendation
  - 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, 2014; RNAO, 2009)

Level of Risk & Corresponding Interventions

- Once the level of risk is identified it is important to consider how to triage the client and what interventions to provide. What follows are some triage and intervention options to consider when factors associated with imminent, high, moderate and low risk are present.

Risk Level	Corresponding Intervention
Imminent Risk	❖ Initiate emergency medical attention and restrict access to lethal means ❖ Involve police if a person is violent or threatening violence towards self or others. ❖ Keep in contact with client until emergency service arrive or until transfer to higher level of care ❖ Consider completion of a wellness check within 24 hours. ❖ Complete documentation
High Risk	❖ Consider initiation of emergency services ❖ Stay with the client until transfer of care to a higher level of care is complete if appropriate. ❖ Confirm client has appointments scheduled with healthcare providers ❖ Provide review/training of coping foundations and complete suicide

	safety plan ❖ Restrict/reduce access to lethal means ❖ Conduct a wellness check within 24 hours ❖ Complete documentation ❖ Consider link or involvement of other community or personal resources with client consent
Moderate Risk	❖ Provide intervention to address coping strategy foundations ❖ Complete suicide safety plan ❖ Restrict/reduce access to lethal means ❖ Provide information on accessing community resources ❖ Complete documentation
Low Risk	❖ Discuss and/or provide intervention to address coping strategy foundations ❖ Discuss protective factors ❖ Restrict/reduce access to lethal means ❖ Provide information on accessing community resources or online resources ❖ Complete documentation

Adapted from the TOH-OWN Manual. (Robinson & Larry, 2020, C-SSRS Clinical Triage Guidelines, 2016, SAFE-T Protocol with C-SSRS, 2016). Reprinted with permission.

Role Paper Best Practice

- Consensus Based Recommendation
  - Advocate for the inclusion of elements in client's safety plan, including restricted access to lethal means (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012).
  - Ensure that the care environment maximizes clients' safety while being as least restrictive as possible (Department of Veterans Affairs & Department of Defense, 2013; LivingWorks, 2014).

Lethal Means Restriction

- Free and paid training available on this subject for clinicians for example: CALM (Counselling on Access to Lethal Means).
  - Teaches clinicians how to reduce access to lethal means by identifying those who require lethal means counselling, inquiring about one's access to lethal means and working with clients and families to reduce harm by restricting lethal means access.
- May be helpful to consider a formal approach to practice when responding to lethal means screening and restriction by preparing guidelines or protocols for the clinical setting. (e.g. screening over the phone, virtually, in session, in hospital, or in the community). (Moscardini et al., 2020)

- ❖ When developing an approach, consider appropriate actions related to age and culture, provincial legislation related to confidentiality, college standards, privacy legislation and duty to warn, Emergency Medical Services (i.e. 911), and identify roles of team members.
- ❖ If client discloses access to means for self harm and suicide, it is recommended the client not handle the items intended for self harm where possible (Stanley & Brown, 2012). For example, have friends and family remove items from the home that the client may use for self-harm or if the client is on the phone with you and is in a room with a gun, ask them to leave the gun in the room and exit the building.
- ❖ It is always important to have the client identify what methods they have considered for suicide and collaboratively problem solve how they will make and/or keep their environment safe (Moscardini, 2020). If they feel stuck for solutions, the clinician could ask permission to offer suggestions.

The following strategies to restrict and reduce lethal means are derived from clients' personal suggestions of what could work for them to improve their safety:

Possible Methods/Lethal Means	**Strategies for safety, lethal means reduction**
Overdose on prescriptions medications	Switch to a weekly blister pack to pick up from pharmacy, dispose of excess medications by returning them to a pharmacy, reduce the amount of over - the - counter medications in the household, have partner keep them in a locked safe, use a medication dispenser (SPENCER)
Motor vehicle accident	Provide vehicle keys to partner when suicidal symptoms are present
Hanging	Instill help from family to remove ropes or cords from home
Power tools	Store at siblings home or friends home
Knives	Discard excess sharps or have family member store in locked drawer
Jumping from bridge	When going for a walk, have a specific, constructive purpose rather than aimless wanderings
Case study: Collaborative restriction process	

Jennifer presented to an initial occupational therapist assessment in a private community clinic and disclosed a recent suicide attempt during the initial interview. She indicated she still had the lethal means, which was a lethal dose of her prescribed antidepressants. She also still had the letter she wrote to leave behind for friends and family. Her risk level continued to be high, with intrusive thoughts of suicide for several hours per day. Jennifer did not have an intent to follow through on her plan. She was agreeable to engage collaboratively in the lethal means restriction process. In this case, there were no other people the client provided consent to involve and her risk level did not require the occupational therapist's duty to report. There was no duty to report in this scenario as the client voiced she did not have intent to complete her plan, and actively engaged in generating a plan to restrict lethal means and continue with treatment.

The client wanted to remove access to lethal means but did not know how, since she needs to continue to take her medication. With permission, the occupational therapist shared several options including: returning to pharmacy for blister packs to be released per week, using a timed medication dispenser machine, or having a trusted friend release one week of pills to her at a time. The client felt most confident to ask a trusted friend to dispense medication to her one week at a time.

The client also wanted to dispose of the letter she had written as a goodbye to her loved ones, but she didn't feel she could throw it out. The OT asked permission to share some other options. The client was agreeable to this and felt comfortable with the idea of burning her note, which could be a symbolic gesture as well as a safe way to dispose of the letter ensuring nobody would ever read it.

The client was also encouraged to have a psychiatric assessment at the local emergency department given her recent suicide attempt. A follow-up phone call was scheduled for the following day to confirm the collaborative plan was put in place by the client.

***Case studies have been de-identified and names have been changed to protect client confidentiality.*

Case study: When to escalate and Involve the authorities

Bob had been working with an occupational therapist for years to support him in living with his brain injury. Recently, Bob had been experiencing a high volume of interpersonal and financial stress. He had low access to support. In this case, he sent a text message to his community occupational therapist's work cell phone after work hours outlining that the stress had become too much and there was "no point anymore" leaving him with no other option, ending his text with "I bid you adieu". The community occupational therapist received this text message at 11pm and attempted to call and text the client with no response. The occupational therapist responded to the text message indicating that the local authorities will be called to complete a wellness check based on the occupational therapist's duty to report outlined in the initial informed consent process. There was no response. The community occupational therapist had to assume based on the intent of suicide outlined in the text message, that there could indeed be a lethal means in place. The community occupational therapist called the local authorities, outlining the text message communication of an intended suicide. The local authorities performed a wellness check, where the client was found alive having made no suicide attempt. The client indicated to the authorities that he had no intent to complete a suicide attempt, and the authorities deemed him capable. The authorities ensured the client followed up with the community occupational therapist, who scheduled an urgent meeting with the client the next day to engage in safety planning and lethal means restriction.

***Case studies have been de-identified and names have been changed to protect client confidentiality.*

CPPF: Implement Plan

Role Paper Best Practice

- Consensus Based Recommendation
  - Provide recommendations, guidance and other expertise on increasing copin problem-solving skills during high-risk transitional times (COT, 2012)
- Practice Point
  - Support clients in improving self-image and stress and time management, as well as problem-solving, coping and social skills.

Healthy Coping Strategies

- It is important to screen the use of coping strategies with your clients as these strategies can assist the client to engage in meaningful occupations (McNamara & Straathof, 2017).

Coping strategies fall into 4 categories: health and wellness routines, changing the body's response to stress, changing the situation and changing attitude (Straathof, 2022a; Straathof 2022b).

- Health and wellness routines such as adequate sleep, sleep hygiene, regular nutritious meals, exercise, social connections, leisure involvement and

medication compliance can help clients to have resilience for various stressors. Developing a daily schedule to incorporate these wellness occupations may be of benefit.

- ➢ Changing the body's response to stress incorporates techniques to access the parasympathetic nerve system. Techniques can include relaxation, deep breathing, distraction, exercise, mindfulness. It is very helpful if the client recognizes early warning signs of stress and exhaustion symptoms that may be associated with stress, illness or suicide risk.
- ➢ Changing the situation may include goal setting, time management and assertive communication that addresses how to express your needs to others or setting limits.
- ➢ Changing attitude regulates emotions through changes in thinking. Negative thinking will increase the intensity of distressing emotions. An example of a negative thought could be, " there is no way I can be helped with the stressors I am facing." Teachings in this area could include recognizing distortions in thinking, challenging and reframing negative thoughts, practicing gratitude and positive affirmations.

- ❖ Suicide safety intervention may include training in coping strategy foundations prior to setting up a formal suicide safety plan which ensures that the intervention is more comprehensive (Straathof, 2022a; Straathof 2022b; McNamara & Straathof, 2017). This may be an opportunity to discuss one's cultural, religious, and/or spiritual beliefs as it could be a factor in discussions around suicidality and acting on suicide thoughts (Jacobs et al., 2003).
- ❖ The following chart indicates coping categories and strategies. Modules for training in various strategies can be found in Coping Strategies to Promote Occupational Engagement and Recovery (program manual) (McNamara & Straathof, 2017). Clinical judgement is used to determine where coping strategy development is needed so that all modules do not need to be administered for effectiveness

    - ➢ Examples of modules that may be helpful include: healthy lifestyles, stress management, assertive communication for daily occupations, and attitude strategies to promote occupational health

Coping Strategy Category	Strategies
Health and Wellness Routines ❖ Can help clients to have resilience for various stressors ❖ Developing a daily schedule to incorporate these routines may be beneficial	❖ Follows a basic health routine ❖ Eats regular, nutritious meals ❖ Practices sleep hygiene ❖ Takes medications as prescribed ❖ Balances self-care, leisure and productive occupations ❖ Attends to spiritual needs

	❖ Participates in regular exercise ❖ Engages in social activities ❖ Keeps medical or counseling appointments
Change Body's Response to Stress ❖ Techniques to access the parasympathetic nerve system ❖ It is very helpful if the client recognizes early warning signs of stress and exhaustion symptoms that may associate with stress, illness, or suicide risk	❖ Knows early and exhaustion signs of stress ❖ Practices relaxation strategies ❖ Distracts self with the 5 senses ❖ Practices mindfulness ❖ Connects with social supports
Change Situation ❖ Addresses how to express needs to others or set limits, manage time and set goals	❖ Uses assertive communication ❖ Knows limits and says no ❖ Manages time ❖ Sets and follows through on goals
Change Attitude ❖ Regulates emotions through changes in thinking ❖ Negative thinking will increase intensity of distressing emotions	❖ Uses affirmations ❖ Practices gratitude ❖ Identifies cognitive distortions ❖ Reframes distortions

Adapted from McNamara & Straathof (2017).

The case example that follows illustrates the use of coping strategies training prior to completing a suicide safety plan.

Case study: Building coping and communication toolbox

Sonia was a 32 year old female, employed for night shifts at a grocery store. She presented to the hospital following a recent break up with her partner. She felt depressed and had taken an overdose of medication. During the interview with the occupational therapist, Sonia said she was sleeping poorly for weeks, skipping meals, and was isolating from friends. She made several negative statements such as "no-one will ever love me" and "I haven't told my friends about the break up because they have their own problems and I don't want to be a burden". She was also quite distressed that she would lose her job as she had not told her employer she was in hospital and did not know how to have this conversation.

The occupational therapist discussed possible interventions and they agreed on a timeline for training in coping strategies. Sonia prioritized needing to speak with her employer so she was introduced to an assertive communication script and they practiced what she could say to her

boss. She then went on to phone her employer and felt a sense of relief. Next, teaching was provided on the benefits of healthy routines and Sonia committed to several sleep hygiene practices, connecting with a friend and regular meals. She mapped out these activities on a daily schedule. Teaching was then provided on negative thinking and examples of thought distortions as they relate to increased distress. Sonia began journaling one positive success from each day and used grounding techniques to distract from negative self talk. Finally, because Sonia had experienced symptoms of stress for several weeks before taking the overdose, she received training on identifying early and exhaustion symptoms of stress. Once these training sessions were completed, she was invited to collaboratively put together a suicide safety plan. She reported that recognizing stress symptoms and identifying coping strategies for her suicide safety plan was fairly easy to do with the former training she had received.

***Case studies have been de-identified and names have been changed to protect client confidentiality.*

CPPF: Agree on Objectives & Plan

Role Paper Best Practice

- Consensus Based Recommendation
  - Consider interventions addressing occupational issues as part of the safety plan (Hewitt, 2014).
  - 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, 2014; RNAO, 2009).
  - Advocate for the inclusion of the following elements in a client's safety plan (Working Group of the Clinical Practice Guideline for the Prevention and Treatment, 2012):
    - 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

Safety Planning

- Suicide safety planning is best practice for managing suicide (Stanley & Brown, 2012).
- A formal suicide safety plan includes the steps to manage and reduce suicide risk behaviour during a suicide emergency (Stanley & Brown, 2012).
- In a review and study of safety plan utilization, Moscardini et al., (2020) formed the following conclusions:

- ➢ Safety planning reduces risk of suicide attempts, hospital length of stay and improves symptom resolution more quickly.
- ➢ Higher quality of safety plans - meaning inclusion of recommended content, and specificity of actions is important to the efficacy of interventions.
- ➢ Collaborative approach with the facilitator presents results in higher rate of plan completion and retention than safety plans that are self-administered.
- ➢ Manualized safety plan with template for completion improves facilitator comfort and quality of plan completion.
- ➢ Standard safety plan protocols are linked to positive outcomes for frequency of safety plan use by facilitators.

❖ Based on clinical experience, the nature of a safety plan will depend on clinicians assessment of clients level of activation, cognitive function, use of coping strategies, personal support and environment.

- ➢ Client's need to show insight into their situations as well as working memory and problem solving to follow safety plans.
- ➢ Clients struggling to follow basic routines and to tolerate social connection may need interventions to address these issues before completing a detailed safety plan.
- ➢ Clients with cognitive impairments may struggle with the use of completing and utilizing a formal suicide safety plan.

Case study: Safety planning with cognitive decline present

Daisy is a 67 year old female with suspected cognitive impairment who was admitted after saying she wanted to die. Family was having difficulty managing her care needs. She was referred to occupational therapy for assessment and treatment, and suicide safety planning.
A functional assessment was completed indicating mild to moderate impairment in executive function. She had difficulty with working memory, planning and problem solving and became easily frustrated with challenges . She often did not recognize errors in her work and needed assistance to resolve errors. A suicide safety plan was not attempted due to client having cognitive impairment.
Instead, the occupational therapist met with the client and the family to discuss ways to increase support, thereby reducing stress and to make the environment safer. The occupational therapist shared recommendations to modify the home environment, to increase support services for ADLs and IADLs, and to ensure access to lethal means was restricted.

***Case studies have been de-identified and names have been changed to protect client confidentiality.*

Safety Plans Content

❖ Stanley and Brown (2012) and the Center for Addiction and Mental Health (CAMH, 2011) both identify 7 core components for suicide safety planning, that the Canadian Armed Forces Handbook (Zaheer et al., 2017) summarizes as:

1. Recognize warning signs of an impending suicide crisis

2. Remind self of reasons to live
3. Employ internal coping strategies
4. Use social activity for distraction
5. Work with family or friends to manage the crisis
6. Contact professionals or agencies for support
7. Restrict/remove access to lethal means

- Further content considerations in safety plans outlined by Straathof, 2022a; Straathof 2022b can include:
  - Emergency contacts
  - Words of others as to why client is values and appreciated
  - Acts of kindness/gratitude
  - Personal and delegated responsibilities
  - Coping strategy foundations
  - Storage information of the plan with various stakeholders
  - Clear timeline for review by self, and/or with personal and professional supports

CPPF: Implement Plan

Role Paper Best Practice

- Evidence Based Recommendation
  - Ensure clients understand the importance of their mental health treatment plan in mitigating risk of suicide (Gutman, 2005).
- Consensus Based Recommendation
  - 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, 2014; RNAO, 2009).

Suicide Safety Plans: Process

(Stanley & Brown, 2012).

- When completing any suicide safety plan, Stanley and Brown (2012) recommend:
  - Use a collaborative process
  - Use client's wording
  - Discuss client's reaction to the plan and likelihood of using the plan
  - Revise the plan when there is a change in level of risk
- When completing a suicide safety plan, the OT is encouraged to:
  - Ensure informed consent is obtained to copy/scan documents, to place safety plan on electronic health records and then provide copies to the client
  - Complete charting and include clear information on reduction of lethal means, plans for utilization of safety plan, and plans to inform named supports that a safety plan exists

- ➢ Plan a follow up session with the client to confirm contact has been made with named supports and that they are aware a safety plan exists AND that there is a safe plan initiated to dispose of or restrict lethal means

Suicide Safety Plans: Tools

- ❖ Collaborative safety planning can take between 30 and 60 minutes.

Tool	Description
Suicide Safety Plan for Occupational Engagement and Recovery (SSP-OEAR). (Straathof, 2022a; Straathof 2022b)	❖ Used in adult settings at The Ottawa Hospital for those 16+ y/o who do not have cognitive decline. ❖ Includes a collaborative process and provides clinicians with a script moving through the content and process of safety planning. ❖ Suggested use of a mini safety plan wallet card templates to cue clients of safe practice and coping strategies. ❖ The SSP-OEAR includes a safety plan module (English only), [safety plan sample, safety plan template and wallet cards, (French and English)] to complete a suicide safety plan. To view the documents used in the SSP-OEAR, access here.
Patient Safety Plan Template (Stanley & Brown, 2008)	❖ The template offered by Stanley and Brown (2013) is a one page tool that is completed with the adult client. They recommend reviewing their manual to guide safety plan completion prior to completing a safety plan with a client. To view the template, click here. To view the safety plan treatment manual, click here.
Suicide Safety Plan for Youth (The Children's Hospital of Eastern Ontario (CHEO), 2019)	❖ This safety plan, titled "My Safety Plan" offers a sample suicide safety plan to use with youth. It can be accessed here.

School-based Suicidal Ideation Response Protocol (SI Protocol) (Alberta Health Services (Mental Health Online Resources for Educators - MORE), 2019)	❖ It should be noted that this is a resource for professionals working within a school environment and is not suicide prevention training. After completing the modules (SI Protocol: School Administrator, SI Protocol: School Staff, SI Protocol: Point Person, SI Protocol: Mental Health Professional), there are supporting documents that can be accessed such as a copy of a safety plan. The safety plan is not linked here, as MORE encourages professionals to attend the modules in order to receive any updates on the supporting documents. The modules can be accessed here.
Suicide Potential Assessment Grid	❖ This tool is from the Douglas University Mental Health Institute. It is a bilingual tool. It includes colour coding for levels of risk, check mark of risk and protective factors and multiple schedules to track change over time.

CPPF: Implement Plan

Role Paper Best Practice

- ❖ Evidence Based Recommendation
  - ➢ 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).
- ❖ Consensus Based Recommendation
  - ➢ 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.; Magill, 1977).

Phone Applications

(Larsen et al, 2016), (Melia et al, 2020)

Benefits

- ❖ Allows client to have their individualized safety plans at hand wherever they go
- ❖ May be particularly helpful for younger populations, where they may ensure privacy
- ❖ Good option to avoid losing the plan (especially in paper copy) and prompt them to review and modify from time to time

Risks

- Clinical judgement of clinician to decide if a phone app may be a useful adjunct to the safety planning process; some applications reviewed were found to have harmful content
- Apps should only ever be used as an adjunct and must never replace other areas of suicide risk management
- It is recommended that the clinician regularly checks the apps they recommend to ensure any crisis lines or local resources linked are up to date and accessible in the country/province/area

Considerations

- Apps should include all 7 core components of the safety plan described above and some apps also have extra content/features (e.g. educational modules on adaptive coping strategies, or options to insert personalized emergency contacts/local resources).
- Some examples of Canadian applications reviewed by the authors are outlined below. This list is by no means exhaustive and the list is not monitored to determine if apps and resources cited in apps are up to date.

App Name (Developer)	Safety Plan	Personal Contacts	Local Crisis / Support Resources	Education	Notes
Suicide Safety Plan (Inquiry Health)	YES	YES	YES	YES	❖ Some written educational modules on coping strategies ❖ Available for Apple and Android devices
Calm in the Storm (Tactica)	YES	YES	YES	YES	❖ Built in "Relief" section with mindfulness activities ❖ Built in "Learn" Section with education ❖ Prompts regular assessments of levels of distress; targeting long term stress management ❖ Available for Apple devices and accessible by computers.
Be Safe (Connex Ontario)	YES	YES	YES	YES	❖ Created by CAMH - only has resources listed in Ontario and in some select other Canadian cities (Vancouver +

					Halifax) ❖ Creates a personal get help script that helps users find the words to reach out ❖ Available for Apple and Android devices.

Role Paper Best Practice Recommendations in this document are not an exhaustive list. Please refer to the Suicide Prevention in Occuapational Therapy CAOT Role Paper document for a full list of recommendations.

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