Suicide prevention: 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).

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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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: Prevention

Suicide prevention is defined by the Public Health Agency of Canada (2016) as building protective factors, promoting mental health and well-being and reducing risk of future crises. Prevention can include screening followed by further assessment when warranted by screening results. Guidelines for screening and assessment are outlined next, with examples of evidence-based tools that practitioners can employ in their practice.

For the purpose of this document, screening will include considerations of risk factors, warning signs, protective factors, coping foundations, as well as introducing the conversation. Some examples of screening/assessment tools are provided.

CPPF: Societal Context

Role Paper Best Practice

- Evidence Based Recommendation
  - Be knowledgeable about suicide known risk factors, and be vigilant, particularly when the risk factors are compounded (Hawton & Heeringen, 2009; Public Health Agency of Canada, 2016)

Risk Factors

(Robinson & Larry, 2020; The Ottawa Hospital, 2010).

Risk factors are characteristics that have been shown to be associated with an increased likelihood of suicide. They do not cause the problem, and are not symptoms of an illness, but rather are factors that have been shown to influence the likelihood of suicide (The Ottawa Hospital Mental Health Policy, Procedure, Protocol Manual, 2010). Clinical reasoning must be used to determine which risk factors are applicable to your client. Risk factors could include:

❖ **Demographic** ➢ Advanced age ➢ Adolescent or young adult age ➢ Male (highest number of suicides) ➢ Female (suicide attempts) ➢ Ethnicity (indigenous individuals aged 14-24, caucasian individuals) ➢ LGBTQIA+	❖ **Psychosocial** ➢ Low Socioeconomic status (SES) ➢ Recent drop in SES ➢ Widowed, divorced, separated, single ➢ Socially isolated ➢ Social withdrawal ➢ Family adversity or poor relationships ➢ Occupational stress or humiliation ➢ Perception of being a burden to others ➢ New incarceration
❖ **Physical** ➢ Physical illness ➢ Pain ➢ Disability ➢ Change in functional status	❖ **Historical** ➢ Family history of suicide and/or substance abuse ➢ Previous suicide attempts or other self-harm acts ➢ Ideas or plans ➢ Impulsive or violent traits ➢ Absconding ➢ Childhood trauma ➢ Medication non-compliance
❖ **Clinical** ➢ Past and/or current psychiatric illness or affective disorders ➢ Substance abuse disorders ➢ Unanticipated clinical improvement or sudden change in attitude ➢ Cognitive impairment	❖ **Psychological** ➢ Low ambivalence about living vs. dying ➢ Hopelessness ➢ Loss of enjoyment in previously meaningful activities ➢ Severe, unremitting anxiety ➢ Panic attacks ➢ Shame ➢ Humiliation ➢ Low self-esteem ➢ Aggression or violence against others ➢ Agitation ➢ Cognitive rigidity, polarized thinking ➢ Poor locus of control

	➢ Extremely narcissistic vulnerability
❖ **Increased Lethality** ➢ Means to complete the act (medications, firearms) ➢ Plan (suicide note) ➢ Intent to complete ➢ Evidence of self harm ➢ Intoxication	

Adapted from the TOH-OWN Manual (Robinson & Larry, 2020; The Ottawa Hospital (2010). Interprofessional protocol: Acute suicide risk assessment. Mental Health Policy, Procedure, Protocol Manual, Mental health program. Adapted and reprinted with permission from: The Ottawa Hospital.

Warning Signs

(The Ottawa Hospital, 2010).

As it is hard to know if someone is thinking about suicide, warning signs can help identify whether individuals are more likely to attempt suicide. Some warning signs include:

- ❖ Formulation of a plan
- ❖ Threatening suicide, detailing suicide plans or researching methods
- ❖ Increased access to lethal means (pills, guns etc)
- ❖ Talking about suicide or death with themes of hopelessness and worthlessness
- ❖ Increased intensity of suicidal ideation
- ❖ Engaging in risky behaviour
- ❖ Self-neglect and/or poor self care
- ❖ Change in personality or mood

The Ottawa Hospital (2010). Interprofessional protocol: Acute suicide risk assessment. Mental Health Policy, Procedure, Protocol Manual, Mental health program. Adapted and reprinted with permission from: The Ottawa Hospital.

Role Paper Best Practice

- Evidence Based Recommendation
  - Be knowledgeable about known protective factors (Public Health Agency of Canada, 2016)

Protective Factors

(The Ottawa Hospital, 2010).

Protective factors can safeguard individuals from suicidal thoughts and actions. These factors often provide people with a sense of importance, meaning, purpose and connection to others. Some protective factors include:

- Responsibility to family
- Social support
- Life satisfaction
- Children at home
- Pregnancy (except among individuals with postpartum psychosis or mood disorder)
- Cultural, spiritual, or moral attitudes against suicide
- Adaptive ability to cope with stress or frustration
- Positive problem solving skills
- Engaged in work or school

The Ottawa Hospital (2010). Interprofessional protocol: Acute suicide risk assessment. Mental Health Policy, Procedure, Protocol Manual, Mental health program. Adapted and reprinted with permission from: The Ottawa Hospital.

CPPF: Practice Context

Role Paper Best Practice

- Practice Point
  - 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.

Evaluate Risk Management Procedures in the Workplace

(Canadian Association of Occupational Therapists [CAOT], 2012; Hewitt, Hebert & Vrbanac, 2019).

- OTs are expected to continuously evaluate their knowledge, skills, and abilities within unique practice settings.
- Within the profile of practice of OTs in Canada, OTs are expected to be “change agents” and have the expertise to advance occupational therapy in this area.

- It is important to review the quality of service being provided within the practice area on a continuous basis. This can mean reviewing funding, management, policy and procedures.
- Clinicians must advocate for best practices for suicide management across all sectors. Occupational therapists can create system level change by:
  - Assessing if practice setting is serving clients at high risk for suicide.
  - Assessing if adequate prevention, identification, response, and communication is being used by all members of the team.
  - Advocating for development of community integrated suicide prevention strategies, appropriate crises management, early intervention and response.
  - Nominating a team member to be gatekeeper trained then upkeep training and continuously assess implementation of these strategies in the clinical environment (Hewitt, 2014; Isaac, 2009, Robinson et al., 2013).
  - Educating management and stakeholders on the scope of occupational therapy and asking for occupational therapists to take part in continuous education initiatives.
  - Learning about other disciplines abilities when it comes to management of suicide prevention, intervention and postvention.
- It is important to review literature and policies to demonstrate the importance of occupational therapy led suicide prevention at an institutional level.
- Some tools to help with advocacy work for policy and system level change include:
  - Suicide Prevention in Occupational Therapy CAOT Role Paper: Demonstrates the scope of involvement of OTs in supporting prevention, intervention and postvention of suicide (Hewitt, Hebert & Vrbanac, 2019)
  - COTO: Managing Risks in Occupational Therapy Practice: Demonstrates the ability to assess, evaluate, and analyze risk in day to day practice (College of Occupational Therapists of Ontario, 2020).
  - Accreditation Canada: Provides guidelines on how organizations should address patient safety and suicide. Includes evidence for the inclusion of suicide initiatives in the OT practice setting (Acceditation Canada, 2020).
  - The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care: Overviews evidence based work for easy to implement strategies for suicide risk assessment (Brodsky, Spruch-Feiner & Stanley, 2018).
  - Plan-Do-Study-Act (PDSA): Provides a standardized rapid test tool for quality improvement of new organizational initiatives when put into practice (Health Quality Ontario, 2013).

Case Study: Improving practices within the practice setting

While working as an occupational therapist as a member of the Ontario Worker's Network (OWN), we as occupational therapists would frequently see clients who were discouraged and angry. Pain and loss of income were significant stressors that often lead to individuals reporting loss of meaning in their previous roles and hopelessness about their future. As the COVID-19 pandemic arrived in March 2020, practice shifted to a virtual model of care. The clinicians found this quite challenging, as it was very difficult to understand the mental health needs of our clients through a computer lens. We subjectively found an increase in positive scores on the PHQ-4+1 outcome measure that we were required to complete on the first assessment with individuals. After this concerning finding, we felt education and tools to manage distressed individuals was needed. We began to examine gaps in our own knowledge to improve service delivery within our practice setting.

This led us to complete a literature review upon which we discovered the Columbia Suicide Severity Rating Scale (C-SSRS). We found that this would be a quick, easy and evidence-based tool to further investigate the client's ideation, intensity and overall risk for self-harm. Our confidence could improve knowing we address the whole client during our short time together. We began to complete the C-SSRS on clients with a positive score on the PHQ-4+1, question five. Then we proceeded to review policies and procedures within the institution where we worked so that we could appropriately triage clients based on their risk score from the C-SSRS. We created a manual for onboarding clinicians to the practice process addressing suicide risk. Within this text, we provided additional rationale and resources to improve individuals confidence with assessment. The next phase of implementation will involve running a PDSA cycle to determine how we can improve the quality of this work based on clinician feedback and client outcomes.

-Occupational Therapists from the Ontario Workers Network (The Ottawa Hospital, 2021).

CPPF: Setting the Stage

Role Paper Best Practice

- Evidence Based Recommendation
  - 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, 2014).
- Consensus Based Recommendation
  - 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).

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

Introducing the Conversation

(Centre for Suicide Prevention, 2008; Horowitz et al, 2012; Kroenke et al, 2001).

- ❖ Asking directly about suicide by saying are you thinking about suicide or thinking about killing yourself is important. There is no evidence that asking directly about suicide will make clients suicidal or make them engage in self-harm.
- ❖ Broaching the subject allows the client to talk about their feelings.
- ❖ Questioning about suicide can assist the clinician to assess how high the risk is for suicide. For example: If a client has had previous suicide attempts and/or thoughts of suicide, has developed a plan for suicide and organized the means to carry out the plan, then they may be much more prepared to follow through on suicide action.

Examples of questions follow to open the conversation related to suicide risk. Best practice is to ask directly if the client is thinking of killing themself (LivingWorks, 2014). A clinician may want to consider screening for suicide with each client in their practice.

Seniors	❖ *"If you did not wake up the next morning, would that be a good thing? If yes, would you do anything to help that along?"* ❖ *"Have you ever had thoughts of hurting yourself or killing yourself?"*
General Adult Population ❖ As stated in the PHQ-9 (Kroenke et al, 2001):	❖ *"Have you ever thought you would be better off dead?"* ❖ *"Have you ever had thoughts of hurting yourself or killing yourself?"*
Children (Considered 12+ years old) ❖ As stated in the ASQ (Horowitz et al, 2012):	❖ *"In the past few weeks, have you felt that you or your family would be better off without you?"* ❖ *"In the past few weeks, have you wished you were dead?"* ❖ *"Have you been having thoughts about hurting yourself or killing yourself?"*

Children (Under the age of 12 years)	❖ *"Are you depressed or very sad lately?"* ❖ *"Did you ever feel so upset or sad that you wanted to die?"* ❖ *"Are you thinking about hurting yourself or killing yourself?"*(Centre for Suicide Prevention, 2008).

CPPF: Assess/Evaluate

Role Paper Best Practice

- Evidence Based Recommendation
  - 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).

Screening & Assessments

- Examples of several standardized screening tools are below, targeted at various populations. Please note this is not an exhaustive list.

Assessment	Psychometric Properties	Validated for use with
Ask Suicide Screening Questions (ASQ) (Horowitz et al., 2012) The ASQ asks 4 questions, and if a client answers yes to any of the four questions, this assessment provides the next necessary steps to address suicidal ideation with the client.	Sensitivity=96.9 Specificity=87.6	Youth aged 10-21. Adult medical clients.
Patient Health Questionnaire (PHQ-9) (Na et al, 2018) The PHQ-9, or the shortened version the PHQ-4+1, is a subjective survey of depressive symptoms, including thoughts of suicide. This is common screener for symptoms of depression which may warrant the use of a	Sensitivity=87.6 Specificity=66.1	Adult Older Adult

suicide-specific screening tool, should someone score a positive outcome on question #9. Research demonstrates that PHQ item for suicide risk alone is often unclear and leaves clinicians unprepared to assist individuals.		
Columbia Suicide Severity Rating Scale (C-SSRS) (Posner et al., 2013) This suicide assessment tool is very popular in the literature for being simple, efficient, effective, universal, and evidence supported. It supports suicide risk assessment through a series of simple, plain-language questions. Client's responses help clinicians triage whether someone is at low, moderate or high risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. **See Appendix 1 for further details regarding resources for the C-SSRS.	Sensitivity=94-100 Specificity= 99-99.4 Cronbach alpha=0.73-0.95	Very young children to older adult

Role Paper Best Practice

- ❖ Consensus Based Recommendation
  - ➢ 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).

Levels of Risk

If no risk is identified, continue to indicate screening has been completed but no risk has been identified at the time of assessment.

Levels of Risk	Description
Imminent Risk	Suicidal ideation is present and the client has intent to act on thoughts with a plan and has access to means to hurt themselves at this immediate time.
High Risk	Suicide ideation is present and client has intent to act on thoughts with a plan in the past month and/or suicidal behaviour in the past 3 months
Moderate Risk	Suicidal ideation with method but without a defined plan, intent or

	behaviour in the past month and/or multiple risk factors and few protective factors.
Low Risk	Wish to die or suicidal thoughts with no method, plan, intent or behaviour or suicidal ideation more than one month ago.

Adapted from 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 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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Appendix 1

Click here to review the Columbia Lighthouse Project (different C-SSRS versions, evidence and training)

C-SSRS Training resources: There is videotaped training available; the Full C-SSRS (56-minutes) and the Screener version (25-minutes).

To download a training video for the **Full and Screener versions**, please:

1. Click on this link.
2. Click on the download button in the upper right corner to download the file to your computer.

To download a training video for the **Screener version only**, please:

1. Click on this link.
2. Click on the download button in the upper right corner to download the file to your computer.