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Addressing Suicide in Entry-to-Practice Occupational Therapy Programs: A Canadian Picture

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Addressing Suicide in Entry-to-Practice Occupational Therapy Programs: A Canadian Picture

Abstract

Worldwide, over 800,000 people die each year by suicide, leaving many behind to grieve the loss. Preventing suicide involves reaching people before they are in crisis (prevention), helping them to navigate a crisis that could result in suicide (intervention), and addressing the aftermath of a suicide loss or attempt (postvention). Healthcare professionals, including occupational therapists, unitedly acknowledge the lack of skills, knowledge, and competence in all facets of suicide awareness and prevention in their professional training and in practice. To improve this situation, suicide prevention skills must be taught in entry to practice programs, so they will filter into the practice of all occupational therapists. Thus, the purpose of this study was to discover how competencies related to suicide prevention are currently taught to student occupational therapists in Canadian universities. A cross-sectional descriptive design was used to survey the 14 Canadian university occupational therapy programs. 12/14 programs responded. All endorsed the use of a range of pedagogical approaches, but there was little similarity from one university to another. Learning activities mainly related to mitigating imminent suicide risk (intervention) and illustrated a lack of attention to the continuum of suicidal behavior (prevention, intervention, and postvention). All universities showed a clear willingness to improve their approach, but there is no current gold standard to strive for. Future initiatives can support research in this regard to ensure student occupational therapists are better prepared to address the full continuum of prevention, intervention, and postvention with explicit attention to an occupational perspective.

Keywords

Suicide, occupational therapy, curriculum, pedagogy

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Addressing Suicide in Entry-To-Practice Occupational Therapy Programs: A Canadian Picture

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ABSTRACT

Worldwide, over 800,000 people die each year by suicide, leaving many behind to grieve the loss. Preventing suicide involves reaching people before they are in crisis (prevention), helping them to navigate a crisis that could result in suicide (intervention), and addressing the aftermath of a suicide loss or attempt (postvention). Healthcare professionals, including occupational therapists, unitedly acknowledge the lack of skills, knowledge, and competence in all facets of suicide awareness and prevention in their professional training and in practice. To improve this situation, suicide prevention skills must be taught in entry to practice programs, so they will filter into the practice of all occupational therapists. Thus, the purpose of this study was to discover how competencies related to suicide prevention are currently taught to student occupational therapists in Canadian universities. A cross-sectional descriptive design was used to survey the 14 Canadian university occupational therapy programs. 12/14 programs responded. All endorsed the use of a range of pedagogical approaches, but there was little similarity from one university to another. Learning activities mainly related to mitigating imminent suicide risk (intervention) and illustrated a lack of attention to the continuum of suicidal behavior (prevention, intervention, and postvention). All universities showed a clear willingness to improve their approach, but there is no current gold standard to strive for. Future initiatives can support research in this regard to ensure student occupational therapists are better prepared to address the full continuum of prevention, intervention, and postvention with explicit attention to an occupational perspective.

Introduction

The statistics are clear: worldwide; over 800,000 people die by suicide each year - one person every 40 seconds – while many others survive an attempt (World Health Organization [WHO], 2014). Millions are left behind to grieve the loss (Spillane et al., 2017). Given the worldwide pervasiveness across the lifespan, suicide has been described as a “public health crisis” and a “global health issue” (Novalis, 2017, p. CE1). The magnitude of suffering related to suicide necessitates a public health response, which can take the form of *universal* or population-level prevention strategies (such as mental health promotion), *selective* strategies (focused on vulnerable groups such as people who have experienced trauma, abuse or disaster, refugees and immigrants, and those bereaved by suicide), and *indicated* strategies (including education and training for health workers; WHO, 2014). While the need is great for as many people as possible to serve as *gatekeepers* (those likely to have first contact with someone having thoughts of suicide), knowledge and skills across the continuum of prevention (upstream approaches, intervening before the individual is in crisis), intervention (often crisis intervention) and postvention (for those left behind after a suicide loss, or for those who are at high risk due to a previous attempt) are critical. Health professionals, including occupational therapists and their students, must be prepared.

Although suicidal ideation, behaviors, and attempts are commonly associated with mental health practice, increasingly, people at risk of suicide are encountered across occupational therapy practice settings (Hewitt et al., 2014; Novalis, 2017). For example, among veterans, suicide has been described as an epidemic, with wide-reaching impacts (Kashiwa et al., 2017). Facing chronic illness (such as cancer) and functional decline (including mobility challenges and inability to complete personal care routines) may precipitate increased thoughts of suicide in older adults (Kjølseth et al., 2010). Those who are marginalized (e.g. persons living in homelessness, Indigenous peoples) may be at greater risk, and suicide among young people is increasing, with experiences such as cyberbullying having a significant impact (Nierengarten, 2018). As Aquila and colleagues (2020) pointed out, additional risk factors can arise from various traumas or stressors such as chronic pain, war, sexual violence, grief, bullying, financial problems, and family conflicts. Thus, the need to be on the alert, not only where mental health services are provided, but in all practice settings is paramount.

Approximately 20% of individuals who die by suicide have contacted a healthcare service within one month prior to their death (Roush et al., 2018). Many more come to the attention of healthcare following a suicide attempt. Within the literature, healthcare professionals unitedly acknowledge the lack of skills, knowledge and competence in all facets of suicide awareness, prevention, crisis and supportive management, in professional training and in practice (Canady, 2018; Cross et al., 2019; Robinson-Link et al., 2019; Ryan et al., 2017). Although healthcare is often provided using team approaches, competency development is typically discipline-specific. Some disciplines are in the early stages of adopting roles and responsibilities in mitigating suicide risk. Only a minority of healthcare disciplines have written about their role in suicide prevention and urge their respective colleagues to commit to, at minimum, the gatekeeper role (Bolster et al., 2015; Bolton, 2015; Hewitt et al., 2019; Osteen, 2016).

A 2014 survey of Canadian occupational therapists (n = 585 respondents) working in different practice domains revealed 88% had provided some suicide intervention over the course of their career (Collins et al., 2014). Occupational therapists can play an important role working directly with clients throughout the suicide continuum in the assessment of suicidal risk or as they support clients to find more meaning in life through occupation:

They support their clients in planning, initiating and tracking short- and long-term goals that enable participation in meaningful activities. They address possible risk factors for suicide, connect clients with networks of community resources and help clients structure and organize their daily lives to balance what they want, need or are expected to do (Hewitt et al., 2019, p.11).

Suicide Action Montreal, a well-established organization aiming to prevent suicide in Canada, identified precipitating factors of suicidal ideation to include work and school failure, job loss, driver's license being revoked, and decline in functional autonomy (<https://suicideactionmontreal.org/en/suicide-risks-factors/>). These elements are the focus and practice domains of occupational therapists.

Nursing and social work literature offers some evidence-based criteria about how to effectively teach suicide prevention skills; both go beyond didactic approaches to include an interactive component to bolster self-efficacy in the development of suicide prevention skills (Cramer et al., 2019; Wu et al., 2014). A study of pharmacy students also integrated an interactive component by engaging people with lived mental illness experience into simulation experiences to enable students to practice the skills learned in Mental Health First Aid (MHFA) (O'Reilly et al., 2019). Within the Canadian occupational therapy profession, formalized gatekeeper training (for example, Applied Suicide Intervention Skills Training (ASIST) or Question, Persuade, Refer (QPR) has been recommended (but not mandated) for both students and practicing occupational therapists as an intervention for addressing suicide risk in practice (Hewitt et al., 2019).

Although issues of suicide are or will likely be present in all healthcare providers' practices, the lack of literature regarding the content and process for teaching suicide preparedness across the spectrum of prevention, intervention, and postvention declares the lack of a "gold standard" for doing so. This profound gap in professional preparation and training both during formative discipline-specific education, and during post-graduation professional development learning must be addressed (Almeida et al., 2017; Patel et al., 2016; Pompili et al., 2017). It is imperative for health professionals to be trained to better communicate with and support people who are at risk for suicide, and their networks (O'Reilly et al., 2019). Furthermore, there is an expectation that occupational therapists are "competent to practice safely, effectively, and ethically" in diverse practice contexts (ACOTRO, 2011, p. 12). Thus, given people at risk of suicide present across occupational therapy practice settings, it is imperative for competencies to be developed across the continuum of suicide prevention, intervention, and postvention. As a first step in enhancing competency development, the purpose of this study was to describe how competencies related to suicide prevention, intervention and postvention are currently taught to student occupational therapists in Canada.

Methods

A cross-sectional descriptive design (Gallagher, 2014) was used to conduct a review of current suicide prevention-intervention-postvention training practices and initiatives in Occupational Therapy (OT) curricula within Canadian universities. The study was led by a sub-committee (the authors – five diverse occupational therapists) of the Canadian Association of Occupational Therapists (CAOT) Practice Network – Addressing Suicide in Occupational Therapy Practice (network comprised of academics, instructors, clinicians, and researchers across the country). The primary data collection source was an online survey. It included a table to complete followed by four open-ended qualitative questions. It was prepared, revised and finalized by the authors. The survey was sent by CAOT to all 14 Canadian occupational therapy programs, followed up by planned reminders. Each participating university was asked to choose a representative to complete the survey.

The survey required respondents to verify if and how suicide prevention across the continuum was being taught in their program. Using a narrative approach, they were asked to report time spent, and the content for each of several pedagogical methods commonly used in competency-based programs. These included readings, lectures, written assignments, practice or simulations, problem-based learning, personal testimonials, and reflective exercises. The second section consisted of the four open-ended questions regarding the use of specific prevention, intervention or postvention training programs regarding suicide (mandatory or encouraged; within and beyond the curriculum), relevant contextual factors within each setting; and plans for revising, increasing or integrating suicide prevention skill development in their respective curricula now or in the near future (see Appendix 1 for complete survey).

To analyze the findings provided in the table, each author was responsible for collating data for one or two pedagogical methods, labelling the data according to content themes (e.g. clientele in case vignettes) or counting frequencies of occurrence (e.g. number of reflective exercises). For the open-ended questions, each author reviewed the responses for one question by familiarizing themselves with the data, coding common responses and converging ideas to represent the findings. The team collaborated to review the results and resolve discrepancies. The findings were synthesized and provided to each author to review for accuracy. Preliminary results were sent out to all 14 Canadian universities with occupational therapy programs for review (including to the eight programs who initially responded, and to the remaining six programs as a means of knowledge translation, and to encourage further responses). Following receipt of four additional surveys, two members of the research team separately completed the analysis and produced a final synthesis which was reviewed by all authors.

Results

In total, 12 out of 14 Canadian OT programs (85%), representing all Canadian regions, responded to the survey. All 12 programs addressed suicide within their curricula, but the content, methods and approaches used and depth to which the subject was covered varied widely.

Pedagogical Approaches

To acquire knowledge about the topic of suicide, results indicated that 11 out of 12 (92%) programs included mandatory readings and/or lectures about risk factors, suicide prevention and treatment approaches in the crisis intervention phase. Readings stemmed from governmental publications, articles from media, scientific journal articles, CAOT publications, various book chapters and the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5 (American Psychiatric Association, 2013). The readings were diverse, with few programs indicating similar reading assignments to other programs. Most readings related to persons living with a mental illness or to seniors, with only four programs out of 12 (33%) having readings outside of a mental health focus. Problem-based learning was used to address the subject in 9/12 programs (75%), using clinical vignettes to illustrate clients of various age groups who live with a variety of mental health conditions. Some programs used vignettes related to military veterans living with trauma or persons who have been victims of intimidation or marginalization, including Indigenous populations. Six programs out of 12 (50%) offered students access to testimonials provided by community organizations or individuals with lived experiences (including guest speakers or pre-recorded videos). Only two programs out of 12 (17%) explicitly addressed suicide through a population level, public health perspective. Six of the 12 programs (50%) offered practical experiences to students in class, which could then be consolidated in clinical settings during fieldwork. The practical experiences utilized simulation or engagement with standardized clients who presented with a mental health condition and experienced suicidal ideation. In these interactions, students used therapeutic skills (such as building rapport) and practiced interviewing and evaluation of suicidality to determine an action or safety plan. In half of the programs (50%) students practiced interventions targeting prevention of future suicide attempts. In one case, the activity consisted of visiting a community organization targeting suicide prevention activities. Students prepared a report on the organization and potential contribution of occupational therapy in each setting.

The use of assignments addressing the topic was variable. Some programs reviewed knowledge around the topic with various types of exams, or through the development of conceptual maps or case analysis. Reflective activities were used in a limited capacity, such as reflection on a personal or clinical experience (e.g., use of fieldwork journal).

Mandatory or Suggested Training

Only one school out of 12 (8%) required students to participate in formal training offered by an external officially-recognized suicide prevention program. They did so by providing the QPR program to all students in their first term of study, prior to the first fieldwork course. Approximately 10 programs (80%) suggested such training to students, but it was not mandatory, and students were expected to organize and pay for the training themselves. Out of these 10 programs, six suggested ASIST (<https://www.livingworks.net/asist>); one suggested QPR (<https://qprinstitute.com/>); one suggested Dialectical behavioral therapy (Linehan, 2014) for future professional development for suicide crisis intervention; and finally, two programs suggested training from a recognized provincial community-based organization, JEVI Suicide Prevention Center - Estrie (JEVI Centre de prévention du suicide - Estrie).

Contextual Factors Influencing Integration of the Topic in the Curriculum

The survey yielded little commentary on this topic. Nevertheless, the results indicated teaching content was reflective of provincial policies. One program pointed out the need to make strategic choices when limited time is allocated to mental health practice more generally. Another program reported the need to respond to student requests relative to this topic, specifically with regards to postvention.

Planned Curriculum Revisions

Finally, seven out of 12 programs (58%) indicated they had recently reviewed or regularly examined the ways in which suicide management was addressed in their curricula. Reasons for reviewing included provincial policy, law changes, new evidence, new best practice guidelines or in response to recommendations from the CAOT practice network. Planned changes regarding curriculum or pedagogy included partnerships with local organizations to enhance pedagogical activities, bringing in people with lived experience as a teaching partner and varying types of vignettes used to represent settings beyond the psychiatry context. One school did not address suicide prevention within their program, and it had not previously been on their radar.

Discussion

Across programs, the findings of the survey showed a broad range of pedagogical methods being used, but a lack of consistency in what was provided and how. There was also a lack of attention to the full spectrum of suicide prevention initiatives related to prevention, intervention and postvention, with most attention going toward intervention. Furthermore, the results indicated the topic of suicide was taught primarily through a bio-medical lens and less with an occupational perspective which could encompass, for example, sociological and philosophical content. Ideally, a more holistic approach should consider the person, the context and the occupational therapist through a continuum including prevention, crisis intervention and postvention with individuals and survivors. All three phases should include attention to significant occupations and focus on elements such as meaning, resilience, hope and flow in one's life, moving away from a negative emotional outlook (Novalis, 2017; Sweeny et al., 2020; Griggs, 2017). It is noteworthy to mention all responding programs showed clear willingness to improve how the subject was approached in their respective curricula. Presently, most schools point students in the direction of "gatekeeper" training, but do not articulate in any detail how the unique skill set of occupational therapists and a focus on engaging people in meaningful occupation could offer a great deal to the field.

There is now a federal framework for suicide prevention entitled "Working together to prevent suicide in Canada". The mission of this federal initiative is to "prevent suicide in Canada, through partnership, collaboration and innovation while respecting the diversity of cultures and communities that are touched by this issue" (Government of Canada, 2016, p. 12). As the CAOT Practice Network (Addressing Suicide in Occupational Therapy Practice) moved to align with this initiative, it identified the importance of preparing occupational therapists and their students to draw on their unique skill sets to develop the competencies needed to address suicide through an occupational perspective which they may encounter in fieldwork and in practice.

Tardif (2006) defined a competency as a “complex know–act based on the mobilization and combination of knowledge, skills, attitudes and external resources” (p. 22) that can be applied in different settings. Developing a competency requires not only knowing what to do, and how to do it, but being able to do it as the situation demands in various settings. Thus, to gain knowledge and skill, blending a variety of pedagogical methods with learners should thus be favored.

The development of this competency with an occupational perspective will be important for student occupational therapists since the incidence of suicide secondary to occupational disruptions such as unemployment, poverty, homelessness, social isolation, restriction to occupational opportunities, and uncertainty about the future is likely to increase. Already, some speculation as to how COVID 19 will impact suicidal ideation is emerging. For example, Aquila and colleagues (2020) in Italy noted people waiting for COVID 19 swab test outcomes, obsession with the virus and fear one may have become infected, entrepreneurs at risk of bankruptcy, employees in precarious employment situations after the lockdown, and elderly people navigating solitude all contributed to recent suicides or suicide attempts (Aquila et al., 2020). In addition, a recent study conducted in China suggested engaging in flow-inducing activities (where one becomes fully immersed in an activity) maybe an effective protective factor against the detrimental effects of a period of quarantine (Sweeny et al., 2020), offering further support for an occupational perspective.

Implications for Occupational Therapy Education

This Canadian survey demonstrated that Canadian Occupational Therapy programs did provide some relevant knowledge and tools to entry-level students on the topic of suicide with a variety of client populations but lacked a gold standard against which to measure. Beyond the Canadian context, since very little has been published in the occupational therapy literature, curricula could be broadened to better address the full continuum of prevention, intervention and postvention with explicit attention to an occupational perspective. Diverse pedagogical methods should be used to engage students in interactive, authentic situations or well-crafted simulations to mobilize different types of knowledge (know, know-how, know-how to be) in different contexts with diverse populations. These methods should optimally be accompanied with feedback stemming from multiple sources (clients, educators, peers), coaching and introspective reflection. A range of resources are available through the Mental Health Commission of Canada (<https://www.mentalhealthcommission.ca/English/what-we-do/suicide-prevention>). A recommended next step could be to expand the study internationally, to collaborate with additional stakeholders, such as interdisciplinary team members, students, persons with lived experience and community organizations, and to co-produce a framework that could guide future initiatives in theory development and practice. As mentioned in the introduction, risk of suicide is a worldwide concern, a public health crisis and a global health issue – the time to act is now.

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Appendix 1

SURVEY

1- Is suicide prevention/intervention/postvention taught within your curriculum? Please indicate briefly which areas of the suicide prevention continuum are addressed in your program:

If you indicated yes to suicide prevention, intervention and/or postvention, could you please provide an approximation of how much planned time (in hours or numbers) is spent on suicide prevention and a brief description of the content for each category in the chart below?

	1a Mandatory readings	1b Written assignments relating to the subject	1c Practical experience or skills	1d Problem based learning	1e Access testimonies	1f Reflective exercises	1g Lectures
Suicide Prevention/ Intervention/ Postvention (if a column focusses in particular on one area of the suicide prevention continuum, please indicate so)	Hours: Content:	Number: Content:	Hours: Content:	Number case vignettes: Content:	Number testimonies: Content:	Number: Content:	Hours: Content:

2- Is there any mandatory training, related to suicide prevention and intervention in addition to the curriculum content (e.g. ASIST, QPR or JEVI)? Please describe.

3- Is there any encouraged training, related to suicide prevention, in addition to the curriculum content (e.g. ASIST, QPR or JEVI)? Please describe.

4- Are there any contextual factors that influence the education on suicide prevention in your curriculum?

5- Is your university program currently in the process of thinking or rethinking the integration of suicide prevention in your curriculum or planning to do so in the near future? What will be those changes and why?