



# **CANADIAN ARMED FORCES**

## **Clinician Handbook on Suicide Prevention**



Canadian Psychiatric Association

*Dedicated to quality care*

Association des psychiatres du Canada

*Dévouée aux soins de qualité*

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Suicide is a significant issue in Canada and in the Canadian Armed Forces (CAF). The assessment, management, and treatment of a suicidal patient can be challenging and stressful, but can also be very rewarding for clinicians. This clinician handbook was prepared by the Canadian Psychiatric Association (CPA), in collaboration with Directorate of Mental Health, as a resource to assist clinicians when working with patients at risk of suicide. It also provides guidance in postvention, because when a patient takes their life, it is so important that we support our colleagues and others affected by the death. We are grateful for the opportunity to collaborate with the CPA, and we are confident that this clinician's handbook will provide useful and timely information to assist you in your practice.

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# INTRODUCTION

Each year nearly 4,000 Canadians lose their lives to suicide.<sup>1</sup> It is the second leading cause of death among persons aged 15 to 34 in Canada.<sup>2</sup> While the clear majority of people suffering from mental health issues do not die by suicide, over 90% of suicide victims were suffering from a psychiatric or substance use disorder at the time of death.<sup>3-5</sup>

The Canadian Armed Forces (CAF) has commissioned this clinician handbook on suicide prevention in a military context in consultation with the Directorate of Mental Health. This clinician handbook is designed for the use of all clinicians, both military and civilian, working within the CAF health care system. These clinicians include, but are not limited to, primary care physicians, psychiatrists, psychologists, nurses, social workers, addiction counsellors, physician's assistants, mental health chaplains, and medical technicians.

This handbook was informed by several evidence-based guidelines and reports:

1. *United States Veterans Affairs / Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013).*<sup>6</sup>
2. *United States Air Force Guide for Suicide Risk Assessment, Management, and Treatment (2014).*<sup>7</sup>
3. *United States Air Force Primary Behavioral Health Care Services Practice Manual, Version 2.0 (2011).*<sup>8</sup>
4. *American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors (2003, 2010).*<sup>9</sup>
5. *Centre for Addiction and Mental Health (CAMH) Suicide Prevention and Assessment Handbook (2011).*<sup>10</sup>
6. *Suicide Risk Assessment Inventory: A Resource Guide for Canadian Health Care Organizations (2011).*<sup>11</sup>

The handbook is composed of five sections. The first provides an overview and information about suicide and suicide prevention, in both a Canadian and military setting. We hope this information is relevant and interesting to clinicians and can increase their awareness, comfort with, and understanding of this topic. The next three sections focus on screening, assessment, and management of patients at risk for suicide, and are designed to be easy to read and apply for clinicians within all disciplines. Finally, section five, "The Clinician's Experience," focuses on issues and challenges that you face in your work, including barriers to suicide risk assessment, training resources, documentation, balancing confidentiality and safety in a military setting, working with families and the military chain of command, and coping with losing a patient to suicide.

It is our hope that this clinical handbook will serve as an easy-to-use, evidence-based resource for health care providers to guide the identification, assessment, and management of CAF members at risk for suicide. Death by suicide is a tragedy for the patient, as well as his or her family and community, and can be distressing for all clinicians involved in the patient's care. While predicting death by suicide with 100% certainty is impossible, organizations and individual clinicians should strive to ensure that they are engaging in a suicide risk assessment that meets the gold standard of care. A formalized, consistent approach will support clinicians who are undertaking the challenging, emotional work of caring for those at risk for suicide. Further, it is our hope that speaking openly about suicide risk with CAF members will reduce stigma and improve access to and engagement in quality mental health care.

# GLOSSARY OF TERMS

A shared language for suicide-related phenomena allows clinicians to communicate clearly and effectively with each other and their patients. The terms in this glossary are used throughout this handbook, and are in keeping with the definitions used in suicide assessment guidelines and research. The terms below are taken from the definitions provided in the *American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* and the Columbia-Suicide Severity Rating Scale (C-SSRS).<sup>12–14</sup>

**Suicide:** Self-inflicted death with evidence that the person intended to die.

**Suicidal Ideation:** Thoughts of wanting to die by suicide or wishing to be dead.

**Passive Suicidal Ideation:** Passive wish to die (I wish to sleep and not wake up). No intent or plan is present.

**Active Suicidal Ideation:** Thoughts of killing oneself (can be present with or without intent or plan).

**Suicidal Ideation With Intent:** Thoughts of suicide with a subjective expectation and desire for a self-destructive act to end in death.

**Suicidal Ideation With Plan:** Thoughts of suicide with details of plan fully or partially worked out.

**Preparatory Acts or Behaviours:** Acts or preparation toward a suicide attempt.

**Suicidal Communication:** Writing or talking about suicide, wish to die, or death; threatening to hurt or kill oneself.

**Planning a Method for Suicide:** Developing a plan to die, taking steps to prepare for an attempt (i.e., purchasing gun, preparing noose, or stockpiling medications), rehearsing plan.

**Preparing for Death:** Engaging in behaviour to prepare for anticipated death (i.e., making a will, saying goodbye to friends and family, writing a suicide note, giving away belongings, arranging care for dependents).

**Suicide-Related Behaviours:** Deliberate self-harm, suicide attempts, and death by suicide.

**Deliberate Self-Harm:** Willful infliction of pain or self-injurious acts without intent to die.

**Suicide Attempt:** Self-injurious behaviour that does not result in death with evidence that the person intended to die or was ambivalent about death.

**Aborted Suicide Attempt:** Potentially self-injurious behaviour in which the person intended to die but stopped the attempt before physical harm occurred.

**Lethality:** Objective risk of medical damage associated with suicide-related plan or behaviour (patient's perception or lethality may not correlate with actual risk).

**Risk Factors:** Modifiable and non-modifiable factors that increase the likelihood of suicidal behaviour.

**Warning Signs:** Evidence that a patient is at high risk for suicide in the immediate future (minutes, hours, days).

**Protective Factors:** Personal, social or environmental factors that decrease the likelihood of suicidal behaviour.

# SUICIDE: BACKGROUND INFORMATION FOR CLINICIANS

## SUICIDE IN THE MILITARY

### OVERVIEW

Suicide is the third leading cause of mortality in Canadian Armed Forces (CAF) personnel over the past 25 years.<sup>15</sup> Between 1995 and 2015, 239 Regular Force men died by suicide; 56 between 1995 and 1999 (19.9/100,000), 50 between 2000 and 2004 (19.0/100,000), 51 between 2005 and 2009 (18.5/100,000), 68 between 2010 and 2014 (23.5/100,000), and 14 suicides in 2014 (24.9/100,000).<sup>16</sup> Between 1995 and 2015, 14 Regular Force women died by suicide.<sup>17</sup>

### RISK FACTORS FOR SUICIDE AND SUICIDE ATTEMPTS

#### Demographics: sex and age

U.S. and Canadian data suggest that those who die by suicide in the military are disproportionately men.<sup>18,19</sup> In most countries around the world, women experience higher rates of suicidal ideation and behaviour, while men die by suicide more frequently.<sup>20,21</sup> Younger age groups have been associated with higher risk for suicide in the military.

#### History of suicide attempts or deliberate self-harm

A personal history of suicide attempt or deliberate self-harm is the **single most important risk factor** for death by suicide in both military and civilian populations, regardless of demographics or diagnosis.<sup>22–29</sup>

#### Mental illness, substance use, and mental health care

The presence of a diagnosis of a mental health disorder is strongly associated with suicidal ideation, suicide attempts, and death by suicide in military members.<sup>30</sup> Mood disorders, anxiety disorders, trauma-related disorders, personality disorders, and substance use disorders are all associated with elevated risk for suicide.<sup>31–33</sup> The risk is highest in those who have been diagnosed or treated within the past month; risk then decreases over time from diagnosis and treatment, but remains elevated even five years or more after diagnosis.<sup>34,35</sup>

It is important to note that not every service member who has a diagnosis of mental illness or substance use disorder will experience suicidal ideation, and most people with suicidal ideation do not attempt or die by suicide. However, about half of CAF members who died by suicide were receiving care for a mental illness or substance use disorder at the time of death. The *2016 Report on Suicide Mortality in the Canadian Armed Forces (1995 to 2015)* indicated that 42.9% of suicide victims had a documented depressive disorder, 35.7% had a trauma-related disorder, 28.6% had an anxiety disorder, and 42.9% had a documented substance use disorder.<sup>36</sup> Overall, 64.3% of suicide victims had at least two mental health or addictions diagnoses at the time of death.<sup>37</sup>

Inpatient mental health hospitalization, and recent mental health hospitalization in particular, is a major risk factor for suicide for military personnel.<sup>38–42</sup> Service members with a history of inpatient hospitalization are between seven and 20 times more likely to die by suicide, even after controlling for other risk factors including

history of suicide attempts or self-harm behaviour.<sup>43,44</sup> The 12 months following hospitalization are a particularly high-risk period, but the risk persists over the patient's lifetime.<sup>45,46</sup>

## Sleep disturbances

Sleep difficulties have also been associated with elevated risk for suicide in military settings.<sup>47</sup> Service members with sleep disturbances, including short sleep duration, had higher rates of depression, posttraumatic stress disorder (PTSD), panic disorder, substance use disorder, and suicide attempts.<sup>48</sup>

## Health-related stressors

### ► *Traumatic brain injury*

Traumatic brain injury (TBI) has been shown to increase risk for suicide attempts and death by suicide in civilian and military populations.<sup>49–51</sup> Patients with TBI have higher rates of psychiatric disorder and functional impairment, but it appears the risk for suicide persists even after accounting for these factors.<sup>52</sup>

### ► *Chronic pain and medical illness*

Chronic pain and medical illness are known risk factors for suicide attempts and death by suicide.<sup>53–56</sup> Within a military population, physical health concerns including pain have been linked with suicidal behaviour.<sup>57–60</sup>

## Deployment and combat-related trauma

Studies of CAF Regular Force veterans found no direct association between suicidal ideation and deployment, a finding consistent with earlier studies that have controlled for other suicide risk factors.<sup>61,62</sup> However, deployment factors (including trauma and other stressors) may predict an increased presence of other risk factors for suicide. The rates of PTSD and panic disorder among Regular Force personnel who deployed were twice as high compared with those who had not deployed.<sup>63</sup> In contrast, non-deployed Regular Force personnel (5.4%) were more likely to report symptoms of alcohol abuse or dependence than their deployed colleagues (3.4%).<sup>64</sup>

## Non-combat related trauma

A history of childhood trauma is an independent risk factor for suicidal ideation and behaviour in civilian and military populations.<sup>65–70</sup> Child abuse exposure is higher among military personnel compared to the general population. In a 2002 CAF sample, 1% to 15% of respondents endorsed having a history of childhood trauma, including experiencing serious physical or sexual abuse, or witnessing serious physical abuse in the home.<sup>71</sup> Other studies have reported rates of childhood trauma ranging from 17% to 50%.<sup>72</sup>

In addition to childhood physical and sexual trauma, other traumatic events, including domestic violence and adult sexual trauma, have been associated with higher rates of suicide attempts in the CAF.<sup>73</sup> A “dose-response” trauma effect was noted; as the number of traumas increased, so did the risk for suicide attempt.<sup>74</sup>

## Psychosocial stressors

Psychosocial and health-related stressors, including marital and family conflict, financial stress, disciplinary and legal issues, bereavement, and chronic pain or disability are risk factors for suicide attempts and death by suicide in military populations.<sup>75–82</sup> These stressors may be chronic in nature (e.g., ongoing marital discord or work stress) or more acute (e.g., bereavement or divorce). The *2016 Report on Suicide Mortality in the Canadian Armed Forces (1995 to 2015)* identified at least one life stressor in 92.9% of suicide deaths; 78.6% had more than one stressor, and 50.0% had at least three psychosocial stressors prior to death.<sup>83</sup>



## Impulsivity

Impulsivity has been shown to be a risk factor for suicide in the general population.<sup>84–86</sup> Studies have also shown that conditions associated with increased impulsivity, including PTSD, substance use disorder, or proximal interpersonal stressors, have been linked with suicidal behaviour.<sup>87–89</sup>

## Access to firearms

Access to firearms is a risk factor for suicide. The *2016 Report on Suicide Mortality in the Canadian Armed Forces (1995 to 2015)* identified death by firearm as the cause of death in 5/14, or 35.7% of all suicide deaths.<sup>90</sup>

## Mental status changes: intoxication, psychosis, mood lability, or dramatic change in presentation

Acute mental status changes, including intoxication and new psychotic symptoms, are associated with increased risk for suicide.<sup>91,92</sup> Clinicians must take these changes very seriously, as a patient's risk for suicide can change rapidly and unpredictably in these contexts. Finally, some studies have suggested that people can appear much calmer prior to engaging in suicidal behaviour.<sup>93,94</sup>

## Family history of suicide

A family history of suicide or suicide attempts is associated with increased risk for suicide in both civilian and military settings.<sup>95,96</sup> Eliciting a family history of mental illness and suicide-related behaviour is a key component of a suicide risk assessment.

### ► **Protective factors**

Personal, social, and care-related factors can reduce the risk for suicide in military members.<sup>97,98</sup> While an absence of risk factors is protective against suicide (for example, no current mental health or addiction concerns), protective factors foster resilience and promote safety in context of suicide risk.<sup>99</sup>

Personal traits, including positive coping strategies and the ability to perceive, understand, and manage emotions, and having a sense of agency, have been shown to be protective against suicide ideation, suicide attempts, and suicide in armed forces members.<sup>100,101</sup>

Social support is defined as “the presence of others, or the resources provided by them, prior to, during, and following a stressful event.”<sup>102,103</sup> Social support comprises “belonging” (a sense of “fitting in”), “tangible support” (material support to assist with ongoing issues), “appraisal support” (emotional validation and constructive feedback), and “esteem support” (expressions of confidence, respect, and concern).<sup>104,105</sup> Forms of social support, including family engagement, having children, and religious affiliation have been shown to protect against suicide in civilian and military settings.<sup>106–109</sup>

### ► **Mental health care service use**

#### **Overview**

In 2013, 16.5% of CAF Regular Force personnel had met criteria for one or more of five common mental disorders in the previous 12 months. Depression and PTSD were the most prevalent disorders, affecting 8.0% and 5.3% of personnel, respectively.<sup>110</sup> These disorders impair well-being and may result in impaired productivity and absenteeism, military attrition, job burnout, decreased organizational commitment, and deployment readiness.<sup>111–113</sup>

#### **Barriers to care**

Barriers to care may include stigma, difficulties accessing care, and negative beliefs about the utility of treatment.

## ► **Stigma**

Stigma is defined as a “brand” or “mark of infamy” associated with a specific subgroup or identity.<sup>114</sup> In practical terms, **mental health stigma is a set of negative beliefs about people who are suffering from symptoms of, having impairment from, or receiving treatment for mental illness or substance use disorder.** Mental health stigma can take three different forms: social stigma, self-stigma, and label avoidance.<sup>115</sup>

**Self-stigma** is the loss of self-esteem and self-efficacy that occurs when an individual internalizes the stigmatizing ideas of their social environment and starts to believe that they are of less value and will be rejected by most people.<sup>116</sup> In military settings, self-stigma can lead to feelings of shame as well as secrecy and social withdrawal, which can exacerbate mental illness through loneliness and isolation.<sup>117</sup>

**Social stigma** refers to the reaction of the social group endorsing stereotypes and acting against the individual who reports mental distress and seeks treatment.<sup>118</sup> Fear of social stigma and the discriminatory actions it may lead to, for instance, receiving differential treatment by unit leadership, would add to the distress of soldiers who are already struggling with mental health or addiction problems.<sup>119,120</sup>

**Label avoidance** is linked closely with social stigma and refers to the purposeful avoidance of disclosing mental health or addiction symptoms or using mental health services to avoid the stigma and negative effects of a formal diagnostic label might entail.<sup>121</sup>

## ► **Negative views of treatment**

Negative attitudes toward mental health or addiction treatment have been shown to predict poor mental health care engagement in military populations.<sup>122–124</sup> This association indicates that negative beliefs about mental health care, including negative attitudes about risk and efficacy of treatment or the belief in self-management may be as or more important than stigma as a barrier to care.<sup>125,126</sup>

# STEP 1:

## IDENTIFYING PEOPLE AT RISK FOR SUICIDE

### KEY POINTS

- Every patient should be screened for suicide risk at their initial appointment for a mental health or addiction concern, or for any concerns that are associated with higher risk for suicidal behaviour (chronic pain, traumatic brain injury, insomnia, etc).
- Suicide risk changes over time.
- Clinicians must screen for suicide risk in patients identified as “at-risk” at every appointment.
- Reviewing psychiatric history, including history of addiction and suicidal behaviour, can help identify at-risk patients.

## OVERVIEW

The first step in the assessment and management of suicidal behaviour is to identify those who are at elevated risk for suicide. “Suicide screening” focuses on the identification of individuals at risk for suicide through specific screening questions, and can be done alone or as part of regular health care.<sup>127</sup> “Suicide assessment” refers to a clinician’s comprehensive risk evaluation, and is covered in the next section on suicide risk assessment.<sup>128–130</sup>

Suicide screening for identified target groups, including those reporting mental health symptoms, psychosocial stressors, or medical conditions associated with suicide risk, has been shown to be effective in identifying those at risk for suicide.<sup>131,132</sup> Further, suicide screening of at-risk patients can support the provision of effective mental health care and provide valuable information to better understand the patient’s level of risk throughout the course of care.<sup>133</sup> For example, it is crucial to know if a patient has a history of depression and suicidal behaviour and is currently stable, in case their condition changes in future. Since suicide risk changes over time, any patient identified as being at-risk should be screened at every clinical encounter.

Step 1 of this manual will provide primary care and mental health clinicians with an approach to screening for suicide risk in new patients and patients with whom they have an ongoing therapeutic relationship, as well as information on how to identify at-risk groups for suicide.

## APPROACH TO SCREENING FOR SUICIDE RISK

### GENERAL RECOMMENDATIONS

If a patient has already been identified as being at elevated risk for suicide (i.e., they have disclosed thoughts of suicide or are experiencing severe depressive symptoms), the clinician should proceed directly to the suicide risk assessment outlined in Step 2. The following sections review clinical scenarios where it is prudent to screen for suicide risk, and provide an approach to suicide screening.

The Columbia-Suicide Severity Rating Scale (C-SSRS) Screener/Recent is a useful screening tool in primary care and is available in English and French (Appendix 1).<sup>134</sup> The tool only takes a few minutes to administer, consists of six questions, and is completed by the clinician. For patients seen in follow-up, the C-SSRS Screener/Since Last Contact (Self-Report) is also available (Appendix 2).<sup>135</sup>

## CLINICAL SCENARIOS WHERE SCREENING IS INDICATED

### Meeting a new patient for a mental health or an intake assessment

1. Review confidentiality and limits to confidentiality:
  - All information shared with health care clinicians is confidential, and health care clinicians are bound by provincial and federal privacy legislation. Information will not normally be disclosed to chain of command or families without the patient's consent.
  - If the patient is at imminent risk for harm to self or others and immediate action is needed to ensure safety, a clinician must ensure safety (i.e., urgent referral to an emergency department). The clinician may seek out collateral information from others, provided the clinician does not share any patient information without patient consent.
2. Review existing documentation:
  - The Canadian Forces Health Information System (CFHIS) contains the recruiting medical history and physical exam record, Periodic Health Assessments (PHA), Enhanced Post-Deployment Screening (EPDS), as well as care received prior to your meeting with the client.
  - Review documentation for any mental health concerns (e.g., major depressive disorder, PTSD, anxiety disorders, substance use disorders, adjustment disorders).
3. Take a thorough mental health history including the use of substances, ask about psychosocial stressors, and ask about any history of suicidal thoughts, self-harm, or suicidal behaviour:
  - The goal is to have as much information available to you as possible to understand the patient's current and future risk for suicide.
  - If the patient has new active mental health or substance use concerns, proceed to a full suicide risk assessment.
4. Conduct a screen for suicide risk. We recommend using the C-SSRS. Document the results appropriately.
5. If the patient reports "yes" to any question on the C-SSRS, proceed to full suicide risk assessment and management.
6. Ask about the people who are most important to the patient including family, friends, and supports within the CAF or other groups, including religious supports.
7. Provide information to the patient about warning signs for suicide, crisis supports, and family resources.

### Patient follow-up, no identified risk factors

1. Patient should be screened, ideally using the Outcome Questionnaire, OQ-45.2.
2. If the patient's answers indicate a risk for suicide, proceed to full suicide risk assessment and management (Step 3).

### Screening for suicide risk in at-risk groups

The C-SSRS Screener/Recent can be used across all mental health diagnoses and should be completed for all patients presenting with mental health concerns, psychosocial stressors, history of substance use disorder, history of medical issues related to suicide, or history of suicidal behaviour.<sup>136</sup> If the patient reports "yes" to any of the six questions on the C-SSRS, proceed to a full suicide risk assessment. Patients in groups associated with higher demographic risk for suicide should be screened for suicide at every appointment.

### ► ***Patients with a history of suicidal behaviour, self-harm behaviour, or suicidal ideation***

A history of suicidal behaviour is the most important predictor for suicide death across all populations, age groups and within a military setting.<sup>137–142</sup> If a patient discloses a history of suicidal behaviour, self-harm behaviour, or suicidal ideation for the first time, a full suicide risk assessment is warranted, regardless of the time that has passed since the ideation or behaviour. Depending on the results of the risk assessment, it may be advisable to conduct a suicide risk screen at each subsequent visit, with attention paid to any changes in ideation or behaviour since the last appointment.

### ► ***Patients with symptoms of mental illness and substance use disorders***

When assessing and treating a patient with major depressive disorder, we strongly recommend that clinicians use a standardized rating tool, for example, the Personal Health Questionnaire 9 (PHQ-9) (Appendix 3), in addition to the C-SSRS. The PHQ-9 is brief, completed by the patient and scored quickly by the clinician. Studies have suggested that patients receiving measurement-based care experience higher rates of remission, faster time to remission, and more appropriate medication treatment than those who do not.<sup>143,144</sup>

Importantly, item 9 of the PHQ-9 screens for presence and duration of suicidal ideation (“thoughts that you would be better off dead or of hurting yourself in some way”). If a patient scores greater than zero on this question, proceed to a full suicide risk assessment.

### ► ***Patients experiencing chronic medical issues associated with suicidal risk***

Several medical conditions have been associated with higher risk for suicidal behaviour in military populations, including chronic pain, insomnia, seizure disorders, and TBI.<sup>145–147</sup> These patients require suicide screening at every visit.

Further, certain presentations, including fatigue, poor concentration, and medically unexplained symptoms, may be proxies for depression or anxiety.<sup>148</sup> Patients presenting to primary care with these complaints should be screened for depression using a PHQ-9 scale (Appendix 3). A positive response to item 9 pertaining to suicidal ideation necessitates a full suicide risk assessment.

### ► ***Reported concerns from friends, family, clergy, or service members***

Concerns expressed by friends, family, clergy, or service members about a patient’s well-being are of utmost importance. If they identify mental health concerns or escalating substance use, be sure to ask if they have any concerns for their family member’s safety: “Has your loved one expressed a wish to die?”; “Have they disclosed any thoughts of wanting to kill themselves?”; “Have they acted on these thoughts?”; and “Have you had concerns for your own safety or the safety of those around you?”

Confidentiality prohibits the sharing of patient information, but you can receive information from family and friends. If family members identify any safety concerns, proceed directly to a formal suicide risk assessment, even if the patient does not endorse suicidal ideation.

### ► ***Mental health assessment***

If a patient is being referred from primary care for a formal mental health or addiction assessment, whether it is non-urgent, urgent, or emergent, a full suicide risk assessment should be conducted.<sup>149,150</sup>

# STEP 2: SUICIDE RISK ASSESSMENT

## OVERVIEW

In the previous section, we discussed the importance of screening for suicide risk. If a full suicide risk assessment is indicated, this section will support you through conducting one. This section will focus on assessment within primary care and mental health settings.

It is important to note that suicide risk assessment is not an exact science, and it is impossible for clinicians to predict and prevent suicide with certainty on an individual level. The goal of a formalized suicide risk assessment is to stratify risk, as best we can, as low, medium, or high acute risk to best ensure patient safety, manage the modifiable risk factors leading to suicide risk, and respect an individual's autonomy and treatment goals. It is important to compare the person's suicide risk to their own risk over time. **"Step 2: Suicide Risk Assessment"** is adapted from the *United States Veterans Affairs / Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013)*.

## WHAT IS "SUICIDE RISK ASSESSMENT"?

Suicide risk assessment refers to the process by which clinicians systematically collect and evaluate evidence to estimate a patient's risk for suicidal behaviour.<sup>151–154</sup> The assessment is a collaborative process wherein the clinician gathers information from multiple sources, including the patient, his or her family and close contacts, other health care professionals involved in care, and available clinical records.<sup>155,156</sup>

While the obvious goal of a suicide risk assessment is to identify those at highest risk for suicide and in need of immediate intervention to prevent suicidal behaviour (i.e., urgent psychiatric consultation or hospital admission), a suicide risk assessment can also determine appropriate treatment, mobilize strengths and supports, and guide safety planning.<sup>157–159</sup>

Sequential suicide risk assessments allow the clinician and patient to identify changes to suicide risk over time and help ensure the patient is receiving appropriate treatment for their underlying mental health condition, their substance use, and/or psychosocial stressors.

## INDICATIONS FOR SUICIDE RISK ASSESSMENT

If a patient has already been identified as being at elevated risk for suicide (e.g., they have disclosed thoughts of suicide or are experiencing severe depressive symptoms), the clinician should proceed directly to a suicide risk assessment. **It is important to note that there are situations in which a full suicide risk assessment is indicated even in the absence of reported suicidal ideation or behaviour.**<sup>160</sup> Situations where a full suicide risk assessment is indicated are as follows:<sup>161</sup>

1. The patient screens positive for suicide risk at any appointment via screening tools (i.e., endorses wish to die or thoughts of killing oneself on PHQ-9 item 9; screens positive on C-SSRS self-report).

2. The patient reports any thoughts of suicide during assessment and management of mental health issues, substance use issues, or medical conditions associated with risk for suicide (TBI, pain, sleep disturbance).
3. The patient reports thoughts of suicide during a periodic health assessment (PHA) or enhanced post deployment screen (EPDS).
4. Any assessment for new or worsening mental health symptoms (including depression, PTSD, and especially high-risk conditions like postpartum depression or psychosis, mania or hypomania, or any psychotic symptoms).
5. In the context of any identified deliberate self-harm or suicide-related behaviour that has not been explored or has occurred recently (i.e., within the last year).
6. Family, friends, unit members, clergy, or command have expressed concerns about the patient's behaviour or safety.
7. After a patient has been discharged from hospital for suicidal behaviour.
8. A new or anticipated major change in social situation or loss (i.e., marriage break-up, legal charges, military discipline, impending release).
9. A full suicide risk assessment should be completed at any mental health intake or crisis assessment.

## STANDARDIZED SCALES AND SUICIDE RISK ASSESSMENT

Several rating scales have been developed to aid clinicians in the suicide risk assessment process and are widely used in research and some clinical settings.<sup>162–164</sup> Although suicide is a rare event and difficult for even the most skilled mental health professional to predict, robust evidence suggests that formalized tools improve the quality of risk assessment.<sup>165–169</sup>

The Columbia-Suicide Severity Rating Scale (C-SSRS) is a suicide risk assessment tool that has been shown to predict suicidal behaviour in several populations and settings, including hospitals, primary and mental health and addiction clinics, research studies, and schools.<sup>170–175</sup> It is also widely used in military settings, including the U.S. Marine Corps, U.S. Air Force, and Israeli Defense Forces.<sup>176–178</sup> The C-SSRS has a military-specific tool that can be very useful for CAF clinicians as one part of a formal risk assessment. Suicide assessment tools have been shown to improve the quality of risk assessment particularly for those with less experience or comfort in this field.

## GUIDE FOR MANAGEMENT AND TREATMENT

Clinicians estimate a patient's suicide risk to inform **immediate, short-term, and long-term** management and treatment plans. In keeping with several clinical and organizational frameworks including the *United States Veterans Affairs / Department of Defense Clinical Guidelines* by which this handbook is informed, suicide risk is characterized as high acute, moderate acute, low acute, and not acutely elevated.<sup>179–182</sup> However, simply stating that a patient is at low, medium, or high risk without any context or planning is not helpful for either the patient or the clinician.<sup>183</sup> New approaches to suicide risk assessment are shifting from a categorical assessment of risk to a model which incorporates the patient's "risk status" (his or her risk relative to a population, for example all CAF members who are receiving care for mental health issues) and "risk state" (his or her current risk compared to personal baseline or other time points).<sup>184</sup> The suicide risk assessment also should guide care planning and resource allocation.<sup>185–187</sup> "Step 3: Management and Treatment of the Patient at Elevated Risk for Suicide" provides clinical guidance on translating the suicide risk assessment into a management and treatment plan.

Table 1 on page 19 of this manual, adapted from the *United States Veterans Affairs / Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*, is a useful tool for clinicians to determine which patients are at high, moderate, and low acute risk for suicide. Patients without current or recent suicidal ideation and no warning signs are classified as “not at elevated acute risk” for suicide. It is important to remember that suicide is not always a predictable outcome and that clinician judgment can supersede guidelines.

## APPROACHES TO SUICIDE RISK ASSESSMENT

### COMMON COMPONENTS OF A SUCCESSFUL ASSESSMENT

A suicide risk assessment can be conducted by any clinician in any treatment setting. The approach and content covered vary, but common components are shared by all assessments. A good suicide risk assessment is contingent on: 1) creating a safe and comfortable environment; 2) clear and transparent framing about the limits of confidentiality and the rationale for the assessment; 3) a thorough review of suicidal ideation, intention, preparatory behaviour, and past attempts; 4) assessing the need for collateral information; and 5) formulation and documentation.

#### Creating a safe, comfortable, and supportive environment

Talking about suicide can provoke feelings of anxiety and shame in patients, and can feel uncomfortable for clinicians.<sup>188,189</sup> Several factors can mediate these difficult emotions and promote a more effective assessment.

##### ► **Safety**

If a patient is threatening or aggressive, clinicians should not attempt a suicide risk assessment on their own. If a patient appears to be at imminent risk of harming self or others, or has already engaged in violence or self-harm and continues to appear agitated, police should be called and the assessment should be conducted in an emergency department setting.

##### ► **Clinician training and confidence**

Studies have suggested that a lack of confidence in their skills impacts the comfort that some clinicians have in asking about suicide.<sup>190</sup> Clinician education in suicide risk assessment has been shown to improve the quality of the assessment. The Columbia Lighthouse Foundation offers free online training courses for clinicians who would like to use the full C-SSRS as part of their practice: (<http://cssrs.columbia.edu/training/training-options/>).

##### ► **Navigating time constraints**

Screening for mental health issues at the first meeting with a patient and reviewing previous documentation (see “Step 1: Screening for Suicide Risk”) can save time when a formal risk assessment is required, by ensuring the clinician is aware of any past diagnosis and treatment of mental health conditions, family history of suicidal behaviour, and personal history of suicidal ideation or behaviour. Although the first few suicide risk assessments may be time consuming, with practice, the majority can be completed in 15 minutes or less. Using a consistent format to document your assessment and formulation can also support rigorous and efficient practice. A suicide risk assessment documentation template is included in this section for use by clinicians (Appendix 4).



## Reviewing confidentiality and its limits

The Canadian Forces Health Services Group Instruction 5026-56, the *Privacy Act*, and the *Personal Information Protection and Electronic Documents Act (PIPEDA)* outline required privacy practices within the CAF health care system. However, clinicians must intervene if a patient presents as a risk for significant bodily harm to self or others.

As described in the screening section, the clinician and patient should review the following:

- All information shared with health care clinicians is confidential and health care clinicians are bound by federal legislation and CFHS policy. Information will not be disclosed to chain of command or families without the patient's consent.
- If the patient is at imminent risk for harm to self or others and immediate action is needed to ensure safety, a clinician must ensure safety (i.e., urgent referral to an emergency department, breaking confidentiality if necessary). The clinician may seek out collateral information from others, provided the clinician does not share any patient information without patient consent.

# SUICIDE RISK ASSESSMENT

## ASSESSING NEW-ONSET SUICIDE RISK

A new assessment of suicide risk can occur the first time you are meeting a patient, or can happen if a patient with whom you have an existing relationship screens positive for suicide risk or discloses new suicidal ideation. When assessing a patient for the first time, follow the protocol steps outlined below<sup>191</sup>:

1. Conduct a current state suicide risk assessment, focusing on thoughts of suicide, plans, preparatory behaviour, recent self-harm, or suicidal behaviour.
2. Review the risk factors and warning signs that can move someone from ideation to intent to behaviour.
3. Integrate all information to estimate the patient's risk compared to their own baseline, and determine the level of care required.

Assessing risk for suicide can be stressful for clinicians and patients. **It is important to remember that asking a patient about suicide does not increase his or her risk for suicide.**

## Assessing for suicidal ideation, intent and plan, preparatory behaviour, and recent suicide-related behaviour

The clinician should use a structured approach to review current and lifetime suicidal ideation, intent and plan, preparatory behaviour, and recent suicide-related behaviour. The C-SSRS Lifetime/Recent Version can provide a thorough guide for clinicians assessing for suicide who have been trained to use this tool (Appendix 5).<sup>192</sup> This tool provides guidance for clinicians to evaluate suicidal ideation, intent, preparatory behaviour, and suicide-related behaviour both in the past month and when the patient has had the strongest thoughts of suicide over his or her lifetime.<sup>193</sup>

Questions should be asked in a calm, non-judgemental, and supportive fashion, in a step-wise manner (i.e., starting with suicidal ideation and progressing to intention, preparatory behaviour, and suicide attempts). The expectation certainly is not that the clinician will ask every suggested question below; it is our goal that the suggested questions provide comfort and a frame for the clinician to conduct a safe and thorough assessment.

### ► **Suicidal ideation**

The following areas should be covered in part of the assessment and are presented along with sample questions applicable to various clinical scenarios and reasons for assessment. Clinicians should cover the last month as well as the patient's lifetime. It is important to note that suicidal ideation can occur with or without intent and with or without a plan.

1. Explore attitudes toward living and presence of **passive suicidal ideation** (i.e., wish to die and not wake up). The clinician can begin by asking questions about the patient's feelings about life in general and these can be contextualized by the information previously collected.<sup>194</sup>

Suggested questions:

- "Have you ever felt that life isn't worth living?"
  - "Have you ever wished you could go to sleep and not wake up?"
  - "I see on the PHQ-9 you completed today that some days you have thoughts about death. Can you tell me more about this?"
  - "Your spouse told me you mentioned that if you didn't wake up one morning, it would be a relief. Is this a feeling you've had recently?"
  - "Did something happen that led to these thoughts?"
2. The clinician should then ask direct questions about **active suicidal ideation** (i.e., thoughts of killing oneself):
    - "Have you actually had any thoughts about killing yourself?"
    - "Have you ever fantasized about ending your life?"
    - "On the Columbia-Suicide Severity Rating Scale screener that you fill out every time you visit, I see that you've had new thoughts of killing yourself. Can you tell me more about this?"
  3. The clinician should then characterize the suicidal ideation by asking when the thoughts started, the content, intensity and frequency, and the patient's emotional reaction to the thoughts. The clinician should also determine if this is the first time the patient has felt this way, and compare it to previous lifetime episodes of suicidal ideation:
    - "Can you describe the suicidal thoughts to me?"
    - "How frequent are the thoughts? Do they come a few times a week? Every day? How long do they last? Have you noticed any triggers for them?"
    - "How intense are the thoughts? Are they getting more intense?"
    - "How do the thoughts make you feel? Are they upsetting? Do they relieve you?"
    - "Have the thoughts ever been more frequent or intense than they are now? When was that? What's different?"

### ► **Suicide plan and suicide intent**

**Active suicidal ideation with plan** refers to thoughts of suicide with details of a plan fully or partially worked out.<sup>195,196</sup> **Suicidal ideation with intent** refers to thoughts of suicide with a subjective expectation and desire for a self-destructive act to end in death.<sup>197,198</sup> Patients may experience **active suicidal ideation without a plan or intent**, **active suicidal ideation with a plan but no intent**, **active suicidal ideation with intent but no plan**, or **active suicidal ideation with intent and plan**.<sup>199</sup> It is the clinician's responsibility to clarify the strength of the intent and the plan's lethality, feasibility, and access to means.

1. The clinician should focus on the content of the suicidal ideation, particularly on any methods of suicide that the patient has described, and the lethality of the plan:
  - “When I asked you to describe the thoughts, you mentioned that sometimes you imagine hanging yourself. Can you tell me more about this?”
  - “Do you ever think about ways in which you would end your life?”
  - “How much time do you spend thinking of ways to end your life?”
  - “Do you think that the plan would result in your death?”
  - “Have you told anybody about your plan? Have you thought about how people can keep you safe, or are you trying to figure out ways to isolate yourself to make carrying out the plan easier?”
  - “Have you ever thought about methods to kill yourself before this? When were the thoughts the most intense?”
2. The clinician should explore the feasibility and access to means required for the plan disclosed. **The clinician should always ask about access to firearms, access to medications, and non-prescription drugs regardless of the plan disclosed:**
  - “You mentioned that you have thoughts of overdosing on your medication. How much medication do you have at home? Do you think it’s enough to end your life? Have you thought about how you would obtain more?”
  - “Do you have firearms in your home? Do you have access to a firearm?”
  - “You stated that you have thoughts of using a helium tank to end your life. Do you know where you would find one? Are they easily accessible?”
3. The clinician should explore in detail the patient’s intent to die. **Intent to die is a key risk factor for suicide:**
  - “Some people are bothered by suicidal thoughts and do not wish to die. Other people feel that suicide is the best or only option for them. How do you feel?”
  - “What makes suicide feel attractive to you? What makes it less attractive?”
  - “Tell me about your wish to die. How intense is it? What has kept you safe to this point?”
  - “Do you see yourself ending your life today? This week? At some point in the future?”
  - “Are there certain times where you feel a wish to die more intensely (e.g., after a fight with a loved one, or when intoxicated)?”
  - “What would need to happen for you to end your life?”
  - “What would need to happen for you to decide you don’t want to die?”
  - “Have you ever wanted to die more than you do right now? Tell me about that time. What’s the same? What’s different?”
  - “How in control of your suicidal thoughts do you feel right now? Have there been moments over the past month that you felt less in control? Can you see yourself acting on suicidal urges impulsively?”
4. The clinician should assess the patient’s perceptions of the consequences of suicide and the deterrents for engaging in suicide-related behaviour (attempts or death by suicide):
  - “If you were to end your life, how would it affect people around you?” (Themes of burdensomeness or alienation place patient at higher risk for suicide).<sup>200,201</sup>

- “What are your reasons for living?”
- “Are you hopeful that things can improve?”
- “What do you think will help you feel better than you do today?”

### ► **Preparatory acts or behaviours**

**Preparatory acts or behaviours** refer to acts or preparation toward a suicide attempt.<sup>202,203</sup> Preparatory acts and behaviours include **suicidal communication** (writing or talking about suicide, a wish to die, or death, or threatening to hurt or kill oneself), **planning a method for suicide** (developing a plan to die, taking steps to prepare for an attempt; for example, purchasing a gun and rehearsing plan), and **preparing for death** (engaging in behaviour to prepare for anticipated death; for example, making a will, saying goodbye to friends and family, writing a suicide note, giving away belongings, or arranging care for dependents).<sup>204,205</sup>

Preparatory acts and behaviours have been identified as **clear warning signs** for incipient suicide attempts and confer high risk status to the patient, even in the absence of other risk factors.<sup>206</sup> If a patient engages in these acts or behaviours but minimizes them to any clinician, further urgent mental health assessment is still warranted.

#### 1. Assessing for suicidal communication

The clinician should ask about methods of communicating thoughts to others, including writing or talking about suicide or threatening to hurt or kill oneself:

- “Have you mentioned to any person that you are close to that you have been having thoughts of suicide? Have you ever done so?”
- “Your fellow service member expressed concern that you have mentioned that life isn’t worth living. Can you tell me about that conversation?”
- “You mentioned that when you are angry, you tell your spouse you ‘might as well kill’ yourself. When was the first time this happened? What reaction were you hoping for? Have you ever meant this? How worried are they about you?”

#### 2. Assessing for planning a suicide attempt

Many people who have suicidal ideation have mental images or fantasies about how they would end their lives, but most do not engage in planning behaviour. This planning behaviour includes spending time to develop a plan to die, taking steps to prepare for an attempt, and rehearsing a plan. The clinician must assess for these behaviours carefully:

- “Have you researched ways to end your life online? How much time do you spend doing this? How often do you do it?”
- “Have you considered several plans and decided on one that seems the most feasible to you?”
- “What steps have you taken to prepare for suicide? Have you acquired a firearm? Stockpiled medication? Purchased a rope? Researched bridges?”
- “Have you considered strategies to facilitate the suicide attempt” (i.e., planning to seclude yourself, using intoxicants or other substances to reduce fear of death)?”
- “Have you practised or rehearsed (i.e., walked through the attempt mentally, loaded a gun with bullets, cut yourself with the intention of gaining courage for death, put noose around your neck)?”

#### 3. Assessing for preparations for death

The clinician must ask about any behaviour designed to prepare for death, including saying goodbye to loved ones, writing a suicide note, arranging finances, or arranging care for dependents:

- “Have you tried to make contact with loved ones to say goodbye?”

- “Have you been making arrangements for your death, like writing a new will, obtaining life insurance, or sorting out your finances?”
- “Have you written or practised writing suicide notes?”
- “Have you given away any of your belongings or arranged care for pets in anticipation of death?”

### ► ***Suicide-related behaviour (suicide attempts and deliberate self-harm)***

While an absence of history of suicide attempts does not preclude death by suicide, its presence increases the risk for suicide considerably.<sup>207</sup> **A recent suicide attempt** is an indication for the need for urgent assessment of suicide risk by a mental health professional.<sup>208,209</sup>

Deliberate self-harm without intent to die is an independent risk factor for suicide, and escalating self-harm behaviour (i.e., increasing frequency or severity from baseline) is a potential precursor for death by suicide.<sup>210–212</sup>

1. Conduct a thorough history of past suicide attempts and aborted suicide attempts
  - The clinician must ask about the number of past suicide attempts and review the circumstances for each, including 1) mental health symptoms prior to attempt, 2) level of planning, 3) efforts made to seclude self / how the person was found (i.e., did they call for help), 4) lethality and medical consequences, 5) help-seeking thereafter, and 6) emotional reaction to surviving the attempt.
  - The clinician can ask how the current situation is similar or different to past suicide attempts.
  - For patients with multiple suicide attempts, the clinical picture is more complicated and a referral to a mental health professional is warranted even in the absence of acute risk.
2. Review history of deliberate self-harm (including cutting, scratching, or hitting self; head-banging; and burning self)
  - Characterize onset, frequency, severity, change in patterns, and intent.
  - Review patient’s explanatory model (i.e., to relieve stress, to punish self, to communicate distress, to manage dissociation).

## **Reviewing risk factors, protective factors and warning signs for suicide**

1. Assess non-modifiable risk factors
  - Much of this information is readily available to the clinician (age, sex, marital status).
  - Some information, including sexual orientation, gender identity, and family history of suicidal behaviour, should be obtained here if appropriate.
  - Ask about medically-related risk factors including history of TBI and chronic pain.
  - You will already have completed a suicide risk history which informs the patient’s non-modifiable risk.
2. Assess for acute risk factors and warning signs
  - Ideally, you will have much of this information available to you from your first encounter with this patient (see: “Clinical Scenarios: Meeting a New Patient for a Mental Health or an Intake Assessment”).
  - Identify any previous diagnoses of mood disorder, anxiety disorder, psychotic disorder, personality disorder, and substance use disorder. Review any psychiatric hospitalizations.
  - Review current psychiatric symptoms and their severity and intensity. Scales can be useful here, including the PHQ-9 for depressive symptoms. Review any current substance use, including alcohol, cannabis, stimulants, benzodiazepines, and opiates.
  - Ask about any new or worsening medical issues, specifically chronic pain and TBI.

- Review any recent medication changes or side effects (for example, selective serotonin reuptake inhibitors [SSRIs] in people under age 24 may be associated with increased risk for suicide).
- Ask about current psychosocial stressors: relationships, work performance or conflict, or financial stress. Review any changes in level of function and any recent losses.
- Pay particular attention to signs and symptoms related to warning signs of suicidal behaviour, including aggression and violence toward others, increasing impulsivity, worsening general anxiety, panic attacks, insomnia, hopelessness, and psychosis.<sup>213</sup>

### 3. Assess for protective factors

- Assess for personal, social, and treatment-related protective factors:
  - Is the patient forthcoming, open, and honest about their suicidal thoughts? Are they willing to discuss a safety plan with their family?
  - Did the person come to care on their own? Are they hopeful and positive about treatment?
  - Have they disclosed their distress and suicidal thoughts to loved ones or colleagues? Have their loved ones or colleagues been supportive?

## Assessing the need for collateral information

If a patient presents on his or her own and is at low acute risk for suicide, collateral information may not be necessary to obtain. However, if the patient provides consent, engaging with family and the patient's unit can be helpful in creating a safety plan.

In the case of high acute risk for suicide, especially in patients who are guarded, vague, or minimizing their preparatory or suicide related behaviour, collateral information from family is recommended.

If the patient is at low or moderate acute risk but has been identified by family, clergy, or fellow service members as being at risk for suicide, collateral information must be obtained if the patient consents. If consent is not provided, remember that a clinician can collect information from loved ones without disclosing patient information. If the assessment was prompted by family or another person's concerns, that person should always be contacted.

## Suicide risk formulation and documentation: Integrating all information to estimate risk for suicide, focusing on risk status and risk state

Suicide risk formulation refers to integration of the suicide risk assessment to assign a level of acute suicide risk. The risk formulation allows clinicians to assign the appropriate level of care to address the patient's safety and to provide adequate treatment to reduce his or her risk, improve symptoms, and promote recovery. The suicide risk assessment should comment on the patient's **risk status** (his or her risk relative to a population, for example all people diagnosed and receiving care for depression) and **risk state** (his or her current risk compared to personal baseline or at times of higher risk).

Table 1 provides a framework for determining the level of risk and appropriate level of care. Appendix 6 provides examples of risk formulation and illustrates the way the safety and treatment plan flows from the level of risk. Finally, Appendix 4 provides a documentation template that can be used by all primary care clinicians.

**TABLE 1. Determining Level of Risk for Suicide and Appropriate Action in Primary Care\***

RISK FOR SUICIDE ATTEMPT	INDICATORS OF SUICIDE RISK	CONTRIBUTING FACTORS†	INITIAL ACTION BASED ON LEVEL OF RISK
High Acute Risk	<input type="checkbox"/> Persistent suicidal <b>ideation</b> <input type="checkbox"/> Strong <b>intention</b> to act or plan <input type="checkbox"/> Not able to control <b>impulse</b> OR <input type="checkbox"/> <b>Recent suicide attempt</b> or <b>preparatory behaviour</b>	<input type="checkbox"/> Acute state of mental disorder or acute psychiatric symptoms (psychosis, agitation, intoxication) <input type="checkbox"/> Acute <b>precipitating</b> events (recent loss, conflict or fall in status) <input type="checkbox"/> Inadequate <b>protective</b> factors	<input type="checkbox"/> Discuss the need for immediate emergency mental health evaluation with patient <input type="checkbox"/> Contact nearest hospital for emergency assessment <input type="checkbox"/> If patient is unable or unwilling to be safely escorted to hospital, certification under your province or territory's mental health act <input type="checkbox"/> Obtain collateral information from family <input type="checkbox"/> Should advise Base or Wing Surgeon (B/W Surg) <input type="checkbox"/> Thorough documentation
Moderate Acute Risk	<input type="checkbox"/> Current suicidal <b>ideation</b> <input type="checkbox"/> <b>No intention</b> to act <input type="checkbox"/> <b>No recent attempt</b> or <b>preparatory behaviour</b> or rehearsal of act	<input type="checkbox"/> Existence of <b>warning signs</b> or <b>risk factors</b> †† AND <input type="checkbox"/> Limited <b>protective</b> factors	<input type="checkbox"/> Refer for urgent mental health assessment (psychiatry or psychology) for further evaluation <input type="checkbox"/> Obtain collateral information to inform safety planning, including limiting access to means <input type="checkbox"/> Thorough documentation
Low Acute Risk	<input type="checkbox"/> Recent suicidal <b>ideation</b> <input type="checkbox"/> <b>No intention</b> to act or plan <input type="checkbox"/> Able to control <b>impulses</b> <input type="checkbox"/> No planning or rehearsing a suicide act <input type="checkbox"/> No previous attempt	<input type="checkbox"/> Existence of <b>protective</b> factors AND <input type="checkbox"/> Limited <b>risk</b> factors	<input type="checkbox"/> Consultation with mental health services <input type="checkbox"/> Initiate treatment for underlying issues <input type="checkbox"/> Safety planning <input type="checkbox"/> Encourage collaboration with military supports and family <input type="checkbox"/> Thorough documentation

† Modifiers that increase the level of risk for suicide of any defined level include the following:

- Acute state of substance abuse: alcohol or substance abuse history is also associated with impaired judgment and may increase the severity of the suicidality and risk for suicide act.
- Access to means (firearms, medications) may increase the risk for suicide act.
- Existence of multiple risk factors or warning signs or lack of protective factors may increase the risk for suicide act.

†† Evidence of suicidal behaviour warning signs in the context of denial of ideation should increase the clinician's index of suspicion (e.g., contemplation of plan with denial of thoughts or ideation)

\* This table is adapted from Table 1. Determine Level of Risk for Suicide and Appropriate Action in Primary Care from the *United States Veterans Affairs / Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide* (p. 19).

## Assessing on-going suicide risk

We recommend screening for suicide risk in all patients receiving mental health care in primary care settings. The C-SSRS – Since Last Visit (Self Report) (Appendix 2) is a useful tool in these cases.

We recommend a formal suicide risk assessment at every appointment for people at moderate and high risk for suicide. Additionally, we recommend a formal suicide risk assessment if the patient screens positive for suicidal thoughts or meets any of the criteria outlined earlier in the “Indications for Suicide Risk Assessment” section (see Step 2). With appropriate training, the C-SSRS – Since Last Contact (Clinical) (Appendix 7) can support primary care physicians in completing a recurrent risk assessment.



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# **STEP 3: MANAGEMENT AND TREATMENT OF THE PATIENT AT ELEVATED RISK FOR SUICIDE**

## **GENERAL PRINCIPLES**

### **OVERSIGHT AND COORDINATION OF CARE**

Primary care clinicians, including general duty medical officers (GDMOs), civilian family physicians, nurse practitioners, and physician assistants, oversee patients' care. The primary care clinician can communicate with any medical or mental health professionals providing treatment.<sup>214</sup> When a member is known to be at elevated acute risk for suicide, primary care clinicians monitor both access to services and effectiveness of prescribed treatment.<sup>215</sup> Primary care clinicians should be informed if a patient misses an appointment in order to assess for barriers or resistance to accessing care.<sup>216</sup> Further, the primary care clinician should receive regular updates from other care providers about the patient's progress.

We also recommend that the primary care clinician convene regular case reviews and interdisciplinary case conferences where all service providers can meet in-person or via telephone to discuss the patient's progress. Ideally, the patient and his or her family members would be included as well.<sup>217</sup>

### **COMMUNICATION WITH THE CHAIN OF COMMAND (MEDICAL EMPLOYMENT LIMITATIONS)**

Medical Employment Limitations (MELs) refer to administrative constraints on a CAF member's work schedule, tasks, roles, environments, or geographical locations due to a medical condition, as determined through a medical assessment.<sup>218</sup> MELs allow primary care clinicians to communicate to the chain of command and are designed to protect CAF members from tasks and duties that they may be unable to complete safely or effectively.<sup>219,220</sup> In particular, geographic restrictions are essential to allow a member to remain in the local geographic area so that he or she may attend appointments.

MELs do not specify the nature of the medical condition; a patient's mental health and risk for suicide would not be disclosed without the patient's consent, unless the patient or a clearly identified individual(s) is at imminent risk and confidentiality should be breached. However, in many cases, support and involvement from command can be beneficial in reducing concerns about shame or stigma and creating an integrated return-to-service plan. Care providers can discuss with patients the potential benefits of command involvement and assure them that their health information is protected.<sup>221</sup>

### **PATIENT-CENTRED CARE**

Every treatment plan should consider the patient's needs, preferences, goals, and values.<sup>222</sup> The patient should have the opportunity to make informed decisions about their care and treatment if they are capable to do so, in collaboration with their health care team.<sup>223</sup> Trust, rapport, and good communication between the patient and the health care team are essential.



It is important to note that the assessment and management of patients at risk for suicide can create an adversarial and mistrustful dynamic between the patient and the provider. Patients may regret disclosing information when it results in involuntary hospitalization or MELs. Transparency, honesty, and empathy, as well as a clinician confident that he or she is making appropriate decisions after a thorough assessment that is guided by evidence, can alleviate some of this tension.

## FAMILY INVOLVEMENT

Family involvement with patient consent can support safety planning, treatment, and recovery. Family members should also be provided with education, information, and emotional and tangible support as needed. If the patient consents, health care providers should offer information about mental health diagnoses, medication (benefits and potential side effects), community services, and support groups. They should also contribute to safety planning and be provided with information about warning signs for suicide. They should be provided with contact information for the treating team including who to call if the patient's situation worsens or if they need support or advice. If consent is obtained, the clinician should also meet with family members alone and together with the patient to allow for the provision of sensitive information and collaborative safety planning.

Finally, family members can work with the patient and the health care team to restrict access to lethal means within the home.<sup>224–227</sup> They can help ensure that firearms are not easily available at home. If firearms remain at home, family members can ensure that they are locked and stored separately from ammunition, and that the patient is not able to access them.<sup>228,229</sup> Family members should also endeavour to keep alcohol and drugs of abuse out of the family home. Medications should be stored and locked, and the care team, family member, and pharmacy should work with the patient to ensure they do not have access to dangerous quantities of medication.<sup>230–232</sup> Family members can also safely store sharp objects, including razor blades and knives.<sup>233</sup>

The Canadian Forces Health Service (CFHS) offers resources to families of service members with mental health concerns. “You’re Not Alone” (<http://www.forces.gc.ca/en/caf-community-health-services/mental-health-resources.page>) is a website that provides information and resources for both CAF members and families. The Family Information Line is available seven days a week, 24 hours a day (1-800-866-4546).

Appendix 8 is a handout for families that reviews warning signs for suicide and provides information on what to do if their loved one is in crisis.

## NOT RECOMMENDED: NO–SUICIDE CONTRACTS

A “no-suicide contract” refers to an agreement between a patient and a clinician that states that the patient will either refrain from engaging in suicidal behaviour or inform a relative or healthcare provider of any suicidal intent or preparatory behaviour.<sup>234</sup> No-suicide contracts are used commonly in clinical settings; however, **there is no evidence that suggests they reduce suicide risk**, nor are they useful in protecting clinicians from malpractice claims.<sup>235–237</sup>

## COMPONENTS OF A TREATMENT PLAN

The assessed level of suicide risk (low acute risk for suicide, moderate acute risk for suicide and high acute risk for suicide) guides the level of care provided to each patient. The components of the treatment plan, however, are shared across all levels of risk. Conceptualizing suicide risk on a continuum is important because it allows the clinician to continuously engage in dynamic safety planning that is the least restrictive and most focused toward recovery. In this section, we will review the components of treatment for those at acute risk for suicide, including:

1. Determining the appropriate level of care
2. Safety planning
3. Treating underlying mental health conditions
4. Treating substance use disorder
5. Providing psychosocial supports
6. Providing targeted suicide-related interventions

## DETERMINING THE APPROPRIATE LEVEL OF CARE AND FOLLOW-UP

The first and most important step in managing suicide risk is assessing the patient's immediate safety and determining the most appropriate setting for treatment. "Step 2: Suicide Risk Assessment" outlined the steps required to ascertain a patient's acute risk for suicide: high acute risk, moderate acute risk, low acute risk, and not at elevated risk for suicide. Table 1, adapted from the *United States Veterans Affairs / Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*, is a key resource identifying acute suicide risk. Appendix 6 provides four clinical scenarios which highlight the clinical differences across the risk levels.

### High acute risk for suicide

Patients at high acute risk for suicide are those who have persistent suicidal ideation, strong intention to act or a well-developed plan, or feel unable to control the impulse to harm themselves.<sup>238</sup> It also refers to those who have had a recent suicide attempt or who have participated in preparatory behaviour. They may also be in an acute state of mental disorder or psychiatric symptoms (psychosis, agitation, or intoxication), or have acute precipitating events and inadequate protective factors.<sup>239</sup>

In this case, the patient must receive an emergent mental health consultation. Most CFHS clinics do not have the capacity to provide emergent psychiatric assessment, therefore patients must be referred to local emergency departments. If emergent psychiatric assessment is available, primary care clinicians may liaise with the psychiatrist or psychologist to determine if referral to an emergency department is warranted, and to determine follow-up care. During assessment, the patient should be monitored at all times by the treating team.

If the patient is not agreeable to being referred to an emergency department, the clinician must consider an involuntary admission certificate for psychiatric assessment under the mental health act for their respective province or territory. An involuntary admission certificate can only be issued by a physician. If the assessing clinician is not a physician, he or she must either ask a physician to see the patient immediately, or consider calling the police and informing them the patient is at imminent risk for self-harm with a request to enforce an involuntary admission. Law enforcement should also be called if the patient is too aggressive or agitated to be transferred safely, or if he or she leaves the premises.

If the patient is intoxicated at assessment and endorsing suicidal ideation, there is a higher risk for suicide due to impulsivity, disinhibition, and greater susceptibility to overdose on other substances. In this case, constant medical supervision is required until the patient can be reassessed. This is best achieved in an emergency department setting.<sup>240</sup>

It is important to note that not every patient designated as "high acute risk for suicide" will be admitted to hospital. Psychiatrists who work in emergency settings are trained to conduct complex suicide risk assessments and may feel the patient is safe to go home or is not certifiable under the province's mental health act. Hospitalization is often most beneficial for people whose risk for suicide is acutely elevated rather than

chronically elevated, those who are experiencing a psychosocial crisis and are in need of stabilization, and those who have symptoms that can be targeted by rapid intervention (i.e., symptoms of mania or psychosis, or severe depressive symptoms).<sup>241</sup>

In all cases, provide written collateral information to the assessing team within the civilian hospital. Ideally, you can call the emergency department ahead of time to provide a report as well as a contact number where you can be reached. If the patient is being discharged, the consulting psychiatrist can provide valuable support in developing a safety plan.

In rare situations where emergency assessment and hospitalization are not available (i.e., deployment), consider evacuation or constant observation in a secure setting until the patient can receive an urgent mental health consultation.

## **Chronic high acute risk for suicide**

A small subset of patients can be classified as having chronic high acute risk for suicide. These adults have a history of multiple suicide attempts and are at elevated risk compared to single suicide attempts.<sup>242–245</sup> Some models of suicide hypothesize that past suicidal behaviour may result in easier activation of future episodes, meaning that those with multiple suicide attempts develop a higher baseline risk for suicide.<sup>246,247</sup>

When assessing suicide risk in patients at chronic elevated risk, a model that describes “acute-on-chronic” risk can be helpful.<sup>248</sup> In this model, acute stressors, including a major depressive episode, increasing substance use, or relationship conflict can increase a patient’s baseline level of suicide risk.<sup>249</sup>

Assessing suicide risk in someone at chronically elevated risk for suicide can challenge even the most experienced clinicians, and we recommend that primary care clinicians consult mental health clinicians early in the care of clients with multiple suicide attempts, even in the absence of current suicidal ideation. A preexisting therapeutic alliance and knowledge of the patient’s risk profile and triggers for suicidal behaviour can be a valuable resource in acute-on-chronic risk assessment.

## **Moderate acute risk for suicide**

Patients at moderate acute risk for suicide are those who have current suicidal ideation with no intention to act and no recent attempt or preparatory behaviour. They have warning signs or risk factors, and limited protective factors.<sup>250</sup> Ideally, this patient is treated in the milieu in which he or she feels the most comfortable. However, situations may arise where inpatient care is required. Emergency assessment and inpatient hospitalization may be indicated in situations where hospitalization presents the best chance for recovery (e.g., very close medication monitoring is required, the patient is at risk for life-threatening withdrawal symptoms, or the patient’s environment puts them at elevated risk for suicide), or if the patient is unable or unwilling to engage in safety planning or provide consent for collateral information for safety concerns only.

In general, patients at moderate acute risk for suicide require urgent mental health assessment (i.e., within one week). They may do well in outpatient settings, ideally with a high level of care (i.e., visits at least once a week or as often as the patient requires). They should be screened for suicide risk at every appointment.

## **Low acute risk for suicide**

Patients at low acute risk for suicide may have had recent suicidal ideation but have no intention to act, can control impulses, have not engaged in preparatory behaviour, and have no previous attempts. They have limited risk factors and some protective factors.<sup>251</sup> These patients can be safely managed as outpatients and may benefit from consultation to a mental health clinician for added support, treatment recommendations, and

safety planning. They should be seen for reassessment within a week by the primary care clinician and should be screened for suicide risk at every appointment.

## Not at elevated acute risk for suicide

Patients with no recent suicidal ideation and no history of suicide-related behaviour fall into this category. They can continue to receive treatment as usual for their mental health or substance use disorders.<sup>252</sup>

## Transitioning between levels of care

### ► *Discharge from psychiatric inpatient unit*

A history of psychiatric hospitalization is a major risk factor for death by suicide, as suicide risk is most elevated immediately after discharge from hospital and remains elevated for at least one year.<sup>253–256</sup> The risk for suicide in the four weeks after discharge from hospital is approximately 100 times higher than the rate observed in the general population.<sup>257,258</sup> If a patient is admitted to hospital, the primary care clinician should contact the treating team in the hospital immediately to discuss the patient's condition, treatment, safety, and discharge planning. The patient must be reassessed immediately upon discharge and followed closely (at least weekly) for the first six weeks after discharge, with suicide risk assessments completed at each visit.

### ► *Safety planning*

Safety planning refers to a collaborative process by which a patient and his or her care team create an individualized plan that outlines an approach the client can take to stay safe when faced with increasing suicidal thoughts.<sup>259–261</sup> One approach to safety planning is a formal “safety planning intervention” designed to mitigate suicide risk.<sup>262–264</sup> Safety planning can be done for all people at acutely elevated risk for suicide, and is especially important in those at high acute risk for suicide, particularly when transitioning from a higher to a lower level of care.<sup>265,266</sup> The following approach is taken from Stanley and Brown's 2012 description of a “safety planning intervention” and incorporates features of other safety plans, including the template described in the *Centre for Addiction and Mental Health Suicide Prevention and Assessment Handbook*.<sup>267,268</sup> A safety plan template for use with clients can be found in Appendix 9 and takes about 20 to 45 minutes to complete with a patient.<sup>269</sup> **A safety plan should be revisited and revised when there is a change in level of risk or level of care.**

The core components of the safety plan include:<sup>270,271</sup>

1. Recognizing warning signs of an impending suicidal crisis
2. Reminding self of reasons for living
3. Employing internal coping strategies
4. Using social contacts and social settings as a means of distraction from suicidal thoughts
5. Using family members or friends to help resolve the crisis
6. Contacting mental health professionals or agencies
7. Restricting access to lethal means

We recommend that patients carry a copy of their safety plan in their wallets and keep copies in locations that are easily accessible in times of crisis, including by the bedside, on the refrigerator, or in their car.<sup>272,273</sup> They can also share a copy with family and close friends and keep an electronic version on their phone.<sup>274,275</sup> Family involvement in and education about the safety plan can improve adherence to the plan and can help families know what to do and what to expect in the case of elevated risk for suicide.<sup>276,277</sup> Fellow unit member(s) or unit leadership involvement may also be helpful if the patient is amenable.<sup>278</sup>

## Recognizing warning signs of an impending suicidal crisis

The first step in a patient's safety plan focuses on identifying warning signs that precede intensifying thoughts of suicide. These warning signs can include personal situations, thoughts or feelings, and behaviours.<sup>279</sup> More specific warning signs (e.g., "When I feel ashamed at work for doing something wrong or looking weak") can be more useful in cueing the use of the safety plan than vaguely described warning signs ("feeling embarrassed").<sup>280</sup>

### ► **Examples of possible warning signs**<sup>281,282</sup>

#### **Personal situations:**

- ☐ Fighting with a significant other
- ☐ Conflict within the workplace
- ☐ Attending a family event and feeling anxious

#### **Thoughts, feelings or images:**

- ☐ Having suicidal thoughts and feeling hopeless and worthless
- ☐ Worsening racing thoughts or anxiety
- ☐ Strong urges to drink alcohol
- ☐ Feeling abandoned and alone
- ☐ Feeling irritable
- ☐ Getting mad at self about financial situation

#### **Behaviours:**

- ☐ Gambling
- ☐ Drug use
- ☐ Spending a lot of time alone

## Reminding self of reasons for living

In a suicidal crisis, it can be challenging for patients to remember their reasons for living.<sup>283</sup> Reasons for living can be relational ("I love my husband and my children and I want to see them grow up"), illness-related ("I know that I am sick, and I know that I will get better"), spiritual ("My faith teaches me that suicide is not an option"), personal ("I've accomplished so much and I am a good person who deserves to live"), or related to hopes for the future ("I want to go back to school and travel the world").

## Employing internal coping strategies

In this step, patients are asked to reflect on what they can do on their own to reduce their thoughts of suicide.<sup>284</sup> Building skills to manage suicidal thoughts on one's own can increase patients' self-efficacy, autonomy, and sense of agency and make them feel less vulnerable to suicidal thoughts.<sup>285</sup> Coping strategies are identified in collaboration between the clinician and the patient; personalized strategies are informed by the patient's life history, personality style, and culture.<sup>286–289</sup> Coping strategies can include going for a walk, listening to music, taking a bath, writing poetry, playing an instrument, spending time with a pet, exercising, engaging in a hobby, cooking or baking, reading, doing chores, meditation, or engaging in spiritual activities.<sup>290–293</sup> The clinician can review the effectiveness of these strategies with the patient; if a coping strategy is not useful, the clinician and patient can review ways to overcome challenges in its use or brainstorm alternative strategies.<sup>294</sup>

## Using social contacts and social settings to distract from suicidal thoughts

The next step in the safety plan focuses on socialization intended to distract from suicidal thoughts versus seeking support for these thoughts explicitly.<sup>295</sup> The goals are to distract from the thoughts, feel connected to others, and experience a sense of belongingness.<sup>296</sup> Strategies can include volunteering, attending locations where socialization occurs naturally (going to a coffee shop, places of worship, AA meetings, libraries, or drop-in centre), or contacting people or groups of people without the goal of discussing suicidal thoughts directly (calling a friend to see a movie, going out to dinner with a family member).<sup>297</sup> Questions that may be useful in identifying useful contacts and settings include:

- “Who helps you feel good when you socialize with them?”
- “Who helps you take your mind off your problems at least for a little while? You don’t have to tell them about your suicidal feelings.”
- “Where can you go where you’ll have the opportunity to be around people in a safe environment?”<sup>298</sup>

Patients should avoid choosing locations where alcohol or drugs are easily available.<sup>299</sup>

## Using family members or friends to help resolve a crisis

If the internal and social coping strategies are not effective, patients can then inform close contacts (family members or friends) to ask for support. In this step, the patient explicitly reveals to others that they are in crisis or experiencing suicidal thoughts.<sup>300,301</sup> The clinician and patient should carefully discuss which close contacts are experienced as supportive, are available, and are aware that the patient is struggling.<sup>302</sup> Clinicians may ask, “Among your family or friends, who do you think you could contact for help during a crisis?” or “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”<sup>303</sup> Ideally, the safety plan is shared with these contacts ahead of time so they are aware and comfortable providing this kind of support.<sup>304,305</sup> Unfortunately, some patients may not feel comfortable disclosing suicidal thoughts or their safety plan with family or friends.<sup>306</sup>

## Contacting mental health professionals or agencies

If the first five steps do not reduce the patient’s distress or thoughts of suicide, he or she can contact mental health services and care team members for support.<sup>307–310</sup> It is important for the patient and clinician to review which health care providers are available to be contacted and at what time.<sup>311</sup> The names, telephone numbers, and locations should be listed in order of patient’s preference and appropriateness.<sup>312</sup> The safety plan should also include after-hours resources (for example, crisis lines or nearest emergency department).<sup>313</sup> Consequences and barriers to contact must also be addressed (for example, is the patient afraid he or she may be hospitalized?).<sup>314</sup>

## Restricting access to lethal means

The discussion about means restriction should occur after the rest of the safety plan is developed to show the patient that there are other ways of coping with distress; this can potentially allow for a collaborative discussion about means restriction.<sup>315</sup>

Even if patients do not have a specific plan for suicide, restricting access to lethal means is an important intervention in suicide prevention, specifically restricting access to firearms.<sup>316–318</sup> Alcohol and drugs of abuse, which can be co-ingested in overdose attempts, should be kept out of the home.<sup>319</sup> The clinician should work with the patient to ensure he or she does not have access to dangerous quantities of medication.<sup>320–322</sup> Safety plans may also include the provision for the safe storage of sharp objects, including razor blades and knives.<sup>323</sup>

Household toxins and poisons should also be stored safely to prevent ingestion.<sup>324</sup> If there are other objects that are identified as being of potential use in a suicide attempt, such as rope or neckties, then these should be stored so that the patient does not have access.

### Reducing frequency of follow-up or terminating specialized mental health care

The frequency of follow-up should be determined collaboratively by the patient, primary care clinician and mental health clinician. If the patient has responded to treatment and has exhibited a reduction in thoughts of suicide, it can be appropriate to reduce the frequency of visits. Prior to any change, a full suicide risk assessment should be conducted to ensure that a new level of care is adequate to meet the patient’s needs. If the clinician is continuing to adjust medication, close follow-up is needed. The patient and patient’s family (if consent is given) should also be made aware of the best way to contact the treating team if symptoms worsen or if the patient experiences new or worsening thoughts of suicide. The patient’s safety plan should also be updated.

## TREATING MENTAL HEALTH CONDITIONS ASSOCIATED WITH ELEVATED RISK FOR SUICIDE

### Overview

Regardless of the level of acute suicide risk, clinicians should actively and aggressively manage mental health or addiction conditions associated with the risk of suicide. Treatment options include medication management, somatic treatments, and psychotherapy. All treatment should be administered in accordance with evidence-based guidelines. We also strongly recommend that clinicians use best practice guidelines to manage specific diagnoses. While guidelines are not a substitute for clinical judgement, they are a tool that can assist in providing evidence-based care and a rational framework for treatment.<sup>325</sup>

We strongly recommend the use of rating scales in treating mental health disorders and addictions. Measurement-based care refers to the systematic use of measurement tools, including validated rating scales, to monitor patient outcomes and support clinical decision-making.<sup>326–328</sup> Table 2 also provides examples of appropriate rating scales that clinicians can use to guide and monitor response to treatment.

**TABLE 2. Selected psychiatric rating scales for use in monitoring symptom severity and response to treatment<sup>329,330</sup>**

DIAGNOSIS	SELF-RATED SCALES
Major depressive disorder or bipolar disorder, depressive phase	Patient Health Questionnaire (PHQ-9)* Beck Depression Inventory II (BDI-II)
Posttraumatic stress disorder	PTSD Checklist for DSM-5 (PCL-5)
Substance use	Alcohol Use Disorders Identification Test (AUDIT)

\* Appendix 3 of this handbook



## Medication management

A full review of the treatment of each diagnosis is beyond the scope of this handbook, but we encourage clinicians to prescribe medications in accordance with evidence-based clinical guidelines for managing the patient's mental health disorder or disorders. In this section, we provide a brief overview about medication-related issues specific to patients at risk for suicide. Medication should not generally be prescribed to address suicide risk in the absence of a psychiatric diagnosis.

### ► *Medications and risk for suicide*

When a patient is identified as being at acute risk for suicide, the clinician should review the patient's current medication regimen, paying attention to the onset or worsening of suicidal thoughts or behaviour and its relationship to medication changes (i.e., stopping a medication, starting a medication, or increasing the dose of a medication). In rare cases, medications can induce thoughts of suicide through unclear mechanisms, potentially including akathisia or restlessness, activation, or inducing manic symptoms.<sup>331–333</sup> Patients under age 25 may be at higher risk for antidepressant-induced suicidality.<sup>334</sup> In 2004, Health Canada and the U.S. Food and Drug Administration issued a black box warning for antidepressants due to an increased risk of suicidal thoughts and behaviour in children and adolescents taking these medications. In 2007, this warning extended to all people under age 25.<sup>335</sup> However, for people at risk of suicide due to untreated major depressive disorder, the risks of medication treatment are very likely to be outweighed by the benefits.<sup>336,337</sup> People under age 25, and all patients on medication therapy who are at acute risk for suicide, should be monitored carefully for worsening of suicidal thoughts or behaviour during the treatment initiation phase.<sup>338–340</sup>

Medications that have been associated with the potential to increase risk for suicide include anti-epileptic agents (felbamate, lamotrigine, oxcarbazepine, tiagabine, zonisamide, valproate, carbamazepine, gabapentin, levetiracetam, pregabalin, and topiramate), acamprosate, belimumab, efavirenz, emtricitabine, rilpivirine, tenofovir, interferon, peginterferon alfa 2a and 2b, metoclopramide, milnacipram, sodium oxybate, tramadol, varenicline, ziconotide, isotretinoin, and zolpidem.<sup>341</sup> Patients at risk for suicide who have taken or will take these medications should be made aware of the risk and monitored closely.

### ► *Lithium for suicidal ideation and behaviour*

Many studies since the 1970s have shown that lithium demonstrates anti-suicidal effects.<sup>342–345</sup> Lithium is a first-line treatment for the manic, depressive, and maintenance phases of bipolar disorder and is a first-line augmentation strategy in major depressive disorder.<sup>346,347</sup> Lithium should be considered for patients at risk for suicide with a diagnosis of bipolar disorder or who have partially responded to an antidepressant.<sup>348–350</sup> Lithium has a narrow therapeutic window and care must be taken to limit the quantities in the patient's possession if they are at risk of overdose. Lithium should only be prescribed in close collaboration between the primary care and mental health providers, as it requires a thorough medical work up prior to initiating treatment, close monitoring, and caution in using it with other common medications (including nonsteroidal anti-inflammatory drugs [NSAIDs] and anti-hypertensive medication).

### ► *Safe prescribing for patients who are at risk for suicide*

The care team, family members, and pharmacy should work with the patient to ensure they do not have access to dangerous quantities of medication. Blister packs, daily dispensing, and entrusting a family member to provide medication can all be useful strategies to prevent overdose. Caution is needed when prescribing medications such as benzodiazepines, and opiates, which can cause disinhibition or respiratory depression and have the potential for abuse.<sup>351</sup>



## Psychotherapy

Psychotherapy is a first-line intervention for several psychiatric conditions, either on its own or in combination with medication.<sup>352–354</sup> CAF service members can obtain psychotherapy through Psychosocial Services, the General Mental Health Program (GMH), or an Operational Trauma Stress Support Centre (OTSSC).<sup>355</sup> Both the GMH and the OTSSC provide psychotherapy, including cognitive-behavioural therapy (CBT), eye movement desensitization and reprocessing (EMDR), cognitive processing therapy (CPT), and prolonged exposure (PE) therapy for conditions such as depression, anxiety disorders, and PTSD.<sup>356</sup> OTSSCs provide assessment and individual and group treatment for members with a diagnosis of a mental illness that resulted from operational duties.<sup>357,358</sup>

Dialectical behavioural therapy (DBT) is one of the few treatments that has shown a reduction in suicidal behaviour in patients with borderline personality disorder.<sup>359–361</sup> DBT consists of four modules (mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness) and includes group and individual therapy components.<sup>362</sup> DBT has also been used to treat people with substance use, eating, and mood disorders.<sup>363</sup>

## TREATING SUBSTANCE USE DISORDERS ASSOCIATED WITH ELEVATED RISK FOR SUICIDE

The presence of a substance use disorder is a major risk factor for suicidal ideation, suicide attempts, and death by suicide in civilian and military populations.<sup>364–367</sup> Intoxicated individuals are at higher acute risk for suicide due to impaired judgement, disinhibition, worsening impulsivity, and greater susceptibility to respiratory depression. If a client is intoxicated and at high acute risk for suicide, they should be transferred safely to an emergency department for stabilization and treatment.<sup>368</sup> If the patient is agitated or aggressive, law enforcement support may be required.<sup>369</sup> Substance use disorders can also promote feelings of isolation, guilt, shame, hopelessness, and despair, and can increase suicidal thoughts or behaviours.<sup>370,371</sup>

## SUICIDE–SPECIFIC INTERVENTIONS

Cognitive-behavioural therapy (CBT) for suicide prevention is a promising intervention for reducing suicide-related behaviour, regardless of diagnosis.<sup>372,373</sup> CBT for preventing suicide can be done on an outpatient basis and therapy is offered in approximately ten sessions.<sup>374</sup>

## PSYCHOSOCIAL SUPPORTS

Suicide risk is informed by biological, psychological, social, and cultural factors. Feeling ashamed of, or trapped by, life circumstances can foster a sense of alienation and burdensomeness in people at risk for suicide.<sup>375–377</sup>

The Canadian Armed Forces Psychosocial Services program offers psychoeducation, crisis intervention and short-term counselling services to address issues and stressors that could be contributing factors to a member's suicidal ideation, including relationship or family-related problems, workplace issues, adjustment difficulties, or personal crises.<sup>378</sup> Military mental health chaplains are also available to provide counselling on matters including grief and moral injury.

Financial stressors, including debt, housing insecurity, and fears about having to leave the military should be assessed and information about supports, such as Service Income Security Insurance Plan (SISIP), should be provided.

# THE CLINICIAN'S EXPERIENCE

## THE EMOTIONAL EXPERIENCE OF WORKING WITH SUICIDAL CLIENTS

Primary care and mental health clinicians regularly work with clients who are at risk for suicide. Working with patients who are at risk for suicide can be challenging, both professionally and emotionally.<sup>379</sup> Research suggests that caring for clients who make suicidal statements or engage in suicidal behaviours is one of the most stressful situations a clinician can encounter.<sup>380</sup> The ambiguity and uncertainty of whether a patient with whom the clinician has developed a relationship will remain safe and alive can cause feelings of inadequacy and helplessness.<sup>381,382</sup> Clinicians can be at risk for burnout, a state of emotional exhaustion, compassion fatigue, and feelings of incompetence.<sup>383–385</sup>

If you are experiencing anxiety or distress related to your work with suicidal clients that is interfering with your ability to enjoy your work or home life, consider asking for help from your supervisor or health care provider.

## LOSING A PATIENT TO SUICIDE

### SUPPORTING CLINICIANS

Losing a patient to suicide is consistently reported as one of the most stressful experiences for health care professionals.<sup>386,387</sup> One-third of all mental health social workers and 50% to 70% of all psychiatrists have experienced a patient dying by suicide, with comparable rates seen in psychologists and mental health nurses.<sup>388,389</sup> Health care professionals not only experience grief reactions, they may also experience feelings of guilt, incompetence, anger, and fear of litigation.<sup>390–392</sup> The following section provides a brief outline of steps that can be taken to support clinical staff following a suicide death.

#### Immediate response

Staff should be provided with information about where they can seek emotional and psychological counselling.<sup>393</sup> Discussing the details of the patient's care to look for problems or assign blame is not appropriate or productive immediately after the event. Encourage staff members to engage in self-care and provide ample opportunities for formal and informal conversations and support. Involvement in bereavement rituals, including attending funerals, speaking with the family, or sending cards or flowers, may be appropriate and helpful, but should be done in a way that respects the family's wishes, boundaries, and confidentiality.<sup>394,395</sup> Staff members may be concerned about potential legal or professional ramifications of the suicide; management can refer them to the appropriate resources, including their college's protective agency or union.

#### Next steps

In the days and weeks after the suicide, debriefing meetings and clinical and peer supervision can be helpful.<sup>396</sup> The goal is to express feelings and provide support rather than assign blame.<sup>397</sup> Once the staff member has regained confidence, the team can review existing processes to see if care for suicidal patients can be improved. In the event of this tragedy, it is crucial to examine the patient-, environment-, and system-related factors, as well as the factors related to care delivery, that may have contributed to this outcome.

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## SUPPORTING FAMILIES, LOVED ONES, AND SERVICE MEMBERS

Family members and friends who lose a loved one to suicide are often referred to as “suicide survivors.”<sup>398–400</sup> In the event of a suicide, providing support to family members and CAF members directly affected by a suicide is of utmost importance. While CFHS does not directly provide health services to civilian family members, where appropriate, clinicians can provide information about accessing civilian care and resources, as well as CAF resources such as the CFMAP Bereavement Services and the Helping Our Peers by Providing Empathy (HOPE) program.

The treating team can contact the family early on to arrange a meeting to offer support. Suicide survivors, including family, friends, and chain of command, are grieving the death, and might also experience other intense emotions including feeling abandoned, ashamed, angry, guilty, confused, or relieved.<sup>401</sup> Clinicians who are working with suicide survivors should be aware that they may be experiencing conflicting and uncomfortable emotions and require an empathic, validating, and non-judgemental response. People may express anger toward the care team, the health care system, the armed forces, their loved ones, or themselves.<sup>402</sup> Anger (in the absence of threatening behaviour) is a normal reaction to grief, and clinicians can provide a safe space for people to process their loss.<sup>403</sup>

The Canadian Association of Suicide Prevention (CASP) website has many resources available for suicide survivors, including a handbook entitled “*After a Suicide: A Practical and Personal Guide for Survivors*.” This handbook contains practical information, including a review of emergency response and investigation; making arrangements; what to say to others; information about grief; and how to support children and teenagers.<sup>404</sup>

# APPENDICES

## APPENDIX 1: COLUMBIA–SUICIDE SEVERITY RATING SCALE (C–SSRS) *Screen Version/Recent*

SUICIDE IDEATION DEFINITIONS AND PROMPTS		Past month	
Ask questions that are bolded and <u>underlined</u> .		YES	NO
<b>Ask Questions 1 and 2</b>			
1) <b><u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>			
2) <b><u>Have you actually had any thoughts of killing yourself?</u></b>			
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.			
3) <b><u>Have you been thinking about how you might do this?</u></b> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."			
4) <b><u>Have you had these thoughts and had some intention of acting on them?</u></b> As opposed to "I have the thoughts but I definitely will not do anything about them."			
5) <b><u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></b>			
6) <b><u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u></b>  Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.  If YES, ask: <b><u>Was this within the past three months?</u></b>		YES	NO

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.  
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## APPENDIX 2: COLUMBIA–SUICIDE SEVERITY RATING SCALE (C–SSRS) *Screener/Since Last Contact (Self–Report)*

Please answer questions 1 and 2	Since Last Contact	
	YES	NO
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts of killing yourself?		
<b>If YES, answer all questions 3, 4, 5, and 6.</b> <b>If NO, skip directly to question 6.</b>		
<b>3) Have you thought about how you might do this?</b> <i>(For example, "I thought about taking an overdose but I never worked out the details about when, where, and how I would do that and I would never act on these thoughts.")</i>	↓	
<b>4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them?</b> <i>(For example, "I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.")</i>		
<b>5) Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan?</b> <i>(For example, "I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.")</i>		
<b>6) Have you done anything, started to do anything, or prepared to do anything to end your life?</b> <i>(For example: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.)</i>		

## APPENDIX 3: PERSONAL HEALTH QUESTIONNAIRE 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
=Total Score: \_\_\_\_\_

---

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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## APPENDIX 4: RISK ASSESSMENT AND FORMULATION DOCUMENTATION TEMPLATE

**Rationale for Suicide Risk Assessment** (i.e., positive screen, new or worsening mental health concerns, repeat assessment for patient at elevated risk for suicide, concerned family member)

### ***HISTORICAL INFORMATION***

**History of Suicide Attempts** (number of attempts, most recent attempt, method, lethality, efforts to seclude, emotional reaction to surviving attempt) **Y/N**

**History of Suicidal Ideation, Intent or Plan, Preparatory Behaviour** **Y/N**

**History of Deliberate Self-Harm** (description of behaviour, onset, frequency, intensity, triggers, explanatory model)

**Non-Modifiable Risk Factors** (gender, age, race, military rank, sexual orientation, gender identity, family history of suicide-related behaviour, history of trauma)

---

## APPENDIX 4: CONTINUED

### ***CURRENT RISK***

**Suicidal Ideation, Intent and Plan, Preparatory Behaviour within the last month;  
Access to Firearms (or since last visit) Y/N**

**Suicide Attempts or Deliberate Self-Harm within the last month (or since the last visit) Y/N**

**Acute Risk Factors** (mental health concerns, substance use, relationship, military, legal or financial stress, recent trauma) **Y/N**

**Warning Signs** (agitation, worsening insomnia, irritability, anxiety, hopelessness, suicidal communication, psychosis including command hallucinations, planning for carrying out suicide plan, making arrangements for death, worsening substance use or intoxication) **Y/N**

**Protective Factors** (personal factors, social supports, religious or spiritual supports, engagement in treatment, ability to safety plan) **Y/N**



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## APPENDIX 4: CONTINUED

**Collateral Information Obtained Y/N** (rationale for same)

--

### ***FORMULATION AND PLAN***

**Risk Formulation:**

--

**Risk Status:** (patient's risk compared to general population, outpatients, inpatients)

--

**Risk State:** (patient's risk compared to their own baseline and other points in their history)

--

**Safety and Treatment Plan:**

--

## APPENDIX 5: COLUMBIA–SUICIDE SEVERITY RATING SCALE (C–SSRS) *Lifetime/Recent Version*

Lifetime/Recent Version

Version 2009-01-14

*Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.*

*Disclaimer:*

*This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale (C-SSRS) are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behaviour depends on the judgment of the individual administering the scale.*

*Definitions of behavioural suicidal events in this scale are based on those used in **The Columbia Suicide History Form**, developed by John Mann, MD, and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M.A., Halberstam B. & Mann J.J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.] Standardized Evaluation in Clinical Practice, pp. 103-130, 2003.)*

*For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; for enquiries and training requirements contact [posnerk@nyspi.columbia.edu](mailto:posnerk@nyspi.columbia.edu).*

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## APPENDIX 5: CONTINUED

<b>SUICIDAL IDEATION</b>		
<p>Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behaviour" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.</p>	<b>Lifetime: Time He/She Felt Most Suicidal</b>	<b>Past 1 Months</b>
<p><b>1. Wish to be Dead</b> Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><b>2. Non-Specific Active Suicidal Thoughts</b> General non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/ associated methods, intent, or plan during the assessment period. <i>Have you actually had any thoughts of killing yourself?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><b>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</b> Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it....and I would never go through with it". <i>Have you been thinking about how you might do this?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><b>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan</b> Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them". <i>Have you had these thoughts and had some intention of acting on them?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p><b>5. Active Suicidal Ideation with Specific Plan and Intent</b> Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i></p> <p>If yes, describe:</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<b>INTENSITY OF IDEATION</b>		
<p>The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.</p>		
<p><u>Lifetime</u> - <b>Most Severe Ideation:</b></p> <p>Type # (1-5) _____ Description of Ideation _____</p>	Most Severe	Most Severe
<p><u>Past 1 Month</u> - <b>Most Severe Ideation:</b></p> <p>Type # (1-5) _____ Description of Ideation _____</p>		
<p><b>Frequency</b> <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day</p>	_____	_____
<p><b>Duration</b> <i>When you have the thoughts, how long do they last?</i> (1) Fleeting - a few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of the time (4) 4-8 hours/most of the day (5) More than 8 hours/persistent or continuous</p>	_____	_____
<p><b>Controllability</b> <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (6) Does not attempt to control thoughts</p>	_____	_____
<p><b>Deterrents</b> <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (6) Does not apply</p>	_____	_____
<p><b>Reasons for Ideation</b> <i>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</i> (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (6) Does not apply</p>	_____	_____

## APPENDIX 5: CONTINUED

<b>SUICIDAL BEHAVIOUR</b> (Checkmark all that apply, as long as these are separate events; must ask about all types.)		<b>Lifetime</b>		<b>Past 3 Months</b>	
<b>Actual Attempt:</b> A potentially self-injurious act committed with at least some wish to die, <i>as a result of the act</i> . Behaviour was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is <b>any</b> intent/desire to die associated with the act, then it can be considered an actual suicide attempt. <b>There does not have to be any injury or harm</b> , just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behaviour or circumstances. For example, a highly lethal act that is clearly not an accident so that no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. <b>Have you made a suicide attempt?</b> <b>Have you done anything to harm yourself?</b> <b>Have you done anything dangerous where you could have died?</b> <b>What did you do?</b> <b>Did you _____ as a way to end your life?</b> <b>Did you want to die (even a little) when you _____?</b> <b>Were you trying to end your life when you _____?</b> <b>Or did you think it was possible you could have died from _____?</b> <b>Or did you do it purely for other reasons/without ANY intention of killing yourself (such as to relieve stress, feel better, get sympathy, or get something else to happen)?</b> (Self-Injurious Behaviour without suicidal intent) If yes, describe:		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<b>Has subject engaged in Non-Suicidal Self-Injurious Behaviour?</b>		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<b>Interrupted Attempt:</b> When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act ( <i>if not for that, actual attempt would have occurred</i> ). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or person is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. <b>Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?</b> If yes, describe:		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<b>Aborted Attempt:</b> When person begins to take steps towards making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behaviour. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. <b>Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?</b> If yes, describe:		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<b>Preparatory Acts or Behaviour:</b> Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). <b>Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?</b> If yes, describe:		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
<b>Answer for Actual Attempts Only</b>		Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:	
<b>Actual Lethality/Medical Damage:</b> 0. No physical damage or very minor physical damage (e.g., surface scratches) 1. Minor physical damage (e.g., lethargic speech, first-degree burns, mild bleeding, sprains) 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive, second-degree burns, bleeding of major vessel) 3. Moderately severe physical damage; <i>medical</i> hospitalization and likely intensive care required (e.g., comatose with reflexes intact, third-degree burns less than 20% of body, extensive blood loss but can recover, major fractures) 4. Severe physical damage; <i>medical</i> hospitalization with intensive care required (e.g., comatose without reflexes, third-degree burns over 20% of body, extensive blood loss with unstable vital signs, major damage to a vital area) 5. Death		Enter Code	Enter Code	Enter Code	
<b>Potential Lethality: Only Answer if Actual Lethality = 0</b> Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; lying on train tracks with oncoming train but pulled away before run over).  0 = Behaviour not likely to result in injury 1 = Behaviour likely to result in injury but not likely to cause death 2 = Behaviour likely to result in death despite available medical care		Enter Code	Enter Code	Enter Code	

## APPENDIX 6: CLINICAL SCENARIOS: SUICIDE RISK ASSESSMENT, MANAGEMENT, AND TREATMENT

### CASE #1: NO IDENTIFIED ACUTE RISK FOR SUICIDE

Corporal Singh is a 25-year-old single female Mobile Service Equipment Operator (MSE Op). She was seen in clinic today for a follow-up regarding a Holter monitor and other investigations after experiencing what was likely a panic attack. She has not experienced panic attacks before, although she acknowledges she has always been “an anxious person.” She is presenting for the first time with mental health concerns, so a full suicide risk assessment was completed.

Cpl Singh has no history of suicidal behaviour and no history of suicidal ideation. She has no history of deliberate self-harm. She has no current active or passive suicidal ideation. She is a gun collector and has firearms at home.

With respect to non-modifiable risk factors for suicide, Cpl Singh has no family history of suicidal behaviour. In terms of acute risk factors, she does meet criteria for panic disorder and likely generalized anxiety disorder. She uses alcohol socially. She has a supportive unit and, although she is single, she has many supportive friends, colleagues, and family members. She is committed to following up with her care, and states that she would advise her clinician if she had any active or passive thoughts of suicide.

**Risk Determination:** Very low acute risk. Patient does not have any suicidal ideation or history of suicidal ideation and is engaged in primary health care.

**Risk Status:** Compared to all military members, Cpl Singh is at, or very near, baseline risk. She does have diagnoses of two anxiety disorders, with recent exacerbation of symptoms, but she does not have many demographic or other clinical risk factors. Her suicide risk is lower than most psychiatric outpatients and almost all psychiatric inpatients.

**Risk State:** Compared to her own baseline, Cpl Singh’s risk state is not elevated. Even though she has a recent exacerbation of anxiety symptoms, she denies any suicidal ideation. Also, she has had episodes of increased anxiety in the past that have never been associated with suicidal thoughts.

#### ► **Management and Treatment**

1. Go to nearest emergency department if she develops thoughts of suicide.
2. Referral to mental health clinician for treatment of anxiety symptoms.
3. Discussion of initiation of SSRI in accordance with evidence-based guidelines.
4. Referral to psychiatrist if there is no, or poor, response to treatment plan.
5. Screen for suicide briefly at each visit.
6. Return to see primary care clinician in two weeks’ time.
7. Clinician to assign appropriate Medical Employment Limitations (MELs).

## CASE #2: LOW ACUTE RISK FOR SUICIDE

Lieutenant-Commander Tremblay is a 37-year-old sea logistics officer, and is married with children. He was seen in clinic today for assessment and management of major depressive disorder. A full suicide risk assessment was conducted as LCdr Tremblay endorsed suicidal ideation on the PHQ-9.

LCdr Tremblay has no history of suicide attempts or history of suicidal ideation prior to the past two months. He has no history of deliberate self-harm.

He began to experience passive suicidal ideation about two months ago, around Christmas time, in the context of his depressive symptoms. He described these thoughts as “I felt like I would be better off dead.” They did not occur every day, but “often enough to make me upset.”

Over the past two weeks, LCdr Tremblay has had fleeting thoughts of ending his life: “I sometimes imagine drowning myself in my bathtub.” He does not consider this a plan: “I would never do anything like that.” He is very distressed by these thoughts and does not wish to act on them. He has not thought about other ways to end his life. He has not engaged in any preparatory behaviour (no rehearsing method or making arrangements for death). He owns a few firearms and keeps them at home.

LCdr Tremblay has non-modifiable risk factors for suicide: he is middle-aged and male. He also has no family or personal history of suicide attempts.

With respect to acute risk factors, in addition to new-onset active suicidal ideation with a plan and no intent, he has significant symptoms of depression and his PHQ-9 scores have increased since his last appointment. However, he is continuing to perform well at work, does not use alcohol or drugs, and has a supportive relationship with his wife. He does not meet criteria for an anxiety disorder. He did experience some combat trauma several years prior (“I don’t think about it too much”). He has not exhibited any warning signs for suicide. He has no history of violence or thoughts of harming others. He has brought himself in for care, has confided in his wife when suicidal thoughts intensified (she is at this appointment), and his wife now holds the key to his firearm locker. She is worried for him, but has no imminent concerns for his safety. Protective factors include that he is married and has children, religious affiliation and church support (he has confided in his pastor), a supportive commanding officer, faith in the treatment process, good therapeutic alliance, and a willingness to safety plan.

**Risk Determination:** Low acute risk. Patient has suicidal ideation with a poorly formed plan but no intent, limited risk factors, several protective factors, and no warning signs for suicide.

**Risk Status:** Compared to all military members, LCdr Tremblay is at elevated risk for suicide. Compared with all psychiatric patients, LCdr Tremblay is at slightly elevated risk for suicide. Compared with psychiatric inpatients, LCdr Tremblay is at low risk for suicide. His risk can be managed with close outpatient follow-up and psychiatric consultation.

**Risk State:** Compared to his own baseline, LCdr Tremblay is at higher risk for suicide than his baseline. This suggests the need for treatment and support.

### ► **Management and Treatment**

1. Complete a safety plan, and include the following points:
  - a. Go to nearest emergency department if thoughts of suicide intensify.
  - b. Recommend no alcohol use in the next several months, as intoxication can increase risk for suicidal behaviour.

- c. Complete safety plan and provide information to LCdr Tremblay and his wife regarding crisis lines and resources.
  - d. Provide education to his wife regarding warning signs for suicide, means restriction, and information about depression and treatment.
2. Treatment Plan
- a. Primary care clinician will optimize treatment for depression per evidence-based guidelines, and may consider referral to psychiatrist for assessment of medications.
  - b. Referral to mental health clinician for appropriate therapy.
  - c. There is no indication that LCdr Tremblay's condition is interfering with his work; in fact, he states that he feels better when he has the routine of work. While he will require MELs, he should continue working full-time.
  - d. LCdr Tremblay may decide to discuss his depressive symptoms and thoughts of suicide with his unit commander, who he considers to be trustworthy.
  - e. Return to see primary care clinician in one week's time.

## **CASE #3: MODERATE ACUTE RISK FOR SUICIDE**

Sergeant Peterson is a 43-year-old infantryman who is separated from his wife. He was seen in clinic today at the behest of his friend and fellow soldier, who accompanied him to the urgent appointment. Sgt Peterson's colleague, Sgt O'Brien, reported that Sgt Peterson stated "What's the point of any of this? I should just kill myself," in the context of alcohol use earlier this week. Sgt Peterson regretted this statement and agreed that it was time for him to get mental health support.

Sgt Peterson had one suicide attempt 20 years ago, at the age of 23. At the time, he had been diagnosed with depression and was also abusing opiates prescribed to him for a knee injury. He had active suicidal ideation with thoughts of overdose but no intent. In the context of intoxication, his suicidal ideation became active and he became more impulsive, and he took an overdose of opiates. He was found by his roommate, who called 911, and was admitted to hospital for two weeks, where he received treatment for his depression (fluoxetine, 40 mg). He felt ashamed and sorry for his suicide attempt and reconnected with his parents and other supports. He did not require methadone maintenance therapy and stopped using opiates at the time. He enlisted in the military the next year and had been stable since, discontinuing fluoxetine before enlistment. Prior to this episode, he had active thoughts of suicide without intent or plan in high school in the context of bullying and family conflict. He had a history of deliberate self-harm in high school (head banging, once or twice a month when distressed, for six months), but none since.

Within the last two months, Sgt Peterson reports thinking about wanting to die "every day, several times a day." These thoughts are worse when he is intoxicated with alcohol, which is happening two to three times per week (8 to 10 beers a night). When he is intoxicated, he will "look up what could kill me" on the Internet, and thoughts of dying provide him with a sense of relief. Even when he is intoxicated, however, he is ambivalent about his intent: "I want to end the pain, but I don't want to hurt people who care about me. I want things to be better than this." He has not engaged in any preparations for death. He has not thought about a method to end his life. He has not stockpiled any medications. He does not have any firearms at home. Due to his ongoing treatment for alcohol use disorder, he is on MELs that preclude him from driving Department of National Defence vehicles, handling a personal weapon, and working in an operational environment. He has not recently engaged in any self-harm or suicide attempts.

Sgt Peterson has several non-modifiable risk factors for suicide. He is a 43-year-old male. He has a family



history of suicidal behaviour (his mother had an overdose attempt when he was 12 in the context of depression, alcohol use, and marital breakdown). Sgt Peterson also has a history of childhood trauma (witnessed domestic violence, physical abuse from father). **He has a history (remote) of suicide attempt.**

With respect to acute risk factors, Sgt Peterson has several. In addition to suicidal ideation and suicidal communication, he has depressive symptoms (his PHQ-9 score was 20), and meets criteria for social anxiety disorder. His alcohol use escalated on return from deployment three months ago. Although he does not meet criteria for PTSD, combat-related trauma was noted. He also has separated from his wife in the last year and sees his two teenage children less frequently. He came to treatment for his alcohol use disorder three weeks ago with Sgt O'Brien's support. He is concerned about stigma and his career opportunities moving forward.

Warning signs for suicide include his suicidal communication to Sgt O'Brien in the context of intoxication, his alcohol use, and associated worsening suicidal ideation. He has been more anxious lately. He has no other warning signs for suicidal behaviour. He has no thoughts of harming others.

Collateral information was obtained with Sgt Peterson's consent from Sgt O'Brien and his addictions counsellor. Sgt O'Brien stated that he was most worried about his friend three weeks ago, but feels better that he is getting addictions treatment. He stated that he has heard Sgt Peterson make suicidal statements three times over the last month, all while intoxicated, and that Sgt Peterson has expressed regret for same and he has not described a plan or acted on these thoughts. His addictions counsellor states that Sgt Peterson has attended all appointments and has cut down on alcohol use significantly (from daily use to two to three times weekly). He is open to medication therapy to manage alcohol use disorder and will have a consultation with a psychiatrist in two days. No history of withdrawal symptoms or seizures; his addictions counsellor is not concerned about this, as the patient can go up to five days without alcohol use with no symptoms.

**Risk Formulation:** Sgt Peterson is at moderate acute risk for suicide. He has current suicidal ideation, but no intent to act, no plan and no recent attempt. However, he does have warning signs for suicide (intoxication resolved but may recur, and anxiety).

**Risk Status:** Compared to the general military population, Sgt Peterson is at elevated risk for suicide. Compared to others in outpatient treatment for mental health or substance use disorders, he is at elevated risk. Compared with psychiatric inpatients, his risk is equivalent or perhaps slightly lower.

**Risk State:** Importantly, compared to his own history, Sgt Peterson is at elevated risk from his baseline, but has been at higher risk for suicide in the past (for example, at age 23 he had a suicide attempt, opiate use disorder, and fewer protective factors). A month ago, he was likely at an elevated risk compared to today as he was using alcohol more often, was not connected with mental health or addictions resources, and was feeling more hopeless about his care.

#### ► **Safety and Treatment Plan:**

1. Attend to nearest emergency department if thoughts of suicide worsen.
2. The patient is not at high acute risk, and does not require emergent mental health assessment.
3. Safety plan completed, including staying with Sgt O'Brien and his family over the next week to provide support and a stabilizing environment. Sgt O'Brien will remove alcohol from his home, because **alcohol intoxication increases Sgt Peterson's risk significantly.**
4. Provided Sgt Peterson with handout for friends and family with contact numbers and warning signs for self-harm.
5. Spoke with primary care clinician who will see patient in consultation in two days' time to consider medications and/or inpatient treatment for alcohol use disorder.



6. Urgent psychiatric referral made; ideally patient can be seen within one week.
7. Primary care clinician will offer psychosocial referral to Sgt Peterson should he want to see someone to help him manage psychosocial stress.
8. Patient amenable to starting treatment with SSRI to manage comorbid depressive symptoms, prescribed and titrated in accordance with guidelines. The SSRI will also target symptoms of social phobia as it is first-line for both.
9. Referral for psychotherapy to manage symptoms of depression and anxiety.
10. The primary care clinician should aim to keep Sgt Peterson at work, preferably full-time, as this will give him structure and increase his social support.

## CASE #4: HIGH ACUTE RISK FOR SUICIDE

Corporal Simard is a 24-year-old traffic technician. He is single. He presents to his first appointment with his primary care clinician. He was referred by his psychosocial social worker, whom he was seeing for support because he is undergoing disciplinary action at his unit. A suicide risk assessment was undertaken because Cpl Simard endorsed thoughts of suicide on the C-SSRS (screener).

He has a history of one suicide attempt: at age 18, he overdosed on benzodiazepines and required an ICU admission. He also had an aborted suicide attempt last week; he had purchased a rope with which to hang himself, but his ex-girlfriend called 911 after Cpl Simard called to “say goodbye.” The police presented to Cpl Simard’s home. Cpl Simard was taken to the nearest emergency department where he told the doctor, “I was just being dramatic. I wanted her to come over. I wasn’t going to do anything.” He did not disclose that he had purchased a rope. He was disappointed that he was interrupted. He has no history of deliberate self-harm.

Today he continues to endorse strong suicidal ideation and intent (“It’s not a matter of if, but when...what’s the point in living?”). He has given away his dog and has drafted suicide notes to friends and family. When asked why he is disclosing this information, he states “I trust you—and maybe there’s a part of me that wants to get help.” He owns a firearm. When asked if he has thoughts of shooting himself he said, “Doesn’t everyone?” and would not elaborate.

His non-modifiable risk factors include young age and male sex. He has a history of physical trauma and neglect as a child. **He has a history of prior and recent suicidal behaviour.** Acute risk factors include strong depressive symptoms, poly-substance abuse (cocaine and opioids), few close contacts, recent romantic break-up, and military disciplinary action.

He was prescribed an SSRI last month for depression by his primary care clinician but stated, “What’s the point? Unless I overdose on them.”

Cpl Simard was agitated and irritable during the assessment. He was fidgeting in his chair and threatened to leave, and his affect was labile. He was slurring his words slightly and there was some question that he may be intoxicated. He has been communicating suicide intent, engaging in suicidal behaviour, and making arrangements for death. He does not have thoughts of harming others.

With respect to protective factors, the patient does not have many. He is socially isolated with few supports and is ambivalent about treatment (and does not think treatment will be effective).

Collateral information was obtained from the patient’s electronic health record. Given the clear high acute elevated risk, no further attempts were made to obtain collateral information.

**Risk Determination:** High acute risk. Persistent suicidal ideation; strong intention to act; not able to control impulsivity; recent suicide attempt and preparatory behaviour; several warning signs for suicide, including agitation and intoxication; multiple non-modifiable and acute risk factors; and few protective factors.

**Risk Status:** Compared to all military members, Cpl Simard is at extremely elevated risk for suicide. Compared with all psychiatric patients, he is at very elevated risk for suicide. Compared with psychiatric inpatients, Cpl Simard is at elevated risk for suicide. His risk cannot be managed as an outpatient.

**Risk State:** Compared to his own baseline, Cpl Simard is at much higher risk for suicide than his baseline. This suggests the need for emergent assessment, treatment and support.

### ► **Management and Treatment**

1. Safety Planning
  - a. During this current encounter, his primary care clinician (PCC) should assess this patient and ensure safe transfer to an emergency department consultation for admission to hospital. If his PCC is a nurse practitioner or a physician's assistant, then his PCC should liaise immediately with a physician, review the assessment, and the physician can arrange safe transfer to the emergency department.
  - b. The patient should not be left alone and must be accompanied by staff to the emergency department. If he demands to leave and is a safety threat, police must be contacted to apprehend patient under the province's mental health act (physician to complete appropriate paperwork).
  - c. The PCC should communicate immediately with the emergency department to provide collateral information. In this case, acute safety risk overrides patient confidentiality.
  - d. If patient is admitted to hospital, efforts should be made to be in close contact with the treating team.
  - e. PCC will ensure Cpl Simard is on appropriate MELs.
2. Future follow-up and planning will be addressed when emergent safety concerns are addressed. Cpl Simard should have follow-up with both primary care and mental health care within days of his hospital discharge. He will require ongoing safety assessments, evidence-based treatment for depression and substance use disorder, and psychosocial supports.

## APPENDIX 7: COLUMBIA–SUICIDE SEVERITY RATING SCALE (C–SSRS) *Since Last Visit (Clinical)*

Since Last Visit - Clinical

Version 1/14/09

*Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.;  
Burke, A.; Oquendo, M.; Mann, J.*

*Disclaimer:*

*This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.*

*Definitions of behavioral suicidal events in this scale are based on those used in **The Columbia Suicide History Form**, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.] Standardized Evaluation in Clinical Practice, pp. 103 -130, 2003.)*

*For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact [posnerk@nyspi.columbia.edu](mailto:posnerk@nyspi.columbia.edu)*

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## APPENDIX 7: CONTINUED

<b>SUICIDAL IDEATION</b>	
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	Since Last Visit
<b>1. Wish to be Dead</b> Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>  If yes, describe:	Yes No <input type="checkbox"/> <input type="checkbox"/>
<b>2. Non-Specific Active Suicidal Thoughts</b> General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. <i>Have you actually had any thoughts of killing yourself?</i>  If yes, describe:	Yes No <input type="checkbox"/> <input type="checkbox"/>
<b>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</b> Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it." <i>Have you been thinking about how you might do this?</i>  If yes, describe:	Yes No <input type="checkbox"/> <input type="checkbox"/>
<b>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan</b> Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <i>Have you had these thoughts and had some intention of acting on them?</i>  If yes, describe:	Yes No <input type="checkbox"/> <input type="checkbox"/>
<b>5. Active Suicidal Ideation with Specific Plan and Intent</b> Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i>  If yes, describe:	Yes No <input type="checkbox"/> <input type="checkbox"/>
<b>INTENSITY OF IDEATION</b>	
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).  <b>Most Severe Ideation:</b> _____ <div style="display: flex; justify-content: space-between;"> <span>Type # (1-5)</span> <span>Description of Ideation</span> </div>	Most Severe
<b>Frequency</b> <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	_____
<b>Duration</b> <i>When you have the thoughts, how long do they last?</i> (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time	_____
<b>Controllability</b> <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (6) Does not attempt to control thoughts	_____
<b>Deterrents</b> <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (6) Does not apply	_____
<b>Reasons for Ideation</b> <i>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</i> (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (6) Does not apply	_____

## APPENDIX 7: CONTINUED

<b>SUICIDAL BEHAVIOR</b>	Since Last Visit
<p>(Check all that apply; so long as these are separate events; must ask about all types)</p> <p><b>Actual Attempt:</b> A potentially self-injurious act committed with at least some wish to die, <i>as a result of act</i>. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is <b>any</b> intent/desire to die associated with the act, then it can be considered an actual suicide attempt. <b><i>There does not have to be any injury or harm.</i></b>, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. <b><i>Have you made a suicide attempt?</i></b> <b><i>Have you done anything to harm yourself?</i></b> <b><i>Have you done anything dangerous where you could have died?</i></b> <b><i>What did you do?</i></b> <b><i>Did you _____ as a way to end your life?</i></b> <b><i>Did you want to die (even a little) when you _____?</i></b> <b><i>Were you trying to end your life when you _____?</i></b> <b><i>Or did you think it was possible you could have died from _____?</i></b> <b><i>Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?</i></b> (Self-Injurious Behavior without suicidal intent) If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of Attempts _____</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p><b>Has subject engaged in Non-Suicidal Self-Injurious Behavior?</b></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p><b>Interrupted Attempt:</b> When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (<i>if not for that, actual attempt would have occurred</i>). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. <b><i>Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?</i></b> If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of interrupted _____</p>
<p><b>Aborted or Self-Interrupted Attempt:</b> When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. <b><i>Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?</i></b> If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of aborted or self-interrupted _____</p>
<p><b>Preparatory Acts or Behavior:</b> Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). <b><i>Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?</i></b> If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Total # of preparatory acts _____</p>
<p><b>Suicide:</b> Death by suicide occurred since last assessment.</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
	Most Lethal Attempt Date:
<p><b>Actual Lethality/Medical Damage:</b> 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; <i>medical</i> hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; <i>medical</i> hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death</p>	Enter Code  _____
<p><b>Potential Lethality: Only Answer if Actual Lethality=0</b> Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).  0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care</p>	Enter Code  _____

## APPENDIX 8: HANDOUT FOR FAMILIES

This handout can be given to family members or close contacts of those at risk for suicide. It provides information on support resources, warning signs for suicide, and contact information for the patient's treating team. This handout is adapted from "Suicidal Thoughts in a Family Member: Care Instructions" (Healthwise Staff, [myhealth.alberta.ca](http://myhealth.alberta.ca), 2016), "Suicide: What to do when someone is suicidal" (Mayo Clinic Staff, <http://www.mayoclinic.org>, 2015), and "Do you know someone who may be considering suicide?" (World Health Organization, [www.who.int](http://www.who.int), 2017).<sup>405–407</sup>

UNDERSTANDING SUICIDE RISK: INFORMATION FOR FAMILY MEMBERS
<b>How can I help my loved one while they are struggling with suicidal thoughts?</b>
<ul style="list-style-type: none"><li><input type="checkbox"/> Asking about suicide won't worsen suicidal thoughts or cause people to act on them. Talking to them about how they are feeling may even help them feel more safe and can help you decide how you can help.</li><li><input type="checkbox"/> Let them know you are there to listen and encourage them to be in communication with their health care team; you can also get in touch with the team if you have concerns that your loved one is feeling more depressed or is not acting like themselves.</li><li><input type="checkbox"/> Encourage your loved one not to drink alcohol or use drugs of abuse, and limit their exposure to situations where alcohol or drugs will be available. If your loved one has a substance use disorder, talk to their treating team about the best approach to take.</li><li><input type="checkbox"/> Offer to accompany them to their health care appointments or to other places that they may find stressful; engage other family and friends to create a support network.</li><li><input type="checkbox"/> If your loved one has a "Safety Plan" and is willing to share, keep a copy for yourself so you know what steps should be taken if they are feeling unwell.</li><li><input type="checkbox"/> Keep information for crisis lines readily available (pre-program them into your and your loved one's phone).</li></ul>
<b>How can I make our home as safe as possible</b>
<ol style="list-style-type: none"><li>1. <b>Make sure firearms are not easily available at home.</b> Ideally, firearms should be removed from the home. If firearms remain at home, they should be locked and stored separately from ammunition, and your loved one should not be able to access them.</li><li>2. <b>Keep alcohol and drugs of abuse out of the home.</b> Store medications safely and work with your loved one, their care team and pharmacy to ensure that they do not have access to large quantities of medications. Lock up pesticides and other dangerous household agents.</li><li>3. Remove access to sharp objects (knives, razor blades) if possible.</li></ol>

## APPENDIX 8: CONTINUED

### What are some warning signs for suicide?

- ☐ Engaging in a suicide attempt.
- ☐ Preparing for a suicide attempt – collecting medications, trying to get access to a firearm, researching ways to kill oneself or trying to buy means for death online.
- ☐ Writing suicide notes, saying goodbye to people, giving away belongings or getting affairs in order.
- ☐ Big changes in their personality, routine, thinking, or level of energy (for example, not sleeping, pacing all day, hearing voices or acting paranoid).
- ☐ Talking about suicide – saying things like, “I’m going to kill myself” or “people will be better off without me”.
- ☐ Feeling trapped, ashamed or hopeless.
- ☐ Risky, violent or self-destructive behaviour, or increasing alcohol or drug use.
- ☐ Withdrawing from things and people and wanting to be left alone.

### What do I do if my loved one is exhibiting warning signs for suicide?

1. **Keep yourself safe.** If your loved one is agitated, threatening or aggressive, ensure your own safety and the safety of others and **call 911**.
2. If your loved one is about to attempt or is attempting suicide and you are not at risk, do not leave them alone and **call 911**.
3. If you can do so safely, take your loved one to the nearest hospital emergency room. Make sure to contact their chain of command and/or health team so they are aware.
4. If your loved one is not willing to go to the emergency department or you are unsure if this is the right thing to do, get help from a professional as quickly as possible. You can call the Military Family Line for support, your loved one’s health care team if someone is available, or a 24-hour suicide prevention hotline.
5. Do not try to argue or challenge your loved one – try to stay supportive and calm if you can.

### Who can I contact if I have questions or I need support?

1. **Crisis lines:**

2. **Canadian Armed Forces Family Information Line** – Call 1-800-866-4546 (North America) or 00-800-771-17722 (Overseas) seven days a week, 24 hours a day for access to trained counsellors and support.
3. **You’re Not Alone: Mental Health Resources for CAF Members and Families** – <http://www.forces.gc.ca/en/caf-community-health-services/mental-health-resources.page>
4. Your loved one’s **primary care provider** or **mental health clinician** – if your loved one has given consent for you to speak to them.
5. Your own **primary care provider** – make an appointment with your own primary care provider to talk about how you’ve been feeling and to get support.

## APPENDIX 9: SAFETY PLAN TEMPLATE

The following safety plan template is adapted from Stanley and Brown's 2012 paper entitled "Safety Planning Intervention: A Brief Intervention to Mitigate Risk for Suicide" and the CAMH Suicide Prevention and Assessment Handbook (2011).<sup>408,409</sup>

SAFETY PLAN
<b>Step 1: Warning signs that I may not be safe</b>
1.
2.
3.
<b>Step 2: Remind myself of my reasons for living</b>
1.
2.
3.
<b>Step 3: Coping strategies that I use to distract myself or feel better</b>
1.
2.
3.
<b>Step 4: Social situations and people that can help distract me</b>
1.
2.
3.
<b>Step 5: People who I can ask for help</b>
1.
2.
3.



## APPENDIX 9: CONTINUED

<b>Step 6: Professionals or agencies I can contact during a crisis</b>
1.
2.
3.
4.
5.
<b>Step 7: Making my environment safe</b>
1.
2.
3.

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