Appendix A: Qualitative interview guides

Patient Qualitative Interview Guide 1 (4-months)

I. Interview - Lived Experience

In this first part of the interview, the focus is on the participant and their lived experience of suicidal thoughts and/or behaviours; their experience of help-seeking for these conditions; and their thoughts on what ideal care looks like. Try to probe for contextual detail; listen closely and aim to understand people and events in detail and the variety of circumstances under which experiences took place. Spend time on the first questions – at least 10 minutes – allowing the participant guide the conversation about themselves so you can get to know them and build rapport before moving on to more challenging topics.

The interview questions below are a guide and should be adapted throughout the interview; try to be flexible and responsive. For example, only ask questions the participant hasn't yet addressed.

Interview questions are in bold

"Thanks again for agreeing to do this interview. Like we talked about at the start, the goal today is to understand your personal experiences of suicidal thoughts and/or behaviours and help seeking, including what has worked well and what has not, and what resources you would have wanted in an ideal world."

1. **The first question I like to ask people is how did you hear about this study and what made you interested to participate?**

2. **Can you tell me a little bit about yourself and your life? Start with anything you like. This is so I can get to know you better.**

   Guidance: One reason for this question is to develop rapport with the participant. Another reason is to understand the participant's strengths by discussing what is important and who is important to them in their lives. This question is a reminder of the support networks and resources the participant has in their life currently. Asking this question is a protective factor for the interview and also highlights protective factors in the person's life.

   Prompts:

   The interviewer may need to use different prompts depending on the person:

-What does a typical day look like these days?/What do you do for work?

-Who are the most important people in your life?/Who's important to you?/ Who are the people closest to you?/Who are the key people in your life?

-What's important to you?/ What are some of your interests?

-Where do you live?/ Where did you grow up?

-What's going on with you these days/ What should I know about you?

3. **Can you tell me a little bit about your physical and mental health history? Maybe we can start with the first time (if ever) in your life you or people in your life had concerns about your mental health.**

(Please take notes on any healthcare providers and services accessed, and timeframes to use later in the interview)

Prompts:

-*What was your life like before you started to be concerned about your mental health?*

-*What was your life like when you were concerned about your mental health?*

-*Can you tell me what happened?*

If participant does not give years/dates for experiences, then ask for them to give approximate years/ages of when these things happened. The interviewer should construct a timeline when listening to the experiences to know when they happened, to keep in field notes.

It would be best if the history and the arc spanned most of the participant's life, from childhood to present. That can be prompted if the participant does not start from childhood. The interviewer can say (as appropriate and with sensitivity):

-*Can you tell me about your experiences in elementary school, in middle school, after high school?*

4. **(If not already covered). Can you tell me about any experiences you had seeking mental health care?**

(Please take notes on any healthcare providers and services accessed, and timeframes to use later in the prompts section)

Prompts:

-If participant has trouble thinking of times they sought help, or to supplement the discussion, ask:

-The first and/or last time they sought help

-Seeking help at the Emergency Room

-Seeking help as an outpatient (hospital outpatient groups, individual or group therapy, seeing a psychiatrist as an outpatient)

-Seeking or receiving help as an inpatient

-Seeking help through suicide/telephone hotlines; 911; family physicians; family/friends; teachers, support groups, other trusted people?

Please ask in each interview as prompts:

-What worked? Helped? (The easiest and/or most positive help-seeking experience(s) they have had)

-What didn't work? Was challenging? (The hardest and/or most negative help-seeking experience(s) they have had)

-What was needed? In an ideal world, when you or someone else seeking mental health care services, what do you think should happen? Should not happen?

Please ask in each interview:

-You have told me about a number of health care providers or services that you encountered and health care services that you accessed, during your experiences of seeking mental health care. I'm going to briefly summarize them. (Please list the health care providers and services accessed).

-Are there any more health care providers or services that you accessed during your experiences of seeking mental health care that we have not talked about, that you would like to mention?

-(If it was not clear from the participant's previous answers): Can you tell me who is on your current treatment team? (e.g.: family doctor, psychiatrist, case worker)

Sensitizing concepts:

- The impact of disrupted or displaced mental health care (e.g.: the pandemic and other factors), social and economic considerations, and the intersection between patterns of distress, gender, ethnicity, age, and experiences of trauma and oppression.
- interventions or processes that are thought to possibly help with managing suicidal ideation – suicide risk assessment, safety planning, means restriction, follow-up contacts and monitoring, information sessions, psychosocial and therapeutic interventions.

5. **(If not already covered). Can you tell me about the first time in your life when you were experiencing suicidal thoughts or behaviors?**

Prompts:

If participant does not give years/dates for experiences, then ask for them to give approximate years/ages of when these things happened. The interviewer should construct a timeline when listening to the experiences to know when they happened.

It would be best if the history and the arc spanned most of the participant's life, from childhood to present.

6. **If not already covered, and when/if it feels appropriate,** ask participants to describe the types of suicidal thoughts they were having. E.g.:

-Can you tell me more about your suicidal thoughts and what they were like?

-Can you describe your suicidal thoughts?

-When do they come up?

-How have they changed over time?

-What's your experience been of them? (i.e.: feel distressing, comforting, a bit of both)

7. **(If not already covered). Have you ever sought mental health care for suicidal thoughts or behaviour?**

(Please take notes on any healthcare providers and services accessed, and timeframes to use later in the prompts section)

Prompts:

-If participant has trouble thinking of times they sought help, or to supplement the discussion, ask:

> *-The first and/or last time they sought help*
>
> *-Seeking help at the Emergency Room*
>
> *-Seeking help as an outpatient (hospital outpatient groups, individual or group therapy, seeing a psychiatrist as an outpatient)*
>
> *-Seeking or receiving help as an inpatient*
>
> *-Seeking help through suicide/telephone hotlines; 911; family physicians; family/friends; teachers, support groups, other trusted people?*

Please ask in each interview as prompts:

-*What worked? Helped? (The easiest and/or most positive help-seeking experience(s) they have had)*

-What didn't work? Was challenging? (The hardest and/or most negative help-seeking experience(s) they have had)

-What was needed? In an ideal world, when you or someone else is experiencing suicidal thoughts or behaviour asks for help, what do you think should happen? Should not happen?

Please ask in each interview:

-You have told me about a number of health care providers or services that you encountered and health care services that you accessed, during your experiences of seeking mental health care. I'm going to briefly summarize them. (Please list the health care providers and services accessed).

-Are there any more health care providers or services that you accessed during your experiences of seeking mental health care that we have not talked about, that you would like to mention?

-(If it was not clear from the participant's previous answers): Can you tell me who is on your current treatment team? (e.g.: family doctor, psychiatrist, case worker)

Sensitizing concepts:

- The impact of disrupted or displaced mental health care, social and economic considerations, and the intersection between patterns of distress, gender, ethnicity, age, and experiences of trauma and oppression.

- interventions or processes that are thought to possibly help with managing suicidal ideation – suicide risk assessment, safety planning, means restriction, follow-up contacts and monitoring, information sessions, psychosocial and therapeutic interventions.

8. **During the pandemic and afterward, we have seen changes in the way people access care.**

   a. Which of your experiences of accessing care do you think may have been influenced by the pandemic?

   b. Please use the relevant statement:

   -*“We have discussed your experiences with help-seeking for suicidal thoughts and behaviours that you had* ***before and after*** *the pandemic started”* OR

   -(if not discussed, or not clear) “*Did you had any experiences help-seeking for suicidal thoughts or behaviours* ***before*** *the pandemic started?*”

   -Then state:

      i. How have your experiences of help-seeking changed as a result of the pandemic?
      ii. How have your experiences of care changed as a result of the pandemic?

II. General Questions – Tying it Together

1. **Do you think your experience was typical for most people you know? How is it similar, how is it different?**

2. **What helped your mental health the most? What didn’t help at all?**
   Prompts:

   -What made these experiences positive?

   -What made these experiences negative?

3. **What does a functioning mental health care system look like for people with suicidal thoughts?**

Prompt (if not already covered adequately in previous questions, or for a last word):

> *-In an ideal world, when you or someone else is experiencing suicidal thoughts or behaviour asks for help, what do you think should happen?*
>
> *-Should not happen?*
>
> *-A related question is what does a functioning public services system look like for people with suicidal thoughts? (e.g.: livable wages, housing, etc.)*

III. Wrap-up and conclusion of the interview

When you have the information you need and are ready to wrap up, you can note that your time together is ending, *briefly* summarize what you've heard, thank the participant for their participation, and then consider one or more of the following wrap-up questions:

- Is there anything else you would like to add?
- Is there anything else I should know?
- Is there anything I should have asked?
- How did the interview feel for you?
- How are you feeling now?

☐When the conversation is complete, turn off the audio-recorder

☐We said at the beginning of the study, that we would monitor your risk levels throughout the study by using a short set of questions about any thoughts of suicide at the beginning and end of each time the study team sees you. Would you be willing to fill out this tool now? The interviewer will read the questions and the tool will be filled out verbally over the phone. If any increased risk is identified, we will arrange resources to help you. We have a wide range of resources to support you, which may include connection to crisis lines, outpatient services, and a phone call with a clinician.

☐If increased risk is identified:

> ☐If the principal investigator is conducting the interview, they will provide clinical support as needed.
>
> ☐If a research team member is conducting the interview, and the participant is not feeling safe to proceed, the interview will be discontinued and the research team member will ask the participant if they would be willing to be contacted by the principal investigator or one of the co-investigators of the study (depending on

who is ‘on call’), who are trained psychiatrists for a phone call for support. If the participant agrees, the interviewer will arrange for this phone call to occur immediately. If the participant is not willing to speak to one of these individuals, contact information from the study resource sheet including crisis resources, telephone helplines and online support will be provided to the participant over the phone. The participant will have previously received this resource sheet by email prior to the interview. The participant will also be advised to go to their local emergency department, as necessary.

☐If no increased risk is identified:

Thank the participant, remind them about the resource sheet, and let them know to feel free to contact you if they have any thoughts or questions after the interview. End the call.

Patient Qualitative Interview Guide 2 (12-months)

(Please complete the interview pre-amble prior to starting the interview)

IV. Interview Part A: Lived Experience

In this first part of the interview, the focus is on the participant and their lived experience of suicidal thoughts and/or behaviours; their experience of help-seeking for these conditions; and their thoughts on what ideal care looks like since the last interview. Try to probe for contextual detail; listen closely and aim to understand people and events in detail and the variety of circumstances under which experiences took place. Spend time on the first questions – at least 10 minutes – allowing the participant guide the conversation about themselves so you can get to know them and build rapport before moving on to more challenging topics.

The interview questions below are a guide and should be adapted throughout the interview; try to be flexible and responsive. For example, only ask questions the participant hasn't yet addressed.

Interview questions are in bold

"Thanks again for agreeing to do this interview. Like we talked about at the start, we're meeting again today, to discuss your experiences since the last interview, and your perspectives on the specific evidence-based interventions for suicide prevention.

I'd like to know what you'd like to focus on most, either to talk about your experiences and what has been happening in your life in the last 8 months since we last spoke, or about what we can improve in the mental health system to support people with suicidal thoughts and behaviours? We will talk about both topics, but I would just like to know what you would like to focus on more."

(The above question will help the interviewer focus the time during the interview more on either Part II or Part II of the interview guide, according to the participant's preferences, and what they would most like to discuss. It is possible that participants with a greater degree of recovery may choose to focus less on the previous eight months and more on the second part of the interview, whereas participants who are still in very active recovery may wish to focus more on the first part of the interview. The interviewer will still cover questions in both parts of the interview.)

4. **The first question I'd like to ask is if you can tell me a bit about what is going on with you and your life these days?**

   Guidance: One reason for this question is to develop rapport with the participant. Another reason is to understand the participant's strengths by discussing what is important and who is important to them in their lives. This question is a reminder of the support networks and resources the participant has in their life currently. Asking this question is a protective factor for the interview and also highlights protective factors in the person's life.

Prompts:

What is a typical day like these days?

Is your day-to-day any different than when we met 8 months ago?

Are some things the same and are some things different?

Extra Prompts:

The interviewer may need to use different prompts depending on the person:

-What do you do for work?

-Who are the most important people in your life?/Who's important to you?/ Who are the people closest to you?/Who are the key people in your life?

-What's important to you?/ What are some of your interests?

-Where do you live?/ Where did you grow up?

-What's going on with you these days/ What should I know about you?

5. **Can you tell me if anything has changed with your physical or mental health since we last spoke?**

(Please take notes on any healthcare providers and services accessed, and timeframes to use later in the interview)

Prompts:

-*To what do you attribute these changes?*

-*Can you tell me what happened?*

If participant does not give the approximate timeline (months) for experiences, then ask for them to give approximate months of when these things happened. The interviewer should construct a timeline when listening to the experiences to know when they happened, to keep in field notes.

8. (If not already covered). Can you tell me about any experiences you had seeking mental health care since we last met?

(Please take notes on any healthcare providers and services accessed, and timeframes to use later in the prompts section)

Prompts:

-If participant has trouble thinking of times they sought help, or to supplement the discussion, ask:

-The first and/or last time they sought help since the last interview

-Seeking help at the Emergency Room

-Seeking help as an outpatient (hospital outpatient groups, individual or group therapy, seeing a psychiatrist as an outpatient)

-Seeking or receiving help as an inpatient

-Seeking help through suicide/telephone hotlines; 911; family physicians; family/friends; teachers, support groups, other trusted people?

Please ask in each interview:

-You have told me about a number of health care providers or services that you encountered and health care services that you accessed, since we last met. I'm going to briefly summarize them. (Please list the health care providers and services accessed).

-Are there any more health care providers or services that you accessed during your experiences of seeking mental health care that we have not talked about, that you would like to mention?

-(If it was not clear from the participant's previous answers): Can you tell me who is on your current treatment team? (e.g.: family doctor, psychiatrist, case worker)

Please ask in each interview as prompts:

-*What worked? Helped? (The easiest and/or most positive help-seeking experience(s) they have had)*

-What didn't work? Was challenging? (The hardest and/or most negative help-seeking experience(s) they have had)

-What was needed? In an ideal world, when you or someone else seeking mental health care services, what do you think should happen? Should not happen?

Sensitizing concepts:

- The impact of disrupted or displaced mental health care (e.g.: the pandemic and other factors), social and economic considerations, and the intersection between patterns of distress, gender, ethnicity, age, and experiences of trauma and oppression.

- interventions or processes that are thought to possibly help with managing suicidal ideation – suicide risk assessment, safety planning, means restriction, follow-up contacts and monitoring, information sessions, psychosocial and therapeutic interventions.

9. **(If not already covered). Can you tell me about any experiences of suicidal thoughts or behavior that you have had since we last met?**

   Prompts:

   If participant does not give a timeline for their experiences (e.g.: month when they happened), then ask for them to give approximate months. The interviewer should construct a timeline when listening to the experiences to know when they happened.

10. **(If not already covered, if the individual had suicidal thoughts and/or behaviour since the last interview). Did you seek help for suicidal thoughts or behaviour since our last interview?**

    (Please take notes on any healthcare providers and services accessed, and timeframes to use later in the prompts section)

    Prompts:

    -If participant has trouble thinking of times they sought help, or to supplement the discussion, ask:

    -The first and/or last time they sought help since the last interview

    -Seeking help at the Emergency Room

-Seeking help as an outpatient (hospital outpatient groups, individual or group therapy, seeing a psychiatrist as an outpatient)

-Seeking or receiving help as an inpatient

-Seeking help through suicide/telephone hotlines; 911; family physicians; family/friends; teachers, support groups, other trusted people?

Please ask in each interview:

-You have told me about a number of health care providers or services that you encountered and health care services that you accessed, since we last met. I'm going to briefly summarize them. (Please list the health care providers and services accessed).

-Are there any more health care providers or services that you accessed during your experiences of seeking mental health care that we have not talked about, that you would like to mention?

-(If it was not clear from the participant's previous answers): Can you tell me who is on your current treatment team? (e.g.: family doctor, psychiatrist, case worker)

Please ask in each interview as prompts:

-*What worked? Helped? (The easiest and/or most positive help-seeking experience(s) they have had)*

-What didn't work? Was challenging? (The hardest and/or most negative help-seeking experience(s) they have had)

-What was needed? In an ideal world, when you or someone else seeking mental health care services, what do you think should happen? Should not happen?

Sensitizing concepts:

- The impact of disrupted or displaced mental health care (e.g.: the pandemic and other factors), social and economic considerations, and the intersection between patterns of distress, gender, ethnicity, age, and experiences of trauma and oppression.

- interventions or processes that are thought to possibly help with managing suicidal ideation – suicide risk assessment, safety

> planning, means restriction, follow-up contacts and monitoring, information sessions, psychosocial and therapeutic interventions.

Prompt the continuation to Part II.

For example,

> “In the time we have left, we’re going to shift gears a little to talk about your opinions on some specific types of help. Some research suggests there are a few different approaches we can take to do a better job of caring for people experiencing suicidal thoughts or behaviours. In this second part of the interview, I’ll tell you a little about these different approaches, and then I’m interested in hearing what you think about them.”

V. Interview Part B: Structured Inquiry –Perspectives on specific interventions

Following from participants' lived experiences, the second half of the interview shifts the focus toward their perspectives on the different types of intervention strategies identified in the literature base. We are interested both in their response to the intervention strategy itself, and their thoughts on how it could be improved and what would be needed to make a particular type of strategy work locally. The intervention strategies covered in this part of the interview include: screening and assessment, safety planning, means restriction, information/education sessions, follow-up contacts and monitoring, and psychosocial and therapeutic interventions. You'll briefly describe each one before prompting them for their thoughts.

As noted above, responsiveness throughout the interview is important; if the participant has already discussed one or more of the intervention types in the first half of the interview (because they experienced one or more first hand, for example), use your judgment regarding the sufficient amount of information required and the utility of revisiting.

1. Screening and risk assessment

When people get care for mental health issues, they are often asked about whether or not they have any suicidal thoughts. This is called a "screen." After the screen, people might be asked more questions about risk factors, like whether a person has a personal or family history of suicidal thoughts or behaviours, or depression, or if they have recently experienced a loss or trauma; and factors that could help protect them, like coping skills, access to care, positive relationships and family support. These extra questions are called an "assessment."

a) **Do you recall ever being asked these kinds of screening and assessment questions? What do you remember?**

b) **Can you tell me about what you found helpful? What wasn't helpful?**

c) **What types of information would be the most important to consider during screenings and assessments?**

d) **[*Show participants a copy of the CSSRS* via screen share. If the interview is not being done by teleconference, describe some of the main sections of the CSSRS for their feedback] What do you think of this? What was your first impression? Is there anything we could add or modify in this approach to make it *more* helpful?**

e) **Ask about risk assessments using smartphones or tech/social media.**

Prompts/Sensitizing Concepts:

-Ask what experiences of assessment were like in different contexts (e.g.: in the ED, in an outpatient setting, inpatient setting or community).

-There may be differences in experiences of assessment, depending on the context – E.g.: going to the ED in crisis having an assessment from someone who you have just met for the first time, versus ongoing assessment in a trusting therapeutic relationship with an outpatient psychiatrist, family doctor, etc.

-There may be different goals and targeted outcomes of assessment in the outpatient clinic setting, than in the Emergency room. That is, in an ongoing therapeutic relationship, the goal may be to see if there are any changes from baseline, etc., in which case an advance directive, or agreement might be implemented, if one exists. Versus in the Emergency Room, the purpose of assessment may to determine the patient’s level of safety, and whether to admit the patient or discharge them

-It will be important to contextualize the different experiences and their outcomes.

-Ask about who did the assessments, using which processes [e.g.: conversational within an ongoing therapeutic relationship; meeting for the first time at the ED and using an assessment tool (have been told it could feel like a checklist), conversational at the ED, etc.].

-Ask for context around how they were feeling at the time (e.g.: in acute crisis, moderately stable, having usual chronic thoughts, etc.).

-Ask about the outcome of the assessment process in these different contexts.

-In the pilot study, many participants spoke very positively, as did service providers or key informants, about the benefits of an ongoing assessment in a trusting therapeutic relationship, especially when there were advance directives in place, or plans for what to do if the result from an assessment was concerning. Ask if any such process for ongoing assessment (agreed number assessments, colour assessments (e.g.: green, yellow, red), or other informal scales) were in place and their experience of using them.

-What are some of your concerns during an assessment? - *In the pilot interviews, participants expressed the following concerns about assessments:*

-Do you answer assessment questions about suicidal thoughts and behaviours truthfully/honestly? Why, Why not?

-Some individuals reported that they do not always answer truthfully for fear of being 'formed', or admitted against their will; conversely, others described exaggerating their feelings of suicidal ideation in order to be admitted because they don't feel safe in returning home.

*-**For participants with chronic suicidal thoughts**:* ***Can you speak - about your experience of sharing suicidal thoughts that are passive and that are always in the background, versus sharing suicidal thoughts that are active with a health care professional? How do you share these different types of thoughts during an assessment? Do you share your passive thoughts?***

Does what you share about your suicidal thoughts depend on the kind of relationship that you have with the care provider who is doing the assessment? Could you explain how this makes a difference?

-This question is because some participants shared that 'alarm bells' would go off for some less experienced health care providers in the community, if the participant spoke about having ongoing passive suicidal ideation. In such cases, it became difficult for them to speak about it, for fear of alarming their therapist or care provider.

-Do you feel that that your level of safety was adequately captured by the assessment you had at the Emergency Room?

-Some participants expressed that their self-perception and experience of being at high risk did not fit with the assessment criteria used to identify someone at high risk or serious risk. For example, if they did not have a 'plan' in place, they may not be considered high risk. However for some, due to their impulsivity, they felt they could still be at high risk, even without a plan.

-Others felt that while they felt safe in the moment (so their level of risk may have been captured in that moment), they were not sure that feeling of safety would continue once they returned home. Circumstances prior to admission which led to feeling suicidal were not always asked about.

-Could you share any experiences of being asked about how you were feeling before you came to the Emergency Room, and the circumstances that led you to seek care during your assessment? Was your situation before you came to the Emergency Room covered? Was this important to be asked?

> *-This question is because some participants said that they felt calmer once at the emergency room so not suicidal in that moment, although they had been suicidal before coming to the ED. They were not sure that they would continue to feel safe, once returning to their home environment, if discharged. Also, some said that the level of safety of the environment that they were returning home to, was not adequately addressed.*

-Have you ever had any experiences where you were having much more suicidal ideation or behaviour than usual and you went to the Emergency Room at that time to seek help? Was the change from your baseline level of suicidal thinking and behaviour discussed during your assessment?

> *-Some service providers and family members/friends talked about the need for advocacy for individuals who have acute-upon-chronic risk. This advocacy was considered important to demonstrate that the increased risk was dangerous to the individual and they should be admitted, or receive more/different care than usual. Unfortunately, based on our pilot data, even with professional advocacy by psychiatrists providing a note when sending an outpatient to the ED, some individuals do not get admitted at this time and the 'acute upon chronic' nature of their situation is not noticed – they may be assessed as just having ongoing chronic suicidal ideation; in addition, a key informant said that acute risk can also be misperceived for younger individuals, because they "present well". So this question is aimed to know more about the concern that 'acute-upon-chronic' suicidal ideation may be missed.*

-For individuals who use substances – Was substance asked about in your assessment? Was it important to address?

> *-Some family member/friends said that substance use was a key factor in their family member or friend's experience of suicidal thoughts and behaviours, but this factor was not asked about during the assessment, and/or treated. Some family members even volunteered information and their concerns about substance use during a family meeting, but later found out it was not in the patient's file. This question is intended to find out if substance use was asked about, during an assessment and what further steps were taken, if it was discussed.*

-For participants with Borderline Personality Disorder – What has your experience with assessment been like at the Emergency Room? Have you ever experienced any stigma in relation to your diagnosis? *(not sure how to phrase this).*

-Some participants with BPD shared that they felt they were unfairly treated at the Emergency Department; Key informants and service providers also discussed a stigma against people with borderline personality disorder, namely, to discharge them as soon as possible.

-Were you ever discharged after an assessment at the Emergency Department? What was that experience like for you? (outcomes)

-Were you ever 'discharged' from the ED when you felt unsafe to leave? What was that experience like, and what did you do?

*-**Where were you discharged to? (e.g.: home, to go stay with family or friends). Do you feel like being discharged was the right decision?***

-(If the person was discharged to 'Bridging'): Can you speak to your experience of being discharged to Bridging after waiting in the emergency room for an assessment?

-Some participants were unhappy with waiting in the Emergency Room for long periods of time and then to be discharged to Bridging.

-(If the person was discharged home) - Was it safe for you to go home at that time? Was the safety of your home environment assessed in relation to suicide risk? That is, did someone ensure that you were going back to a safe environment?

-Some participants shared that they did not feel it was safe for them to return to their home environments, and yet they were being discharged anyway. Some needed to then contact friends or family to stay with, for a period of time, until they felt stable enough to be on their own again. For these participants, they were not asked about their circumstances prior to going to the ED or what led them to feel unsafe, or if the home environment was safe to go back to.

-Did you ever need to wait for a long time or stay overnight before an assessment? Were you there voluntarily? What was that experience like for you? How do you think it affected your assessment? Have you ever left the Emergency Department while waiting for an assessment because the wait was too long?

-We have heard accounts of difficult experiences of staying in the ED overnight, before an assessment. Some individuals left the ED after hearing they would need to wait, without waiting for an assessment – this decision sometimes had negative consequences of care not being obtained in a timely way; Other individuals waited on a bed in the hallway overnight and found it very distressing; some of these individuals found that their assessment, after a very long wait, was very short and in some cases, not very thorough or patient-centered, and they were discharged shortly afterwards, or maybe discharged to Bridging. Waiting for a long time for an assessment and then being discharged was difficult for some people.

-Can you tell me about the kind of support or referrals you received after an assessment? Was the level and kind of support, or referrals helpful?

-Some participants expressed that they would be discharged from the ED because they were not perceived as at immediate risk for suicide, but they were still experiencing acute emotional distress. It is not clear from our former data, what types of supports were provided to these individuals, and if they were perceived as adequate or helpful.

2. Safety planning

A safety plan is a document that contains practical ideas and resources for calming down and staying safe when you are feeling distressed and/or experiencing suicidal thoughts. You create it together with your health care provider and it would include information like your personal warning signs, your reasons for living, the coping strategies that work best for you, and the contact information for family, friends and professionals you can call when you're feeling distressed.

i. Creating a Safety Plan:

a) ***Process of creating a safety plan:*** **Have you ever engaged in creating a safety plan with a health care provider, or with anyone else? What were your experiences?**

Prompts:
-Can you tell me a bit about the process of making your safety plan(s)? When did you make them, with whom? What was that process like? Was it positive or negative. Have you made several safety plans and how/when/with whom were they made?

b) **Can you tell me about what you found helpful? What wasn't helpful?**

Prompts:

-If you have made a safety plan with a service provider, in your recollection, how much time did it take? Was this enough time for you? What was the experience like in terms of time? How much time do you think safety planning needs?

i. (If not addressed) ***Were you ever asked to create a safety plan when you were at the ED? What was the process? For example: Did you have a conversation with someone about it (and at what point? When you were initially admitted, during an assessment with a physician of later on? With whom did you make the plan (or did you fill it out yourself)?***

If yes:

-What was that experience of discussing safety planning at the ED like for you? Is there anything you would change about it?

-Did you use the safety plan you created at the ED after you were discharged? Or did you use another safety plan that you created at another time, in a different context – e.g.: in a therapy group setting such as an outpatient or inpatient DBT group; during an individual outpatient appointment, etc.?

– Creating a Safety Plan in the ED; this question is related to findings from the pilot study about difficulty for some participants to do safety planning when in crisis, at the ED. The question is aimed at learning more about the experience of safety planning at the ED.

ii. (If not previously addressed): ***What about when you were admitted to the hospital? Were you invited to do any safety planning while you were in the hospital? What was the process? What was that experience like for you?***

iii. (if not previously addressed) ***What about when you were going to outpatient appointments? Were you invited to do any safety planning while you were in the hospital? What was the process? What was that experience like for you?***

c) Content of Safety Plan***:*** **What types of information do you think would be essential to include in a safety plan?**

Prompts:
-Can you give me some examples of any safety plans you have made? What was on them?

-When you think about safety plans that you created, which one(s) do you consider to be the most effective? (What does it include? The plan you made 'when'/with 'whom'?)

d) *Content of Safety Plan:* **[*Show participants a copy of a safety plan template via screen share. If the interview is not being done by teleconference, describe some of the main sections of the tool and ask for their feedback.*] What do you think of this? What was your first impression? Is there anything we could add or modify in this approach to make it *more* helpful?**

ii. Implementing or Using a Safety Plan

a) **General aspects of implementing safety plans (outcomes):**

-Can you give me any examples of when you have needed to use a safety plan and how it worked? What was the outcome? Was it effective?

-For a safety plan that had a positive outcome/was effective:

-What prompted you to remember your safety plan, and to use it at a time when you were experiencing suicidal thinking or behaviour? Was there something done or said in the process of creating the plan, that helped you remember it? Why was the safety plan memorable at that time?

-what was the most important aspect of your safety plan for you, the element that kept you most safe? (Inquire what it was about this aspect of the plan that was so effective for them -how it helped).

-How did you make that particular plan? That is, did you make it on your own, with someone, where and when? Or was it made on your own, or with friends, or with a group? Was it adjusted over time?

(if not addressed) Have there been options on a safety plan that you did try, that did not keep you as safe? *(e.g.: crisis hotlines, going to the ED, were mentioned in the pilot interviews as not as effective for some individuals, as informal means of keeping safe, like reaching out to trusted friends or family members.)*

Are there examples of when you had a safety plan, but you just didn't use it? What do you think the reasons were? (e.g. intensity of suicidal thoughts, too depressed, etc.)

b) **Specific aspects of implementing safety plans:**

-Did you have the Emergency Department as a possible option on your safety plan? Did you ever have to use that option? What was your experience with that and the outcome?

-Did you have any crisis hotlines on your safety plan as a possible option? Did you ever use that option? What was your experience with that and the outcome?

-Did you list any other formal mental health services on your safety plan? Did you ever use that option? What was your experience and the outcome?

-Have you ever reached out to a trusted family member or friends for support when you were experiencing suicidal thoughts or behaviour? What was your experience and the outcome? If contacting a family member or friend was effective, ask them: What was it about contacting a family member or friend that helped?

(Note – these questions are because in the pilot data, some of the above options, particularly having the Emergency Department or Crisis Lines on a safety plan, were not effective for some participants and caused them more distress. On the other hand, reaching out to family members/friends listed on a safety plan proved particularly effective for many participants in the pilot data set. So this question is to better understand how specific options discussed in our pilot data, were either helpful or not helpful, when listed on a safety plan).

iii. Planning in advance with a health care professional, or with family and friends

a) If the participant planned in advance with family members or friends for how to respond when they were in crisis as part of their safety plan, ask:

-How did you get this idea, to plan in advance with your family and friends and to make them a part of your safety plan? How did they respond?

-How did the conversation affect your relationship with that person/those people?

***-**Did it make it easier or harder to talk openly about suicide? Was this a new conversation for you to have, just around safety planning or had you spoken about suicide to this person/these people before?*

-Note – this topic was discussed in the pilot data, that some participants and their family members thought that doing safety planning would open lines of communication.

b) ***Did you contact the people you listed on your safety plan when you were in a difficult situation?***

If yes:

How did it go when you implemented the safety plan that you created with a family member or friend? Did you get the support you needed? Were there any difficulties?

c) *(if not already mentioned) -* ***Can you tell me about any experiences of planning in advance with a health care professional?***

-That is, have you ever created a safety plan with a professional in which you would discuss or rate your feelings of safety at your appointments and have a plan of what to do if you really didn't feel safe, for example, having your physician ask you to go to the emergency department?

If yes – how has this approach worked for you? Has it been positive?

3. Means restriction

Means restriction tries to deliberately limit access to lethal methods to create a safer environment. For example, making sure prescription drugs that could be used to overdose are not easily accessible, or making sure that there are no firearms in your living space. The goal is to reduce someone's ability to act on their suicidal thoughts by removing things that could be used to hurt themselves.

a) Do you recall ever engaging in conversations about means restriction with your care team? What would that look like for you?

Can you tell me when these conversations happened? (e.g.: Emergency Room; Outpatient care (including in a short term OR longstanding therapeutic relationship); Inpatient care)?

-How did the means restriction conversation come up in these contexts? (e.g.: during a safety planning discussion, or during an assessment? Was it an ongoing conversation within a longer-term therapeutic relationships, or a one-time conversation at the ED or in another short-term health care context?)

-This question is because some participants in the pilot study, mentioned that means restrictions conversations came up in assessment. Interestingly, means restriction as a topic did not come up very much, in response to the question about safety planning, in the pilot interviews. However, means restrictions are a question on the Safety Planning template. So it will be interesting to see where this question came up.

-What was your experience of discussing means restriction in this context?

-Some points to keep in mind, based on our pilot interviews, are the following:

- The concept of means restrictions may be new to some people – some people in the pilot study had not heard of the concept.

- In addition, some people in the pilot study did not feel like means restriction would be useful for them, either because: they feel like they have a strong sense of 'self-control' (they mainly experience SI, not SB); or they don't feel like they would use a certain means because it is too scary to contemplate (so restricting this means would not apply to them).

b) What do you think are the most important things you and your care team should talk about and do when you are aiming to restrict means and create a safer environment?

The following examples are means restrictions areas that were covered in the pilot interviews:

SAFE PRESCRIBING

-(If not already covered): Can you tell me about any experiences you may have had with safe prescribing? That is, when a physician prescribes your medications in different ways that will help with using them safety, like using blister packs, having weekly prescriptions for a reduced amount of medication available, etc.. What was your experience of these methods? Were they helpful?

-Please note: Safe prescribing was discussed in the pilot interviews, but not at length. Also discussed in the pilot interviews, was that being prescribed smaller amounts might be challenging rather than helpful, if a person was at risk to run out of medication.

-Have you ever experienced times when you were prescribed medications in ways that didn't feel safe for you? (e.g.: being prescribed medications you didn't want to take, so stockpiled them, or being prescribed medications in large amounts at a time in a way that didn't feel safe – these were topics discussed in the pilot interviews.)

HOME ENVIRONMENT

-What are some of the challenges of means restrictions in the home environment? (Some topics discussed in the pilot interviews were the following: not being able to hide items when a person lives alone; needing medications for physical health problems even though they could be harmful if taken as an overdose; and means restrictions for 'everyday items' – please see more about this, below.)

-Can you tell me about any approaches you may have discussed with a health care professional, or came up with on your own, for increasing safety around everyday

items? How did you come up with these approaches (e.g.: on their own, in discussion with a health care professional, etc.?).

-The following are examples about ways to manage safety around everyday items from the pilot interviews. Some ideas were developed in-collaboration with a health care professional, but some were developed by participants on their own:

- putting everyday items in boxes with a note on top about strengths;
-putting items in freezer;
-putting medications in their Canada Post mailbox in a condo that is near the concierge's desk, so they will have to walk past someone to get them
-baby locks on drawers where knives are kept
-creating a safe area at home (e.g.: on their bed), where they could not access any means, and where they would stay until suicidal thoughts passed.
-using candle wax to burn instead of cutting

FIREARMS:

-Can you tell me if anyone has ever spoken to you about restricting your use or access to firearms?

COMMUNITY PUBLIC HEALTH – BRIDGES, SUBWAYS, ETC.

-Can you tell me about any experiences you have had in limiting your exposure to community level factors, to keep yourself safe? Like not going into areas with bridges, subways, etc.

ALCOHOL/DRUGS & COMORBID MENTAL ILLNESS AND ADDICTION

-Can you tell me about the experience of trying to restrict access to alcohol or drugs? (In the pilot interviews, some participants said that restricting access to drugs and alcohol could be challenging and was not much discussed in their conversations with health care professionals. Some also shared that in their experience, substance use concerns and mental health concerns were not treated together, so substance use may not be discussed as a factor in means restriction or as problematic for the person. For a number of participants, as reported by themselves or a family member, using substances increased their suicidal ideation or behaviour.)

ROLE OF FAMILY

-Has a family member or friend ever assisted you with means restrictions, for example, to keep medication in a safe place for you, or to restrict your access to certain items? How did their assistance come about? Did you ask for it, or did they offer? Was it helpful?

c) **What could have made your experience with means restriction *more* helpful?**

d) (if not already discussed) **Can you tell me about any experiences that you have had with means restrictions since we last met?**

4. **Information/education sessions**

Information or education sessions are one-time sessions that would provide general information about suicide, suicidal thoughts and behaviours to help you understand what you're experiencing, including things that are likely to protect you and things that are likely to put you at risk; and the resources that are available to help you in your community.

a) **Have you ever attended an information session like this? What was it like?**

b) **What did you find to be helpful? Not helpful?**

-E.g. (from pilot interviews): feeling not so alone, obtaining important information, reducing stigma to talk about suicide, hearing about methods for prevention, coping mechanisms for depression, anxiety, etc., learning about interventions that could help.

c) **What kinds of information or education do you think would be important to include in these kinds of sessions?**

d) **Is there anything else we could add or modify in this approach to make it *more* helpful?**

-When and where should they be offered?

E.g. from pilot interviews:

-While hospitalized?

-Scheduled at a time when someone could come back to the hospital after an ED visit?

-What format would work best?

E.g. from pilot interviews:

-Online ('real-time', or on-demand?); In-person; Both online and in-person;

-Multiple opportunities to attend (drop-in), or a scheduled opportunity;

-Group sessions or individual sessions? (If individual sessions, use bi-directionally, to ask about what is being done, and also to gather information?)

5. **Follow up contacts and monitoring**

When someone who has been experiencing suicidal thoughts or behaviours leaves the hospital or other health care setting, research suggests it is helpful to follow up with that person within 24 to 48 hours because we know risk is increased right after discharge. Follow-ups could be by phone call, email, letter, text, home visit or in-person meeting and the goal is to provide some continuity and support, stay engaged with the person, and help link them to some outpatient care.

a) **Has someone ever followed up with you or checked in on you after you expressed having suicidal thoughts or behaviours? What was that like?**

b) **What type(s) of contacts do you think would be most helpful?**

E.g. from pilot interviews:

-phone, virtual meeting (teleconference); email, text, in-person.

-Make it optional/Ask for permission

> *-In the pilot, asking for permission was suggested since for some people, their experience at the ED was traumatizing – they might now want any follow-up; or they might want autonomy over the process. Or there were some comments that follow-ups may not be needed if other resources/supports are in place, or if the situation is not urgent, so asking will establish the need.*

-Schedule a follow-up in advance (unexpected contact can be triggering).

-Follow-up from a known health care professional

-Follow-up contact after the ending of a group?

c) **How many times or for how long do you think we should follow up?**

d) **Is there anything else we could add or modify in this approach to make it *more* helpful?**

-Can you tell me what suggestions you would have for follow-up contacts and monitoring?)

6. **Psychosocial and therapeutic interventions**

There is a fair amount of research suggesting that cognitive and behavioural therapies are helpful for people who are experiencing suicidal thoughts or behaviours. In this approach, people have ongoing sessions with a therapist; sessions would be about an hour and take place over many months. These types of therapies aim to teach people to recognize and understand their suicidal thoughts and behaviours; and then the therapist works with the person to develop personal strategies that help them to better manage their emotions and to keep themselves calm and safe when they are feeling distressed.

a) **Have you ever participated in this kind of therapy? Can you tell me about some of those experiences?**

Prompts:

-Ask about experiences of inpatient, outpatient and community experiences of therapy

-How did you access therapy? (e.g.: referral from a health care providers, the person sought it out independently, etc.)

-How did you pay for therapy? (OHIP, own funds, insurance, etc.) (not sure we need this question, but could be helpful).

-When did you access therapy? (at what points in their lives, for what reasons?)

-What format? (online, in-person, by phone, individual, group)

-What was the duration of therapy? Was this duration appropriate? Just right, too long, too short?

b) **What did you find [or *do you think would be*] helpful? Unhelpful?**

c) **What would be important for therapists to know?**

d) **Is there anything else we could add or modify in this approach to make it *more* helpful?**

VI. General Questions – Tying it Together

4. **Do you think your experience was typical for most people you know? How is it similar, how is it different?**

5. **What helped your mental health the most? What didn't help at all?**

   Prompts:

   -What made these experiences positive?

   -What made these experiences negative?

6. **What does a functioning mental health care system look like for people with suicidal thoughts?**

   Prompt (if not already covered adequately in previous questions, or for a last word):

   -In an ideal world, when you or someone else is experiencing suicidal thoughts or behaviour asks for help, what do you think should happen?

   -Should not happen?

4. **A related question is what does a functioning public services system look like for people with suicidal thoughts? (e.g.: livable wages, housing, etc.)**

Family/Friend Qualitative Interview Guide

(Please complete the interview pre-amble prior to starting the interview)

I. Interview Part A: Lived Experience

In this first part of the interview, the focus is on the participant and their lived experience of having a family member or friend who has experienced suicidal thoughts and/or behaviours; their experience of help-seeking for these conditions, either for themselves or for the person they provided support to; and their thoughts on what ideal care looks like. Try to probe for contextual detail; listen closely and aim to understand people and events in detail and the variety of circumstances under which experiences took place. Spend time up front, about 10 minutes, establishing a relationship and building rapport with the participant.

Please avoid referring to the family member or friend as a 'loved one' during the interview, and use the words "family member or friend", or daughter/son/mother/father, etc., depending on the family or friend relationship. The reason to avoid the term 'loved one', is because sometimes family/friend relationships can be quite complicated with a lot of complex and mixed emotions.

The interview questions below are a guide and should be adapted throughout the interview; try to be flexible and responsive. For example, only ask questions the participant hasn't yet addressed.

Interview questions are in bold

"Thanks again for agreeing to do this interview. Like we talked about at the start, the goal today is to understand your personal experiences having a (family member OR friend) who has had suicidal thoughts and behaviours, any care you they have received for these concerns, and your opinions about what is helpful and not helpful. In this first part of the interview, I'd like to talk about your personal experiences."

6. **The first question I like to ask people is how did you hear about this study and what made you interested to participate?**

7. **Can you tell me a little bit about yourself and your life? Start with anything you like. This is so I can get to know you better.**

   Guidance: One reason for this question is to develop rapport with the participant.

   -What does a typical day look like these days?/What do you do for work?

   -Who are the people closest to you?/Who are the key people in your life?

   -What's important to you?/ What are some of your interests?

   -Where do you live?/ Where did you grow up?

   -What should I know about you?

8. **Can you tell me about a time when a family member or friend was experiencing suicidal thoughts or behaviors?**

9. **Did either of you seek help? If so, can you tell me about some of those experiences?**

   a. **What was most helpful? Why? (the easiest and/or most positive help-seeking experience(s) they have had.)**

   b. **Can you tell me about any frustrating or challenging experiences you've had when you were looking for or receiving help? (The hardest and/or most negative help-seeking experience(s) they have had)**

Prompts:

-If participant has trouble thinking of times they or their family member or sought help, or to supplement the discussion, ask:

-The first and/or last time they, or their family member or friend sought help

-Seeking help at the Emergency Room

-Seeking help as an outpatient (hospital outpatient groups, individual or group therapy, seeing a psychiatrist as an outpatient)

-Seeking or receiving help as an inpatient

-Seeking help through suicide/telephone hotlines; 911; family physicians; family/friends; teachers, support groups, other trusted people?

Please ask in each interview:

-You have told me about a number of health care providers or services that you or your (family member OR friend) encountered and health care services that you accessed, during your experiences of seeking mental health care. I'm going to briefly summarize them. (Please list the health care providers and services accessed).

-Are there any more health care providers or services that you or your (family member OR friend) accessed during your experiences of seeking mental health care that we have not talked about, that you would like to mention?
-(If it was not clear from the participant's previous answers): If you know, can you tell me who is on your (family member OR friend's) current treatment team? (e.g.: family doctor, psychiatrist, case worker)

Sensitizing concepts:

- The impact of disrupted or displaced mental health care (e.g.: the pandemic and other factors), social and economic considerations, and the intersection between patterns of distress, gender, ethnicity, age, and experiences of trauma and oppression.

- interventions or processes that are thought to possibly help with managing suicidal ideation – suicide risk assessment, safety planning, means restriction, follow-up contacts and monitoring, information sessions, psychosocial and therapeutic interventions.

- During the pandemic and afterward, we have seen changes in the way people access care.
    - *What have your experiences been?*
    - *How have your experiences with help-seeking, or your family member or friend's experiences changed in relation to the pandemic?*

10. **In an ideal world, when you or someone else is experiencing suicidal thoughts or behaviour asks for help, what do you think *should* happen? *Should not* happen? Why?**

II. Interview Part B: Structured Inquiry – Perspectives on Specific Interventions

Following from participants' lived experiences, the second half of the interview shifts the focus toward their perspectives on the different types of intervention strategies identified in the literature base. We are interested both in their response to the intervention strategy itself, and their thoughts on how it could be improved and what would be needed to make a particular type of strategy work for local families. The intervention strategies covered in this part of the interview include: screening and risk assessment, safety planning, means restriction, information/education sessions, follow-up contacts and monitoring, and psychosocial and therapeutic interventions. You'll briefly describe each one before prompting them for their thoughts.

☐As noted above, responsiveness throughout the interview is important; if the participant has already discussed one or more of the intervention types in the first half of the interview (because they experienced one or more first hand, for example), use your judgment regarding the sufficient amount of information required and the utility of revisiting.

7. **Screening and risk assessment**

When people get care for mental health issues, they are often asked about whether or not they have any suicidal thoughts. This is called a "screen." After the screen, people might be asked more questions about risk factors, like whether a person has a personal or family history of suicidal thoughts or behaviours, or depression, or if they have recently experienced a loss or trauma; and factors that could help protect them, like coping skills, access to care, positive relationships and family support. These extra questions are called an "assessment."

Screening for and assessment of risk for suicide is often a key component of prevention initiatives. Screening is used to identify people who might be at risk; and assessments are used to identify specific factors that increase or decrease risk; modifiable factors that we can target to help reduce risk; and factors that represent risk to safety. Altogether, this information is intended to help clinicians understand how to intervene in the most appropriate way for a particular person.

f) What are your thoughts on the screening and risk assessment approach? Can you think of a scenario in which it might be helpful? Unhelpful?

Prompts/Sensitizing Concepts:

-Have you ever been consulted by a health care professional about your perception of your family member or friend's suicidal thoughts or ideation or about their mental health? (If yes: In what context? E.g.: ED, Outpatient,

Inpatient). Do you feel that this would be important to the outcome of your (family member OR friend)? (Why?)

-Have you ever tried to contribute information about your family member/friend to a health care professional when you weren't consulted by them, to do so? What was your experience? (If not specified: In what context? ED, Outpatient, Inpatient).

-If you were consulted during an assessment, do you feel that your input was taken into consideration by the treatment team for the care plan that was put in place? (In our pilot interviews, one family interviewed said that their concerns about the substance use of their family member was not entered into the chart or taken into consideration by the care team.)

-Have you ever been informed about assessment results of your (family member OR friend)? Do you feel that this would have been important to you? (Why?)

-Have you ever encouraged a (family member OR friend) to go to the ED for an assessment or support, or accompanied them to go to the ED?

> *-Why did you encourage them to go to the ED (e.g.: what was their context, their situation, how were they feeling at the time)?*
> *-What was their experience, and what was your experience of the outcome of this visit?*
> *-Do you know if they were assessed when they were at the Emergency room? If you were there with them, were you consulted?*
>
> *Outcomes from pilot study: some family members or friends were discharged after the assessment; the wait was too long for the family member or friend to wait to be seen, so they decided to leave without being assessed; discharged to Bridging; discharged home again, or admitted?*
>
> *-Do you feel that that the level of safety of your family member or friend, was adequately captured by the assessment you had at the Emergency Room?*
>
> *-What could have been done differently for this visit, in your opinion?*
>
> *-Was this the first time you accompanied this person to the ED? (If no: Can you tell me a bit about the other times? Ask the same accompanying question prompts as for the first visit they described).*

-(if not discussed): Have you had any experiences when a family member or friend went to the ED for suicidal thoughts or behaviours, but was then discharged to your care? What was that experience like? Was this an

appropriate outcome? To what extent were you able to provide support? Do you think they were properly assessed as being able to come home right away?

> *(Note – There are accounts from the pilot data of patients discharged back into the community to their friends or family when they are not ready to be on their own. The care provision then falls to the family members, and sometimes the outpatient psychiatrist, to take care of, and to help the person stabilize as an outpatient. In one example of this scenario from our pilot data, once the patient left their family's care, they completed suicide. In another case, a patient discharged from the ED needed to go to stay with friends for two weeks, to feel safe enough to go home. In another case, a young person with substance use concerns and suicidal ideation was discharged but the family had to provide 24/7 care and the outpatient psychiatrist needed to provide an unsustainably high level of support during this time period. It would be interesting/important to gather more stories about the outcomes of discharge from care from the ED, to family member or friend care.)*

-Can you tell me about the kind of support or referrals that your (family member OR friend) received after an assessment at the ED? Was the level and kind of support, or referrals helpful?

> *-Some participants expressed that they would be discharged from the ED because they were not perceived as at immediate risk for suicide, but they were still experiencing acute emotional distress. It is not clear from our former data, what types of supports were provided to these individuals, and if they were perceived as adequate or helpful.*

g) What types of information do you think would be the most important to consider during screenings and assessments?

-(If not asked and answered in the above section): Have you ever been consulted by a health care professional about your perception of the severity of your (family member OR friend's) suicidal thoughts or ideation? (If yes: In what context? E.g.: ED, Outpatient, Inpatient). Do you feel that this would be important to the outcome of your (family member OR friend)? (Why?)

-Do you think that substance use is important to ask about during an assessment? Was it important to address?

> *-Some family member/friends said that substance use was a key factor in their family member or friend's experience of suicidal thoughts and behaviours, but this factor was not asked about during the assessment, and/or treated. Some family members even volunteered information and their concerns about substance use during a family meeting, but later found out it was not in the patient's file. This question is intended to find*

out if substance use was asked about, during an assessment and what further steps were taken, if it was discussed.

h) **Is there anything else we could add or modify in this approach to make it *more* helpful?**

i) **[*Show participants a copy of the CSSRS* via screen share. If the interview is not being done by teleconference, describe some of the main sections of the CSSRS for their feedback] What do you think of this? What was your first impression? Is there anything we could add or modify in this approach to make it *more* helpful?**

8. **Safety planning**

A safety plan is a document that is intended to contain practical ideas and resources for calming down and staying safe when a person is feeling distressed and/or experiencing suicidal thoughts. It is intended to be completed in collaboration with a clinician and it would include information like the person's individual warning signs, reasons for living, the coping strategies identified as working best for that person, and the contact information for family, friends and professionals to call when feeling distressed.

Research suggests safety planning might help to empower people to better recognize and manage their distress and suicidal thoughts.

i. General Questions about Safety Plans:

a) **Had you ever heard of the term or the process of safety planning before? If so, how did you learn about this term (from a family member or friend, health care professional, from someone else)?**

Prompt/Sensitizing concepts:

-Do you think it would be important to provide more information and education about safety planning to someone like yourself, who provides support for a (family member OR friend) with suicidal thoughts and behaviours? Why or why not?

-While family members or friends were key supports for people with suicidal thoughts or behaviours and were part of their safety plan based on the pilot data, most family members or friends who we interviewed were not very aware of the safety planning process or mechanism. There seems to be a need to educate families and friends more about the safety planning process and their potential role.

b) **What are your thoughts on safety planning? Can you think of a scenario in which this approach might be helpful? Unhelpful?**

Sensitizing Concepts from pilot data:

-One family participant indicated that just like for implementing means restriction, a family member cannot be there 24/7 to enforce a safety plan. Several families shard stories about a service user dying by suicide when they were either in the family's care or shortly after leaving the family's care. In one situation, the family members regretted that they only had part of the picture to keep the service user safe and they did not understand the severity of the service user's situation or their level of risk if they left the family's care, because not much had been conveyed to them, about the situation. In such cases, the service user may be at risk again at that point, if their safety plan is not revisited or re-designed, even, to fit their future context.

-Another family said that although safety plans can be useful, there is much more support and intervention needed to bring their family member to a stable place than one can be included in a safety plan. Implementing the safety plan is just one element and more is needed, otherwise the situation won't change.

ii. Creating a Safety Plan

a) *Process of creating a safety plan:* Have you ever engaged in creating a safety plan with your (family OR friend), a health care provider, or with anyone else? What were your experiences?

If yes - Prompts:

-Can you tell me a bit about the process of making your safety plan(s)? When did you make them, with whom? What was that process like? Was it positive or negative. Have you made several safety plans and how/when/with whom were they made?

-Has your (family member OR friend) ever asked you to plan in advance with you, for example, discussing how they would like you to respond, if they are having suicidal thoughts or behaviours?

If yes:

-How did the conversation about safety planning affect your relationship with your (family member OR friend)?

-Did it make it easier or harder to talk openly about suicide?

-Was this a new conversation for you to have, around suicidal thoughts or behaviours or had you spoken about this with your (family member OR friend) before?

-What was your experience of discussing these topics with your (family member OR friend)?

-Note – this topic was discussed in the pilot data, that some family member participants and their family members thought that doing safety planning would open lines of communication. A number of key informants and service providers expressed it was important to involve supportive family members in safety planning discussions and they tried to do so, when possible (although no family members said they were involved in this type of discussion by a professional). A fairly large number for the small sample of pilot study participants said they had involved a trusted family member/friend in advance safety planning, to let them know what they would like, when they contacted them for support around suicidal thoughts and ideation. In these cases, there were positive outcomes when the participant reached out for support.

b) What types of information do you think would be essential to include in a safety plan?

c) [*Show participants a copy of a safety plan template via screen share. If the interview is not being done by teleconference, describe some of the main sections of the tool and ask for their feedback.*] What do you think of this? What was your first impression? Is there anything else we could add or modify in this approach to make it *more* helpful?

iii. Implementation of a Safety Plan

a) Has your (family member OR friend) ever contacted you for support when they were having suicidal thoughts or behaviours? Can you tell me about this experience? Do you know if they contacted you as part of their safety plan?

b) Have they ever <u>shared</u> their safety plan with you?

Prompts:

-What kind of support did you provide? Do you feel that this support was helpful/what they needed? How did this support help (what was the outcome)? Was anything else needed?

-Was the kind of support that you would provide, agreed upon in advance? How was this agreed-upon? Do you know if your support was part of your (family member OR friend's) safety plan?

-How do you feel about providing this kind of support when your (family member OR friend) is having suicidal thoughts and/or behaviours?

-Have you ever had difficulty in providing support when asked to do so? Or has the support you provided ever not been enough?

-Do you feel that any additional support is needed aside from what you can provide? If so, what?

-Have you ever felt a need for any additional support for yourself (e.g.: someone to talk to, professional support, practical support), when providing this kind of support for your (family member OR friend)?

> *Note – the above questions questions are because in the pilot data, reaching out to family members/friends listed on a safety plan proved particularly effective for many participants when they were experiencing suicidal thoughts or behaviours. Many of the participants had created a plan in-advance, with the family members/friends they would call, for what type of support they would like to have. So this question is to better understand the experience of the family member when providing support at this time.*

9. Means restriction

Means restriction tries to deliberately limit access to lethal methods to create a safer environment. For example, making sure prescription drugs that could be used to overdose are not easily accessible, or making sure that there are no firearms in the living space. The goal is to reduce someone’s ability to act on their suicidal thoughts by removing things that could be used to hurt themselves.

e) Do you think this approach would be helpful? Why or why not?

f) Is there anything we could add or modify in this approach to make it *more* helpful?

Prompts/Sensitizing Concepts:

-Can you tell me about any experiences where you may have played a role in helping your family/friend with means restrictions? What was this experience like (or “what were these experiences like”), for you?

> *E.g. from pilot data: hiding or removing means (e.g.: medications, belts, knives, etc.) from a family member or friend without their knowledge; keeping the medication or other means hidden/in a safe place at the request of the family member or friend; constant observation to prevent the person from using means (very difficult for families to do).*

-If family members/friends did have a role: What were some of the challenges for you, in helping your friend or family member with means restrictions?

> *E.g. from pilot data: not being able to be there 24/7 to provide constant monitoring or constant observation; not being able to enforce environmental means restrictions; not being able to hide the medication well enough, so the family member/friend couldn't find it; not being able to support the person when they left the family home/environment; having a family member/friend get angry at their attempts at means restrictions.*

-Do you think family members/friends should have a role in means restrictions? (Why, why not?)

c) What do you think are the most important things that health professionals should talk about when aiming to restrict means and create a safer environment for someone like your (family member OR friend)?

The following examples are means restrictions areas that were covered in the pilot interviews:

SAFE PRESCRIBING

-(If not already covered): That is, when a physician prescribes medications in different ways that will help with using them safely, like using blister packs, having weekly prescriptions for a reduced amount of medication available, etc.. To your knowledge, was this ever done for your (family member OR friend)? If yes: how did it help? If no: how would it help?

-Have you ever experienced times when your (family member OR friend) was prescribed medications in ways that didn't feel safe? (e.g.: being prescribed medications they didn't want to take, so stockpiled them, or being prescribed medications in large amounts at a time in a way that didn't feel safe) – these were topics discussed in the pilot interviews.

HOME ENVIRONMENT

-(if not already addressed in the previous question): From your perspective as a (family member OR friend), what are some of the challenges of means restrictions in the home environment? (Some topics discussed in the pilot interviews were the following: family members or friends not being able to observe or be present 24/7; means restrictions for 'everyday items' – please see more about this, below.)

-Can you tell me about any approaches you or your (family member OR friend) may have used for increasing safety around everyday items? How did you come up with these approaches (e.g.: in discussion with their family member/friend, with a health care professional, on their own, etc.?).

-The following are examples about ways to manage safety around everyday items from the pilot interviews. Some ideas were developed in-collaboration with a health care professional, but some were developed by participants on their own:

- putting everyday items in boxes with a note on top about strengths;
-putting items in freezer;
-putting medications in their Canada Post mailbox in a condo that is near the concierge's desk, so they will have to walk past someone to get them
-baby locks on drawers where knives are kept
-creating a safe area at home (e.g.: on their bed), where they could not access any means, and where they would stay until suicidal thoughts passed.
-using candle wax to burn instead of cutting

FIREARMS:

-Can you tell me if anyone has ever spoken to you or your (family member OR friend) about restricting their use or access to firearms?

COMMUNITY PUBLIC HEALTH – BRIDGES, SUBWAYS, ETC.

-Can you tell me about any experiences you or your (family member OR friend) have had in limiting the exposure to community level factors, to keep them safe? Like not going into areas with bridges, subways, etc.

ALCOHOL/DRUGS & COMORBID MENTAL ILLNESS AND ADDICTION

-Can you tell me about the experience for your (family member OR friend) of trying to restrict access to alcohol or drugs?

-In the pilot interviews, some participants said that although it might be helpful, on a personal level, restricting access to drugs and alcohol could be challenging, especially when substance use disorders were present. In addition, it was discussed that substance use was not much discussed in their conversations with health care professionals. Some also shared that in their experience, substance use concerns and mental health concerns were not treated together, so substance use may not be discussed as a factor in means restriction or as problematic for the person. For a number of participants, as reported by themselves or a family member, however using substances increased their suicidal ideation or behaviour. Some family members disclosed that although they were concerned about substance use, their concerns were not included in any interventions for their family member OR friend, or even written up in notes of a family meeting.

10. Information/education sessions

Information or education sessions are one-time sessions that would provide general information about suicide, suicidal thoughts and behaviours to help you understand the experience. This includes things like risk factors, protective factors, and the types of resources available to help you and your (family member, friend, or the person you support).

e) **Have you ever attended an information session like this? What was it like? *(Prompt: most positive or most negative aspects).***

f) **What are your thoughts on information or education sessions? Can you think of a scenario in which this would be helpful? Unhelpful?**

Prompts/Sensitizing Concepts:

E.g. (from pilot data): feeling not so alone; obtaining important information; reducing stigma to talk about suicide; learning how to communicate with someone who has suicidal thoughts and feelings (to be validating, to be supportive, to be more clear, how to be really simple, etc.); hearing about methods for prevention; learning about coping mechanisms for depression, anxiety, etc.; learning about interventions that could help.

g) **What kinds of information or education do you think would be important to include?**

h) **Is there anything else we could add or modify in this approach to make it *more* helpful?**

Prompts:

-When and where should they be offered? E.g.: while hospitalized? Scheduled at a time when someone could come back to the hospital after an ED visit?;

-What format would work best?
E.g.:

-Online (‘real-time’, or on-demand?); In-person; Both online and in-person;

-Multiple opportunities to attend (drop-in), or a scheduled opportunity;

-Group sessions or individual sessions? (If individual sessions, use bi-directionally, to ask about what is being done, and also to gather information?)

11. **Follow-up contacts and monitoring**

When someone who has been experiencing suicidal thoughts or behaviours leaves the hospital or other health care setting, research suggests it may be effective to follow up with that person within 24 to 48 hours because evidence suggests a person's risk is highest after they leave the hospital. Follow-ups could be by phone call, email, letter, text, home visit or in-person meeting and the goal is to provide some continuity and support, stay engaged with the person, and help link them to some outpatient care.

e) What are your thoughts on a follow up contact and monitoring approach? Can you think of a scenario in which this might work well? Might not work well?

f) What type(s) of contacts do you think would be most helpful? Why or why not?

E.g.: from pilot interviews:

-phone, virtual meeting (teleconference); email, text, in-person.
-Make it optional/Ask for permission

> *-In the pilot, asking for permission was suggested since for some people, their experience at the ED was traumatizing – they might now want any follow-up; or they might want autonomy over the process. Or there were some comments that follow-ups may not be needed if other resources/supports are in place, or if the situation is not urgent, so asking will establish the need.*

-Schedule a follow-up in advance (unexpected contact can be triggering).

-Follow-up from a known health care professional

g) How many times or for how long do you think we should follow up?

h) As a family member, would you want to receive follow-up contacts?

Sensitizing Concepts:

-In the pilot interviews, one family member suggested to offer follow-up contact and monitoring for family members, particularly if a patient has been discharged to their care, or even if the patient has not been discharged to their care, for additional support. They commented that there are supports for the patient, but the equivalent is not pro-actively offered or set-up for the family member or friend.

i) Is there anything else we could add or modify in this approach to make it *more* helpful?

12. Psychosocial and therapeutic interventions

There is a fair amount of research suggesting that cognitive and behavioural therapies are helpful for people who are experiencing suicidal thoughts or behaviours. In this approach, people have ongoing sessions with a therapist; sessions would be about an hour and take place over many months. These types of therapies aim to teach people to recognize and understand their suicidal thoughts and behaviours; and then the therapist works with the person to develop personal strategies that help them to better manage their emotions and to keep themselves calm and safe when they are feeling distressed.

e) **What are your thoughts on psychosocial and therapeutic interventions? Can you think of a scenario in which these types of therapies might work well? Might not work well?**

Sensitizing Concepts:

-In the pilot interviews, like some other interventions such as safety planning – some family members felt that psychotherapy wouldn't necessarily work if the patient was in crisis, or not in touch enough with reality to be able to benefit. One participant gave an example of a family member whose mental health had severely declined, they were constantly in crisis and also using substances, so the participant thought they were not well enough to benefit from therapy just prior to when they completed suicide. This participant, however, thought that the family member would have benefited from therapy at an earlier point, 'when change would have still been possible'. Their comment speaks to early intervention. The timing of when therapy is offered is important.

-Other family members did see a benefit from therapy, for their family member/friend over time, or even immediately, to prevent suicidal or self-harm behaviour.

f) **What would be important for therapists to know?**

g) **Is there anything else we could add or modify in this approach to make it *more* helpful?**

III. General Questions – Tying it Together

7. **Do you think the experience of your (family member OR friend) was typical for most people you know? How is it similar, how is it different?**

8. **Do you think your experience of a support person was typical for most people you know? How was it similar, how was it different?**

9. **What helped you in providing support to your (family member OR friend) the most? What didn't help at all?**

   Prompts:

   -What made these experiences positive?
   -What made these experiences negative?

10. **What does a functioning mental health care system look like for people with suicidal thoughts?**

    Prompt (if not already covered adequately in previous questions, or for a last word):

    -In an ideal world, when you or someone else is experiencing suicidal thoughts or behaviour asks for help, what do you think should happen?

    -Should not happen?

5. **A related question is what does a functioning public services system look like for people with suicidal thoughts? (e.g.: livable wages, housing, etc.)**

IV. Wrap-up and conclusion of the interview

When you have the information you need and are ready to wrap up, you can note that your time together is ending, *briefly* summarize what you've heard, thank the participant for their participation, and then consider one or more of the following wrap-up questions:

- Is there anything else you would like to add?
- Is there anything else I should know?
- Is there anything I should have asked?
- How did the interview feel for you?
- How are you feeling now?

☐When the conversation is complete, turn off the audio-recorder

Appendix B: Brief Risk Screening Tool

1. Please rate your urges to self-harm on a scale of 0-7 (none-severe).

   0 1 2 3 4 5 6 7

2. Please rate your urges to suicide on a scale of 0-7 (none-severe).

   0 1 2 3 4 5 6 7

3. Please rate your sense of control over any self-harm or suicide urges using a scale of 0-7 (out of control-in control).

   0 1 2 3 4 5 6 7

Appendix C: Risk Management Protocols

In-person session example:

For participants who complete qualitative interviews, there is a risk of anxiety or distress when participants are asked to richly describe their experiences. To avoid harm and minimize distress or risks associated with qualitative interviews, it is important to review the following points:

1. It is important for research analysts (RAs) to re-confirm the emergency phone number, alternate contact number, addresses/fixed locations, access to additional methods (phone) to communicate with supports from the main cohort participants prior to the start of the interview (please see "First Session Introductory Questions" and the guide).
2. Qualitative interview guides will be used flexibly, so that interviewers can modify their environment, approach and/or line of questioning, as necessary, to ensure participants' wellbeing. Participants will also not be pressured to answer any question, they will be reminded that their participation is entirely voluntary, and that they are able to pause, skip any question, or stop altogether at any point in time. They are lastly told that they should notify the interviewer if they are feeling uncomfortable or distressed so their needs can be assessed and addressed.
3. Participants from the main cohort are offered the option of having a support person (e.g., family member or friend) present during the qualitative interview

Please also follow the steps outlined below in sections 1.1-1.3 in any incidences of increased self-injurious thoughts and behaviours, disclosure of child abuse/neglect, or aggression/agitation arise from qualitative interviews during *in-person sessions*.

1.1 Managing increased self-Injurious thoughts and behaviours (SITB) (during in-person sessions)

To proactively monitor and manage any potential increases in risk of SITB among study participants in-person, RAs will administer a brief two-step, three-question screener (see "Risk Screening Tool") before and after every assessment and interview completed in the study. RAs will also administer the PHQ (Patient Health Questionnaire)-9 and (Columbia Suicide Rating Scale) C-SSRS before every assessment. Please see below the step-by-step procedures for different levels of risk:

Scenario 1

High Risk (RED)

Beginning of session, if the participant meets the following:

1. Answers “Yes” to question #5 of the C-SSRS AND
2. Answers ≥ 3 to the question regarding controllability (“Could/can you stop thinking about killing yourself or wanting to die if you want to?”)

After session, if the participant has:

1. A significant change (≥ 2 points) in their risk screening score compared to the score calculated from the beginning of the session and/or reports feeling very unsafe

The participant is considered **high risk** due to active suicidal intent and plan. RAs must follow the steps below:

1. RAs will stop the research session and strongly recommend the participant to speak to the on-call psychiatrist due to concern for their safety (Reminder: Do not panic; rather, refer to this SOP for step-by-step guidelines. Please speak calmly and reassuringly to the participant).

2.

    a. If the participant agrees to speak to the on-call psychiatrist:
        i. The RA will use the CAMH phone available in the meeting room to call the psychiatrist, who is on-call on the session day (the phone call can be placed on speaker if that is preferable). If there is no CAMH phone available, the RA will use their personal cell-phone number to call the on-call psychiatrist. The RA will briefly explain the situation and ask for a safety consult.
        ii. During the safety consult, the psychiatrist will first assess the level of suicide risk;
        iii. If there is imminent risk, the psychiatrist will likely advise the RA to call 911, escort the participant to the CAMH Emergency Department or contact the participant’s clinical team (if the participant is an in-patient at the hospital).

    b. If the participant refuses to speak to the on-call psychiatrist:

        i. RAs will ask to step away momentarily from the interview room (step outside the room) and will call the on-call psychiatrist for a consultation
        ii. The RA will proceed as instructed by the on-call psychiatrist.
        iii. ***Please note:* the RA will only call 911 in situations where the participant is at an imminent risk of death (e.g., "I'm going to end my life right now", "I have a gun", "I overdosed before this visit").

Scenario 2

Moderate Risk (YELLOW)

Beginning of session, if the participant meets the following:

1. Answers "Yes" to question #4 or #5 of the C-SSRS OR
2. Answers ≥ 3 to the question regarding controllability ("Could/can you stop thinking about killing yourself or wanting to die if you want to?")

After session, if the participant has:

1. A moderate change (1 point) in their risk screening score compared to the score calculated from the beginning of the session and/or reports feeling very unsafe

The participant is considered **moderate risk** due to active suicidal intent without a plan. RAs must follow the steps below:

1. RAs will stop the research session and strongly recommend the participant to speak to the on-call psychiatrist due to concern for their safety (Reminder: Do not panic; rather, refer to this SOP for step-by-step guidelines. Please speak calmly and reassuringly to the participant).

2.

    a. If the participant agrees to speak to the on-call psychiatrist:
        i. The RA will use the CAMH phone available in the meeting room to call the psychiatrist who is on-call for the study on that day (the phone call can be placed on speaker if that is preferable). If there is no CAMH phone available, the RA will use their personal cell-phone number to call the on-call psychiatrist.

   ii. During the safety consult, the psychiatrist will first assess the level of suicide risk;
   iii. If there is moderate risk, the psychiatrist will encourage the RA to review the resource list with participants again (See "CAMH-SPCS Information Package") and to recommend the participant to call any of the aforementioned resources should their suicidality and/or self-harm worsen. The psychiatrist can also advise the RA to contact the participant's clinical team (if the participant is an in-patient at the hospital).
   iv. If imminent risk is noted after the safety consultation, the psychiatrist will recommend the RA to call 911, escort the participant to the CAMH Emergency Department or contact the participant's clinical team (if the participant is an in-patient at the hospital).

b. If the participant refuses to speak to the on-call psychiatrist:
   i. RAs will ask to step away momentarily from the interview room (step outside the room) and will call the on-call psychiatrist for a consultation
   ii. The RA will proceed as instructed by the on-call psychiatrist.
   iii. ***Please note:* the RA will only call 911 in situations where the participant is at an imminent risk of death (e.g., "I'm going to end my life right now", "I have a gun", "I overdosed before this visit").

Reporting

As soon as the situation is managed, RAs will report the incident to the PI by phone (if the PI provided support to the participant, RAs will still connect with the PI and Research Coordinator (RC) to debrief). The RA, RC, and PI will complete the necessary study documentation and an Adverse Event Log.

Scenario 3

Minimal Risk (GREEN)

Beginning of session, if the participant meets the following:

1. Answers "No" to question #4 or #5 of the C-SSRS AND
2. Answers < 3 to the question regarding controllability ("Could/can you stop thinking about killing yourself or wanting to die if you want to?") if applicable

After session, if the participant scores:

1. No change in risk screening tool score

The participant is considered **minimal risk** due to no suicidal intent or plan. RAs must follow the steps below:

1. The RA will confirm that the participant is feeling safe and will continue the research session or end the session (if the assessments are completed).

1.2 Managing concerns about child abuse and/or neglect

In the rare case that there is a concern about a youth being abused or neglected (e.g., as expressed by a participant during an assessment/interview), RAs will be trained to respond appropriately and follow legal requirements to report to the Children's Aid Society (CAS) if the youth being described is under 16 years. Recommendations will be offered if the youth is under 18 years.

**Note: It is not RAs' role to make unprompted inquires about child maltreatment or make negative assumptions.

In the rare case that child maltreatment is disclosed:

- RAs will ask three questions to determine:
    1. If this is an ongoing issue;
    2. If it has been reported;
    3. If there are any safety concerns.
- If this is a current issue that has not been reported, RAs will contact the on-call psychiatrist (i.e., PI or co-investigator) and discuss the incident
- The RA will proceed as advised, which may involve reviewing with the participant the availability of urgent or walk-in services, and/or calling CAS, to notify them of the incident

Reporting

As soon as the situation is managed, RAs will report the incident to the PI by phone (if the PI provided support to the participant, RAs will still connect with the PI to debrief).

The RA, PI (and RC if needed) will complete the necessary study documentation and an Adverse Event Form.

1.3 **Managing risk of agitation or aggression**

Despite safeguards taken to ensure RAs are not exposed to challenging behaviours from participants during the study (i.e., aggression, violence), it is important that RAs are able to respond effectively to these behaviours in the unlikely event that they do occur.

The following safety precautions will be taken for any in-person encounter with study participants:

- RAs will take into account environmental considerations when preparing for the meeting (e.g., keeping a direct/unobstructed path to the door, keeping heavy/unmounted objects out of participants' reach or noting their presence, identifying panic buttons, and ensuring the room is unlocked)
- RAs will take a few minutes to observe the participant's initial demeanour, taking note of indicators of agitation (e.g., anger, irritability, pacing, and/or signs of intoxication)
- If participants exhibit challenging behaviour at any point, RAs will consider pausing the assessment/interview to connect with the RC and/or the on-call physician and/or the participant's clinical team (if the participant is in hospital)
- In the event of physical aggression, the RA will leave the space if possible and follow 'Code White' procedures; if leaving is not possible, RAs will locate the panic button and attempt to de-escalate using a calm, slow voice, and/or use TIDES training strategies for de-escalation or self-protection until help arrives. If the RA is injured, they will be advised to seek medical assistance immediately.
- In the event of verbal aggression, the RA will verbally de-escalate by speaking in a slow, calm voice and leave the space. They will connect with the RC and/or on-call psychiatrist (i.e., PI or co-investigator).

Reporting

As soon as the situation is managed (and if necessary, medical assistance is provided), RAs will report the incident to the PI by phone (if the PI was not the on-call psychiatrist). The RA, RC and PI will complete the necessary study documentation, and they may also complete an Adverse Event Form (if applicable).

Appendix D: Supplemental Table

Description of study measures, rationale, and time point of administration (in months)

Measure	***Rationale***	***Time point (months)***				
		0	***2***	***4***	***6***	***12***
Demographic and Clinical History	*Measures demographic and clinical characteristics, including sex, gender, sexual orientation, ethnicity, personal history of mental illness and addictions, family history of mental illness and suicide, medication history, and current medication use.*	•				
Review, Service Utilization History	*Captures mental health service utilization, namely outpatient psychiatric care, ED visits, and inpatient care. Both lifetime utilization history and utilization since each last visit will be assessed.*		•	•	•	•
Columbia-Suicide Severity Rating Scale (C-SSRS lifetime)	*Evaluates the severity of suicidal ideation, suicide-related behaviour with and without intent to die, and lethality (lifetime and past two months). The C-SSRS demonstrates good convergent and divergent validity, excellent internal consistency, moderately good interrater reliability, and high sensitivity and specificity for suicidal behavior classifications when compared to other measures of suicidality* [1–5]. *This*	•				

Columbia-Suicide Severity Rating Scale (C-SSRS past 2 months)	*assessment was also chosen due to its ease of training and widespread use in cohort studies and clinical trials.*	•	•	•	•	•
C-SSRS Suicide Attempt section (since last assessment)						•
Self-injurious Thoughts and Behaviours Interview-Non-suicidal self-injury section (SITBI- NSSI) - lifetime	*Measures the presence, frequency, and characteristics of a range of non-suicidal self-injurious thoughts and behaviours (lifetime and past two months). The SITBI has good construct validity, with strong correspondence between the SITBI and other measures of NSSI, excellent interrater reliability, and strong test-retest reliability* [6,7].	•				
SITBI-NSSI – past 2 months		•	•	•	•	•
Structured Clinical Interview for DSM-V – Research Version (SCID-5-RV)	*Widely used to assess DSM-5 diagnoses, including drug and alcohol use disorders.*	•				
Personality Inventory for DSM-V Short Form (PID- 5-SF)	*Measures DSM-5 personality disorders. The PID-5 has adequate internal consistency, convergent validity with other personality assessments, correlations with broadly conceptualized clinical constructs, and test-retest reliability* [8–10].	•				
Premenstrual Questionnaire	*Captures frequency of menstrual periods since last visit, premenstrual symptoms, and changes in suicidality as related to the menstrual period. There is increasing evidence correlating premenstrual syndrome and premenstrual dysphoric disorder to higher suicidality* [11–13].		•	•	•	•

Barratt Impulsiveness Scale 11 (BIS-11)	*Evaluates three components of impulsivity: attentional, motor, and non-planning. The BIS-11 maintains good criterion-related validity, internal consistency, and test-retest reliability* [14].	•				
Montreal Neurocognitive Assessment (MoCA)	*Determines cognitive abilities across several domains. The MoCA shows good convergent and divergent validity, internal consistency, sensitivity and specificity, and an excellent test-retest reliability* [15–17].	•				
Buss-Perry Aggression Questionnaire (BPAQ)	*Measures impulsive aggression via four subscales, which positively relate to other measures of aggression, have some construct validity, and moderate to high internal consistency* [18,19].	•				
Patient Health Questionnaire – 9 (PHQ-9)	*Screens for depression and measures symptom severity. The PHQ-9 has strong convergent and divergent validity across its severity categories, as well as internal consistency* [20,21]	•	•	•	•	•
Generalized Anxiety Disorder – 7 (GAD-7)	*Screens for anxiety and measures symptom severity. The GAD-7 has good construct validity, correlating well with other anxiety questionnaires, and good internal consistency* [22].	•	•	•	•	•

Beck Hopelessness Scale (BHS)	*Evaluates three hopelessness aspects: feelings about the future, loss of motivation, and expectations. The BHS has strong convergent validity, highly associated with measures of similar constructs, as well as good internal consistency, discriminant utility, and test-retest reliability* [23,24].	•	•	•	•	•
Insomnia Severity Index (ISI)	*Screens for and measures severity of insomnia. The ISI has good convergent validity, correlating well with measures of fatigue, quality of life, depression, and anxiety. This index also shows excellent internal consistency* [25,26].	•	•	•	•	•
World Health Organization- Alcohol Smoking and Substance Involvement Screening (WHO-ASSIST) V3-0	*Measures nicotine, alcohol, and substance use. The WHO-ASSIST has good concurrent, construct and predictive validity, high specificity, and internal consistency* [27,28].	•		•		•
Alcohol Use Disorders Identification Test (AUDIT)	*Collects information on alcohol consumption patterns. The AUDIT maintains excellent sensitivity and specificity, high internal consistency, satisfactory construct validity, and high test-retest reliability* [29].	•	•	•	•	•
Ohio State University (OSU) Traumatic Brain Injury (TBI) Identification Method (OSU TBI-ID) Short Version	*Measures lifetime history of traumatic brain injury. The OSU TBI-ID has high interrater reliability and good predictive validity* [30].	•				•

Brief Pain Inventory (BPI) – Short Form	*Measures sensory and reactive dimensions of pain. The BPI has satisfactory to good construct validity, criterion validity, adequate internal consistency, and acceptable to excellent test-retest reliability* [31].	•	•	•	•	•
Childhood Trauma Questionnaire – Short Form (CTQ-SF)	*Identifies severity of early life adversity using five subscales: physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect (including a denial scale to detect under-reporting). The CTQ-SF shows good evidence of criterion-related validity, structural validity, and internal consistency* [32,33].	•				
Everyday Discrimination Scale (Canadian)	*Examines chronic social stressors related to discrimination. This version has been adapted for Canadian contexts.*	•				
Neighbourhood Socioeconomic Position (SEP)	*Measures environmental protective factors or stressors, such as walkability, availability of healthy foods, safety, violence, and social cohesion. The SEP has good test-retest reliability* [34].	•				

Life Events Checklist for DSM-5 (LEC-5)	*Measures acute stress related to potentially traumatic events, e.g., accidents or injuries, victimization, and threat of death. The LEC-5 has good test-retest reliability, especially for direct reports of sexual assault, physical assault, transportation accidents, natural disasters, and other sexual experiences* [35].	•				
Multidimensional Scale of Perceived Social Support (MSPSS)	*Determines perceptions of social support (e.g., family, friends, and partners). The MSPSS has moderate construct validity as well as good subscale validity, internal reliability, and test-retest reliability* [36–38].	•	•	•	•	•
International Physical Activity Questionnaire (IPAQ)	*Captures health-related physical activity; the IPAQ has acceptable measurement properties* [39,40].	•	•	•	•	•
World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)	*Establishes functional disability across 6 domains: cognition, mobility, self-care, relationships, life activities, and participation. The WHODAS 2.0 shows concurrent validity when*	•	•	•	•	•

Short Form Health Survey (SF-36)	*Measures quality of life in 8 scales: physical functioning, role-physical, bodily pain, general health perceptions, vitality, social functioning, role-emotional, and mental health. The SF-36 has strong item-convergent and discriminant validity, particularly among the physical functioning and mental health scales, as well as high internal consistency* [42,43].	•	•	•	•	•

Table 2 provides the various measures, relevant rationale, and when they are administered. All study measures were selected based on the biopsychosocial model of suicide risk [44]. To capture factors outlined in this model, we selected measures based on their psychometric properties as well as feasibility and convenience of administration.

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