

**National Time Trends in Suicidal Ideation and Attempts and their
Treatment Among Canadian Forces Personnel and the General
Population**

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Abstract

Background: In the context of the Canadian mission in Afghanistan, there has been significant media attention on mental health problems and lack of access to mental health services among Canadian military personnel. It remains unknown whether the prevalence of suicidal ideation, plans, and attempts and their treatment are changing over time or differ between Canadian Armed Forces (CAF) and Canadian General Population (CGP). Herein, we compare prevalence of suicidal behaviours and help seeking between the CGP and the CAF, and examine trends over a ten-year period.

Methods. Data were drawn from four nationally representative Canadian surveys (of respondents age 18-60 years old) designed by Statistics Canada to permit comparisons between populations and trends over time. The CGP surveys were conducted in 2002 (N = 25,643) and 2012 (n = 15,981). The CAF surveys were conducted in 2002 (n = 5,155) and 2013 (n = 6,700). Lifetime suicidal ideation, plans, and attempts, and mental health service use were assessed.

Results: Although in 2002 there were no significant differences between CAF and CGP on suicidal ideation, in 2012/2013, CAF had higher prevalence of suicidal ideation compared to the CGP in the recent surveys (adjusted odds ratios: 1.30-1.60). CAF members with suicidal behaviours had a significantly higher prevalence of all types of help seeking compared with their counterparts in the CGP across both time points.

Conclusions: Canadian military personnel have higher prevalence of suicidal ideation, plans, and mental health service use compared to Canadian civilians.

Introduction

Suicide is a leading cause of mortality around the world among military and civilian populations (1-3). There is increased public attention to suicidal behaviour in Canada, and a number of initiatives are being put in place to reduce suicides through better recognition and treatment of mental disorders (4). Examples of major Canadian initiatives include creation of a national Mental Health Commission of Canada, (5) development of a Federal Framework for Suicide Prevention, (6) large investments in military and veteran mental health services, and targeted efforts to formulate comprehensive suicide prevention strategies among military and veteran populations (4, 7). Despite these initiatives, the prevalence of suicide in Canada has not changed appreciably in recent years (8, 9).

A recent report on suicides in Canadian Armed Forces (CAF) did not find an overall increase in suicide deaths between 1995 and 2014 (10). However, the subgroup of Regular Force male army members had a significant increase in prevalence of suicide over that time (10). The United States (US) army has observed steady increases in the prevalence of suicide attempts and completed suicide by US soldiers since 2004, while the US general population prevalence of suicide has remained unchanged (3, 11, 12). Findings from the US are not generalizable to the Canadian military because of differences in recruitment, deployment policies, and health care systems (13).

Suicidal ideation, plans, and attempts are strong risk factors for death by suicide (14). A history of suicide attempts is the strongest predictor of future attempts (15). Suicidal ideation is also an important target for intervention because previous work has demonstrated a rapid transition from first onset suicidal ideation to plans and attempts within the same year (16). It remains unknown whether there are changes in non-lethal suicidal behaviour in the military and civilian populations in Canada over a 10-year period.

Another area of major public health concern is that the majority of people with suicidal behaviour do not receive any mental health services. Among civilian nationally representative samples in Canada and twenty-one other countries, the majority of suicidal respondents (60%) did not receive any mental health services (17, 18). The use of services by suicidal military personnel in Canada remains unknown. Although the media has recently been highly critical of the CAF and Veterans Affairs Canada about insufficient services available to Canadian military and veterans (19), there has been no previous investigation that has directly compared rates of mental health service use between military personnel and civilians with suicidal behaviors.

To fill these essential gaps in the literature, we examined four Canadian nationally representative surveys that were specifically designed by Statistics Canada to enable comparison across populations approximately 10 years apart (2002 and 2012/13). In this paper, we aim to compare prevalence of suicidal behaviours

and help seeking between the CGP and the CAF over a ten-year period.

Materials and Methods

Samples

Data were obtained from four nationally representative Canadian datasets collected by Statistics Canada: (1) the Canadian Community Health Survey Cycle 1.2 collected in 2002: $n = 36,984$; response rate 77.0%, (2) the Canadian Community Health Survey Cycle 1.2 Canadian Forces Supplement collected in 2002: $n = 8,441$; response rate 81.1%, (3) the Canadian Community Health Survey-Mental Health collected in 2012: $n = 25,113$; response rate 68.9%, and (4) the Canadian Forces Mental Health Survey collected in 2013 $n = 8,393$; response rate 79.8%. We will use the abbreviation CGP for Canadian General Population surveys, and CAF for Canadian Armed Forces surveys. Sampling frames to ensure representativeness of populations were used across all four surveys. Data were collected through face-to-face interviews by trained lay interviewers using computer-assisted interviewing techniques. Participation in each of the surveys was voluntary, and respondent consent was obtained prior to conducting each survey. Respondent privacy and confidentiality was ensured based on the Statistics Act. Details of the four surveys have been published elsewhere (20-22).

Analyses were restricted to respondents 18 to 60 years of age to maintain age comparability across the four surveys. Additionally, only serving Canadian Regular Forces personnel from the two military samples were included in analyses. The total sample size in the merged dataset across the four samples was $n = 53,477$

(i.e., CGP 2002: n = 25,643; CGP 2012: n = 15,981; CAF 2002: n = 5,153; CAF 2013: n = 6,700). Reserve Forces members were excluded from the CAF samples because the sampling design differed between 2002 and 2013 surveys. In 2002, the Reserve Forces were a representative sample, while in 2013 the Reserve Forces only included members that had deployed in support of the mission in Afghanistan.

Measures

Suicidal Behaviours

Suicidal ideation, plans, and attempts were assessed through a series of questions. Respondents were asked if they had (1) seriously thought about committing suicide or taking his/her own life; (2) made a plan for committing suicide; or (3) attempted suicide or tried to take their own life. These were assessed for lifetime and past year time frames. Suicidal plans were not assessed in the 2002 surveys, therefore those comparisons were only computed for the CGP 2012 and the CAF 2013 survey cycles.

Mental Health Service Use

Past-year professional treatment seeking was assessed through a series of questions about contact with a variety of different healthcare professionals for problems with their emotions, mental health, or use of alcohol or drugs in the past 12 months. In this study, healthcare professionals included: (1) psychiatrists; (2) psychologists; (3) family doctors or general practitioners; (4) nurses; and (5) social workers, counsellors, or psychotherapists. Dichotomous assessments were made for each category of healthcare

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professional seen in the past year separately (yes or no). Separate variables were computed for whether the respondent had contact with any healthcare professional in the past year (yes or no) and the total number of professionals seen in the past year (0 to 5).

Sociodemographic Covariates

Sociodemographic variables included in the models as covariates were as follows: age (18 to 29 years; 30 to 39 years; 40 to 60 years), sex (male or female), visible minority status (yes or no), education (high school or less; some post-secondary; university bachelor's degree or higher) and income (less than \$80,000 or \$80,000 or more).

Statistical Analyses

Statistical weights supplied by Statistics Canada were applied to the data to ensure that estimates were representative of each respective population. Bootstrapping was performed as a variance estimation technique using STATA software to account for the complex survey designs. First, overall and then sex-specific prevalence estimates were computed for lifetime and past year suicidal behaviours across the four surveys. A series of multivariable logistic regression models, adjusted for sociodemographic covariates, were computed to test for differences in the prevalence of lifetime and past year suicidal behaviors across the four surveys in the merged dataset.

Second, a series of multivariable logistic regression models,

adjusted for sociodemographic covariates, were computed to test for differences in the prevalence of past year professional treatment seeking among respondents reporting each type of suicidal behaviour across the four surveys in the merged dataset. Third, estimated marginal means were calculated for the total number of professionals seen in the past 12 months by computing coefficients derived from a negative binomial regression model which adjusted for sociodemographic variables. Differences in estimated marginal means across the surveys were calculated using these coefficients.

Finally, time (2002 vs. 2012/13) by population (CGP vs. CAF) interaction terms were entered into multivariate models to test whether the changes in the CAF were greater than in the CGP for all outcomes (i.e., suicidal behaviours and mental health service use).

Results

Table 1 and 2 show the lifetime and past-year prevalence of suicidal behaviours among the four samples. In 2012/2013, however not in 2002, the CAF had significantly higher odds of both lifetime and past-year suicidal ideation and plans than the CGP (AORs 1.32, 1.64, 1.34, and 1.66, respectively). Time by population interaction terms indicated that changes in lifetime suicidal ideation among males were significantly greater in the CAF than the CGP (AOR = 1.27; 95% CI = 1.05, 1.53, $p < .013$).

As reflected in Table 1, there was a significant increase in lifetime suicide attempts among CAF male personnel (AOR=1.51,

reflected in an AOR for the CAF population as a whole of 1.32) and the significant decrease in lifetime suicidal ideation among CAF female personnel (AOR=0.78) from 2002 to 2013. CGP and CAF comparisons indicated few differences in the prevalence of suicidal behaviors in 2002.

Table 3 reports the prevalence of help seeking among those with suicidal behavior. Over the decade, there were significant increases in the prevalence of help seeking across both civilian and military samples. In both time periods, help seeking was significantly higher in the CAF than the CGP. The time by population interaction terms were not significant in the mental health service use models.

Discussion

The present study provides new information about national trends in suicidal behaviour and help seeking among CAF personnel and the CGP. First, in 2012/2013, the CAF had a significantly higher prevalence of suicidal ideation and plans than the CGP. Second, there was a significant increase over the decade in lifetime prevalence of suicide attempts in the CAF, with no significant change over the same time period in the CGP. Third, prevalence of lifetime and past-year suicidal ideation among male CAF members did not change over time, but females in the CAF had a significant decrease in lifetime suicidal ideation. Finally, among people with suicidal behaviour, CAF members had significantly higher prevalence of all types of help seeking and number of professionals seen compared to the CGP.

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The higher prevalence of suicidal ideation and plans among military personnel compared to civilians in recent samples, and the increase in lifetime prevalence of suicide attempts in male CAF members over time, are consistent with previous work in Canada (10), as well as in the US where increasing trends in suicide attempts and deaths have been observed (23, 24).

There are several explanations for these findings. One possibility is that this increase in suicidal behavior may have been related to a concurrent increase in the prevalence of PTSD and other anxiety disorders over time in male CAF members (7, 25, 26). Another potential explanation is that a greater proportion of military personnel may have had increased exposure to traumatic experiences that are more strongly linked to suicidal behaviour during their deployments than previous military cohorts (27). In American soldiers, pre-enlistment suicidal behaviour is common (3). The prevalence of pre-enlistment suicidal behaviour (and related risk factors for suicidality) among Canadian soldiers could have changed over time. However, there have not been any relevant policy changes in the CAF to relax recruitment criteria over this period. Regardless of whether the causes of suicidal behaviour are related to pre-enlistment or deployment-related factors, time trends of increasing lifetime suicide attempts and higher prevalence of suicidal ideation and plans among military samples compared to civilians is an alarming and important observation with public policy ramifications.

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The significant decrease over a ten-year period in lifetime suicidal ideation among military women was unanticipated. In post hoc analysis (data available on request), we explored whether the decrease in suicidal ideation could be due lower combat exposure among female CAF members in recent samples compared with male CAF members. We did not find support for this hypothesis because both military men and women had increases in combat exposure over the ten-year period - *women: 2013 20%, 2002 9%; men: 2013 37%, 2002 21%*. Another potential explanation is that women are more likely to seek mental health services than men and effective treatment of mental disorders are associated with lower rates of suicidal behavior (28). Further examination of the reasons for the decrease in lifetime rates of suicidal ideation among military women is required.

Although the CAF and Veterans Affairs Canada have been criticized strongly in the media about the concerns of lack of access to mental health services (19), at both time points, suicidal military personnel were significantly more likely to access mental health services than their civilian counterparts. The Canadian health care system has been criticized for not being a universal health care system with inequities in access, variation in service provision across provinces, and substantial inefficiencies (29). The present study supports this criticism by showing inequities in receipt of services between civilians and military personnel. Mental health services for military personnel are funded through a federally organized system, while civilians access care through a provincially funded system (29). This

direct comparison between military and civilian samples suggests the need for stronger investment in mental health services for civilians such that there is equitable access to mental health services for civilians and military personnel. The Canadian military has also created post-deployment screening programs (25) and anti-stigma campaigns such that personnel can access services in a timely manner (4). Certain highly stressful occupations such as firefighters and police officers may benefit for screening and anti-stigma campaigns similar to those employed by the military.

There are several limitations to the present study. First, we examined suicidal ideation, plans, and attempts; therefore, findings are not generalizable to completed suicides. Second, recall errors may have biased the reporting of suicidal behavior and help seeking. Increased public attention on suicidal behavior may have also impacted responses to suicide questions in recent surveys. Third, people with severe mental illness may have left military service or not participated in the general population surveys so that the prevalence of suicidal behaviours we documented may be underestimated. Fourth, the 2013 CAF survey did not acquire a representative sample of Reserve Force members. As such, we were not able to examine trends in suicidal behaviour among Reservists. Finally, the lethality of suicidal behaviour was not assessed in the surveys and could have differed over time (30). Nonetheless, the survey methodology was consistent across all four surveys and used state-of-the-art structured diagnostic interviews that are used around the world (31). Finally, our

findings may not be generalizable to other countries with different health systems and policies.

In conclusion, during the period of review, CAF members had a higher prevalence of suicidal ideation and plans, and help seeking compared to civilians. Over a ten-year period, male CAF members demonstrated a significant increase in lifetime suicide attempts during the last decade and female CAF members had a significant decrease in lifetime suicidal ideation. There were no significant time trends in suicidal behaviour among civilians over the same time period. Strong investments in clinical services and research are required to reduce suicidal behaviour among military and civilian populations.

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Table 1. Trends in Lifetime Suicide-Related Behaviors in the Canadian Armed Forces and the Canadian General Population								
Prevalence of Suicide-Related Behaviour	Canadian Armed Forces (CAF)			Canadian General Population (CGP)			CAF vs. CGP	
	CAF(2002) N = 5,153 % (95% CI)	CAF(2013) N = 6,700 % (95% CI)	AOR (95% CI) (2002 = Ref)	CGP (2002) N = 25,643 % (95% CI)	CGP (2012) N = 15,981 % (95% CI)	AOR (95% CI) (2002 = Ref)	CAF vs. CGP (2002) AOR (95% CI)	CAF vs. CGP (2012/2013) AOR (95% CI)
Total Sample								
Ideation	15.7 (14.7, 16.9)	15.4 (14.5, 16.3)	1.04 (0.93, 1.17)	15.2 (14.6, 15.8)	13.3 (12.5, 14.1)	0.93 (0.85, 1.02)	1.09 (0.98, 1.22)	1.32 (1.17, 1.50)
Plan	NA	6.1 (5.5, 6.7)	NA	NA	4.6 (4.1, 5.1)	NA	NA	1.64 (1.35, 1.99)
Attempt	2.5 (2.1, 3.1)	3.0 (2.5, 3.5)	1.32 (1.02, 1.72)	3.6 (3.3, 3.9)	3.5 (3.1, 4.0)	1.10 (0.93, 1.30)	0.92 (0.74, 1.15)	1.14 (0.91, 1.44)
Males								
Ideation	14.8 (13.6, 16.0)	14.9 (13.9, 15.9)	1.11 (0.97, 1.26)	14.0 (13.2, 14.9)	11.8 (10.7, 12.9)	0.88 (0.77, 1.00)	1.03 (0.91, 1.18)	1.30 (1.12, 1.52)
Plan	NA	5.9 (5.3, 6.6)	NA	NA	4.0 (3.5, 4.7)	NA	NA	1.66 (1.33, 2.08)
Attempt	2.1 (1.6, 2.7)	2.6 (2.1, 3.1)	1.51 (1.09, 2.09)	2.4 (2.1, 2.7)	2.7 (2.2, 3.2)	1.23 (0.98, 1.54)	0.83 (0.62, 1.11)	1.15 (0.85, 1.55)
Females								
Ideation	22.6 (20.5, 24.9)	18.4 (15.7, 21.3)	0.78 (0.62, 0.97)	16.3 (15.4, 17.2)	14.8 (13.6, 16.1)	0.98 (0.87, 1.11)	1.48 (1.27, 1.74)	1.36 (1.09, 1.70)
Plan	NA	6.7 (5.2, 9.1)	NA	NA	5.1 (4.3, 6.0)	NA	NA	1.60* (1.09, 2.35)
Attempt	5.8 (4.7, 7.0)	5.4 (3.9, 7.5)	0.92 (0.59, 1.44)	4.8 (4.4, 5.3)	4.4 (3.7, 5.2)	1.03 (0.82, 1.29)	1.22 (0.93, 1.61)	1.42 (0.93, 2.18)

Note. In the CFS 2013 survey, percentages are based on weighted N, which were rounded to a base 20 for confidentiality purposes according to Statistics Canada data release policies. NA = not available in dataset and/or was not released by Statistics Canada to protect respondent confidentiality; AOR = adjusted odds ratio (adjusted for age, sex, marital status, visible minority status, education, and income); CI = confidence interval.

Table 2. Trends in past year Suicide-Related Behaviors in the Canadian Armed Forces and the Canadian General Population								
Prevalence of Suicide-Related Behaviour	Canadian Armed Forces (CAF)			Canadian General Population (CGP)			CAF vs. CGP	
	CAF (2002) N = 5,153 % (95% CI)	CAP(2013) N = 6,700 % (95% CI)	AOR (95% CI) (2002 = Ref)	CGP (2002) N = 25,643 % (95% CI)	CCHS (2012) N = 15,981 % (95% CI)	AOR (95% CI) (2002 = Ref)	CAF vs. CGP (2002) AOR (95% CI)	CAF vs. CGP (2012/2013) AOR (95% CI)
Total Sample								
Ideation	4.2 (3.7, 4.8)	4.3 (3.7, 4.9)	1.13 (0.91, 1.40)	3.9 (3.6, 4.3)	3.6 (3.2, 4.1)	1.00 (0.84, 1.19)	1.11 (0.92, 1.33)	1.34 (1.09, 1.66)
Plan	NA	1.8 (1.5, 2.1)	NA	NA	1.3 (1.0, 1.7)	NA	NA	1.66 (1.18, 2.33)
Attempt	0.3 (0.2, 0.5)	0.4 (0.2, 0.6)	1.33 (0.61, 2.87)	0.6 (0.5, 0.7)	0.6 (0.4, 0.9)	1.29 (0.78, 2.14)	0.61 (0.34, 1.08)	0.88 (0.43, 1.77)
Males								
Ideation	4.0 (3.4, 4.7)	4.3 (3.7, 4.9)	1.17 (0.92, 1.49)	4.0 (3.5, 4.5)	3.4 (2.9, 4.0)	0.90 (0.71, 1.16)	1.11 (0.90, 1.38)	1.43 (1.10, 1.86)
Plan	NA	1.8 (1.5, 2.2)	NA	NA	1.3 (0.9, 1.7)	NA	NA	1.84 (1.22, 2.77)
Attempt	0.2 (0.1, 0.4)	NA	NA	0.5 (0.3, 0.6)	0.5 (0.3, 0.7)	1.11 (0.62, 2.02)	0.42 (0.15, 1.18)	NA
Females								
Ideation	5.3 (4.3, 6.5)	4.3 (2.9, 6.0)	0.93 (0.55, 1.56)	3.9 (3.4, 4.4)	3.9 (3.2, 4.5)	1.09 (0.86, 1.39)	1.41 (1.07, 1.85)	1.17 (0.75, 1.83)
Plan	NA	1.6 (0.8, 2.8)	NA	NA	1.3 (0.9, 2.0)	NA	NA	1.23 (0.55, 2.76)
Attempt	1.1 (0.7, 1.8)	NA	NA	0.7 (0.5, 0.9)	0.7 (0.4, 1.3)	1.40 (0.67, 2.89)	1.69 (0.85, 3.36)	NA

Note. In the CFS 2013 survey, percentages are based on weighted N, which were rounded to a base 20 for confidentiality purposes according to Statistics Canada data release policies. NA = not available in dataset and/or was not released by Statistics Canada to protect respondent confidentiality; AOR = adjusted odds ratio (adjusted for age, sex, marital status, visible minority status, education, and income); CI = confidence interval.

Table 3. Trends in the Prevalence of Past year Treatment Seeking Among the Canadian Armed Forces and Canadian General Population with Past year Suicide-Related Behaviors								
Sector of Treatment	Canadian Armed Forces (CAF)			Canadian General Population (CGP)			CAF vs. CGP	
	CAF (2002) % (95% CI)	CGP (2013) % (95% CI)	AOR (95% CI) (2002 = Ref)	CGP (2002) % (95% CI)	CGP (2012) % (95% CI)	AOR (95% CI) (2002 = Ref)	CAF vs. CGP (2002) AOR (95% CI)	CAF vs. CGP (2012/2013) AOR (95% CI)
Psychiatrist								
Ideation	24.6 (18.6, 31.8)	38.7 (32.3, 45.4)	2.32 (1.42, 3.77)	17.3 (14.5, 20.5)	20.9 (16.9, 25.6)	1.45 (1.00, 2.09)	1.73 (1.03, 2.92)	2.41 (1.39, 4.17)
Plan	NA	45.6 (36.3, 56.9)	NA	NA	35.7 (25.3, 47.7)	NA	NA	1.18 (0.41, 3.46)
Attempt	47.2 (26.6, 68.9)	50.0 (28.9, 74.4)	1.32 (0.11, 16.11)	37.6 (28.1, 48.2)	30.1 (16.7, 47.9)	0.73 (0.31, 1.72)	1.64 (0.49, 5.45)	3.93 (0.84, 18.39)
Psychologist								
Ideation	25.4 (19.4, 32.6)	40.9 (34.4, 47.6)	2.17 (1.35, 3.48)	12.0 (9.5, 15.2)	17.5 (12.6, 23.9)	1.49 (0.95, 2.35)	2.42 (1.26, 4.65)	4.67*** (2.58, 8.47)
Plan	NA	50.9 (40.1, 61.2)	NA	NA	28.2 (16.8, 43.2)	NA	NA	3.88 (0.94, 16.04)
Attempt	48.3 (27.2, 70.1)	50.0 (29.3, 72.3)	0.94 (0.15, 5.74)	17.4 (9.9, 28.6)	32.0 (14.0, 57.6)	2.37 (0.55, 10.23)	4.58 (1.15, 18.15)	6.33 (0.65, 61.56)
Family Doctor								
Ideation	36.0 (29.2, 43.4)	43.8 (36.8, 50.6)	1.48 (0.94, 2.34)	31.2 (27.1, 35.6)	40.0 (33.4, 46.9)	1.53 (1.09, 2.15)	1.94 (1.23, 3.05)	1.71 (1.02, 2.84)
Plan	NA	49.1 (39.8, 59.9)	NA	NA	57.4 (45.0, 68.9)	NA	NA	1.01 (0.33, 3.08)
Attempt	60.7 (37.6, 79.8)	58.3 (35.2, 77.1)	1.18 (0.14, 10.14)	41.2 (31.3, 51.8)	70.8 (53.9, 83.4)	3.55 (1.45, 8.69)	2.68 (0.69, 10.38)	0.55 (0.13, 2.39)
Nurse								
Ideation	14.9 (10.2, 21.2)	29.2 (23.6, 35.0)	2.84 (1.59, 5.09)	4.4 (3.1, 6.1)	7.5 (5.3, 10.5)	1.77 (1.03, 3.06)	7.51 (3.13, 18.06)	6.54 (3.00, 14.28)
Plan	NA	40.4 (31.5, 50.8)	NA	NA	10.8 (6.4, 17.6)	NA	NA	8.53 (1.95, 37.25)
Attempt	35.0 (17.5, 57.8)	58.3 (33.6, 76.9)	2.48 (0.33, 18.98)	12.2 (7.0, 20.5)	11.0 (5.4, 21.3)	0.93 (0.35, 2.47)	5.26 (1.31, 21.15)	23.40 (1.86,

								294.48)
Social Worker								
Ideation	25.4 (19.1, 33.0)	52.6 (45.8, 58.7)	3.76 (2.29, 6.16)	11.6 (8.6, 15.5)	22.5 (18.2, 27.5)	2.43 (1.54, 3.86)	4.17 (2.20, 7.91)	4.84 (2.83, 8.27)
Plan	NA	54.4 (43.8, 64.0)	NA	NA	29.0 (20.5, 39.3)	NA	NA	4.23 (1.39, 12.85)
Attempt	39.5 (20.6, 62.2)	NA	NA	17.1 (11.2, 25.2)	30.6 (17.6, 47.7)	2.19 (0.78, 6.17)	3.60 (1.08, 12.02)	NA
Any Treatment Seeking								
Ideation	51.3 (44.0, 58.6)	73.0 (66.6, 78.6)	3.16 (1.96, 5.08)	42.1 (37.6, 46.8)	57.0 (50.8, 63.0)	1.90 (1.37, 2.62)	2.02 (1.31, 3.13)	3.14 (1.86, 5.28)
Plan	NA	77.2 (68.1, 85.7)	NA	NA	75.7 (66.0, 83.3)	NA	NA	1.84 (0.61, 5.53)
Attempt	72.0 (47.5, 87.9)	NA	NA	58.4 (46.8, 69.1)	79.8 (65.0, 89.4)	2.83 (1.13, 7.11)	2.00 (0.49, 8.22)	NA
Total Number of Professionals ¹	Mean (95% CI)	Mean (95% CI)	χ^2	Mean (95% CI)	Mean (95% CI)	χ^2	χ^2	χ^2
Ideation	1.5 (1.2, 1.8)	2.6 (2.1, 3.0)	21.46	0.7 (0.6, 0.8)	1.1 (1.0, 1.2)	19.73	18.53	34.65
Plan	NA	2.5 (1.8, 3.3)	NA	NA	1.6 (1.3, 1.9)	NA	NA	4.87
Attempt	2.5 (1.4, 3.5)	3.5 (2.5, 4.5)	2.13	1.2 (0.9, 1.5)	1.7 (1.4, 2.1)	7.02	5.12	10.99

Note. In the CAF 2013 survey, percentages are based on weighted N, which were rounded to a base 20 for confidentiality purposes according to Statistics Canada data release policies. NA = not available in dataset and/or was not released by Statistics Canada to protect respondent confidentiality; AOR = adjusted odds ratio (suicide ideation and suicide plan models adjusted for age, sex, marital status, visible minority status, education, and income; suicide attempt models adjusted for age and sex); CI = confidence interval.

¹Estimated marginal means (i.e., adjusted means) were computed from coefficients derived from negative binomial regression models. Suicide ideation and suicide plan models adjusted for age, sex, marital status, visible minority status, education, and income. Suicide attempt models adjusted for age and sex.