Appendix H

Suicide Risk Screening

What is the difference between suicide risk screening and suicide risk assessment?

Screening to refer to a process used to identify individuals who may be at risk for suicide. It involves asking questions about suicidal thoughts/wishes to be dead, plans, or suicide intent.

In a sense, they serve as "triage" by screening in a small set of people who may be at risk of killing themselves. **The "screened-in" group then needs additional step which is standardized interview questions or consultation by a qualified mental health professional – in order to identify the seriousness of the suicide risk**. This next step is called suicide risk assessment.

Suicide risk assessment usually refers to a more comprehensive full evaluation done by a qualified clinician to confirm suspected suicide risk, estimate the immediate danger to the patient, and decide on a plan for intervention and a course of treatment.

What is the task that I am requested to do?

You are requested to do suicide risk screening not assessment.

How do I conduct the screening for suicide?

Use that opening statement:

Now I'm going to ask you some questions that we ask everyone. It is part of the hospital's policy and it helps us to make sure we are not missing anything important.

Suicide Screening

Module 1

1. In the past few weeks, have you wished you were dead or go to sleep and not wake up or even your family is better off without you?
   _____ Yes
   _____ No

2. Have you attempted to kill yourself in the past?

   _____ Yes
   _____ No

   If the patient answers yes to any of the above...

3. Are you having thoughts of killing yourself right now?
   _____ Yes
   _____ No

Module 2

Suggested Script with adults

Sometimes people who get upset or feel bad, wish they were dead or feel they'd be better off dead. Have you ever had these type of thoughts?
When?
Do you feel that way now?
Was there ever another time you felt that way?

Screening Questions for Suicidal Thinking in Youth

Suggested Script with youth:

Age (or Equivalent Maturity Level)	**Suicide Screening Script**
12 years or older	Intro: "I'm going to ask you questions about how things are going and about your mental health." 1. "Do you feel you are under a lot of stress?" 2. "Have you ever felt like life is not worth living?" 3. ** "In the past month, have you felt so bad that you have considered harming or killing yourself? *
10 to 12 years	Intro: "I'm going to ask you a few quick questions about how things are going." 1. "Sometimes people find that they have too much stress. Do you feel this way now?" 2. "Sometimes when people are sad or when they have problems, they think about hurting themselves. Has this happened for you?"
If unable to communicate directly	To guardian: "Do you have any concerns about the safety of your child now? Can you tell me more? Did you ever have concerns about your child with respect to safety or self-harm**?**

** If the question is not answered by the target youth, asking the guardian is appropriate and recommended*

Do I ask everyone I meet about suicide since my employer requested that I screen people for suicide?

No. This is not a universal screening program where everyone is asked about suicide (for example asking all first year university students about having suicidal thoughts).
This is a selective screening. The people you will ask about suicide are the people whom you interact with and articulate suicidal thoughts or wishes or any indication that they may harm themselves.

Remember that suicide has many risk factors (see table A below to see examples) but it is **not** your duty to determine if the person will do self-harm or not. Your responsibility is to pass your concerns to the next level of assessment. The duty of the assessor is to receive your concerns and formulate the suicide risk based on a full suicide risk assessment.

What is the next step if I feel that patient/client screens positive for suicide?

Your service will give you specific directions on the next step and whom to contact for conducting a suicide risk assessment depending on your location. Please talk to your direct supervisor about that next step. The options are

-Contacting the treating clinician of the patient
- Calling the provincial telephone line
-Assisting the transfer to the nearest emergency department
-Calling 911

Table RF
Common Risk Factors for Suicide

Interview Risk Profile	**Individual Risk Profile**
□ Suicidal thinking or Ideation □ Access to lethal means □ Suicide intent or lethal plan or plan for after death (note) □ Hopelessness □ Intense Emotions: rage, anger, agitation, humiliation, revenge, panic, severe anxiety □ Current Alcohol or Substance intoxication /problematic use □ Withdrawing from family, friends □ Poor Reasoning/Judgment □ Clinical Intuition: assessor concerned □ Recent Dramatic Change in mood □ Recent Crisis/Conflict/ Loss	□ Ethnic, cultural risk group or refugee □ Family history of suicide □ Trauma: as domestic violence / sexual abuse/neglect □ Poor self-control: impulsive / violent/aggression □ Recent suicide attempt □ Other past suicide attempts, esp. with low rescue potential □ Mental illness or addiction □ Depression/ anhedonia □ Psychotic □ Command hallucinations □ Recent admission / discharge / ED visits □ Chronic medical illness/ pain □ Disability or impairment □ Collateral information supports suicide intent
Illness Management □ Lack of clinical support □ Non compliance or poor response to treatment	**Circle of support** □ Lack of family/ friends support □ Caregiver unavailable □ Frequent change of home