Suicidal Risk Screening & Assessment

Suicide is the second leading cause of death for North American adolescents.[1,2] Children as young as 8 years old can think about suicide and engage in suicidal behavior.[3] Suicide risk must be determined for all pediatric patients receiving mental health care in an emergency department. Follow these steps to determine risk:

Step 1: Screening for Suicide Risk

- Screen to identify patients at risk of suicide and determine acuity.
- While universal screening is ideal, targeted screening of patients presenting with mental health complaints is appropriate. More than half of these patients may screen positive for risk of suicide.[4]
- Screening should be done at triage, be brief, and ensure patient privacy.
- Use a screening tool with high accuracy to detect risk (e.g., "The Ask Suicide-Screening Questions" with 97% sensitivity for detecting suicide risk).[5]
- Asking about suicide or assessing suicidality does not increase a patient's risk of suicide.[6]

Ask Suicide-Screening Questions (ASQ)[6]

Questions	Responses	Outcomes
1. In the past few weeks, have you wished you were dead? 2. In the past few weeks, have you felt that you or your family would be better off if you were dead? 3. In the past few weeks, have you been having thoughts about killing yourself? 4. Have you ever tried to kill yourself? If a patient answers 'yes' to any of questions 1-4, a 5th question is asked to determine risk acuity: 5. Are you having thoughts of killing yourself right now?	Yes/No	***Acute positive (imminent risk identified):*** Patient answers 'yes' to any of questions 1-4 or refuses to answer AND answers 'yes' to question 5. » The patient's clinical needs are emergent and they should not leave the hospital until evaluated for safety. » The patient should remain under constant observation, ideally in a private room, without access to potentially dangerous objects until a suicide risk assessment has been completed. ***Non-acute positive (potential risk identified):*** Patient answers 'yes' to any of questions 1-4 or refuses to answer AND answers 'no' to question 5. » The patient should not leave the hospital until a suicide risk assessment has been completed. ***Negative:*** Patient answers 'no' to questions 1-4. » The patient does not require a further suicide risk assessment in the emergency department.

Step 2: Comprehensive Suicide Risk Assessment

- Patients who screen acute positive or non-acute positive in Step 1 require in-depth suicide risk assessment to inform safety planning and management.
- Obtain detailed information from the patient and caregivers to inform safety planning and identify risk factors. Modifiable risk factors can then be addressed with targeted interventions.
- Conduct part of the interview privately with the patient. Inform the patient and caregivers of the limits of confidentiality, including your obligation to inform appropriate people about immediate safety concerns.

- Establish rapport by sitting down and making eye contact (where culturally appropriate).
- Demonstrate respect/empathy by using the patient's chosen name/pronouns, explaining the purpose of the assessment and actively listening to the patient.
- Structure the assessment with an interview tool developed for use in the emergency department with patients aged 6 years and older (e.g., HEADS-ED available at www.HEADS-ED.com; HEARTSMAP available at openheartsmap.bcchr.ca).
- Currently, there are no assessment tools that can reliably predict future suicidal behaviour.[7]

Step 3: Safety Planning and Disposition

- To inform safety planning and recommended resources, identify risk factors associated with suicide to understand the patient's background and life circumstances, and inform disposition.[8]
- Some immediate and potentially modifiable risk factors can be addressed during the ED visit such as allowing intoxication to resolve and discussing the importance of restricting access to items that could be used for suicidal behaviour (e.g., sharp objects, medications). Others may require longer-term intervention making it important to facilitate a connection to health care resources.
- Although some risk factors cannot be modified, they remain essential to understanding a patient's risk and mental health needs.

<table>
<tr><th>Potentially modifiable risk factors</th><th>Immediate Risk Factors</th></tr>
<tr><td>- Mental illness, including depression, substance use disorders, bipolar disorder, psychotic disorders, ADHD
- Impulsivity
- Family conflict
- Living outside of home (e.g., unhoused, group home, correctional facility)
- Social isolation
- Access to lethal means (e.g., firearms)
- Lack of connection to health care resources</td><td rowspan="3">- Intoxication*
- Agitation*
- Recent stressful life event

*If present, suicide risk assessment should be repeated once the patient's intoxication and/or agitation has resolved.</td></tr>
<tr><th>Non-modifiable risk factors</th></tr>
<tr><td>- Previous deliberate non-suicidal self-injury or suicide attempt
- Family history of suicide
- History of adoption, bullying, abuse and/or trauma
- Lived experience as transgender</td></tr>
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- For patients who will be discharged from the emergency department, discuss:
  - Safety planning
  - When to access crisis resources and/or return to the emergency department
  - Follow-up plans with primary healthcare provider and/or other health care/community resources

Scan or click the QR code to learn more and to see a full list of references and development team members