BOTTOM LINE RECOMMENDATIONS

Suicidal Risk Screening & Assessment

Suicide is the second leading cause of death for North American adolescents.[1,2] Children as young as 10 years old can experience suicidal ideation 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 two steps to determine risk:

- » ***Step 1:*** Screen to identify those at risk of suicide and determine acuity.
- » ***Step 2:*** Patients who screen positive in Step 1 require in-depth assessment to determine the need for treatment and safety planning.

Step 1: Screening for Suicide Risk

- While universal screening would be ideal, targeted screening of those presenting with mental health complaints is appropriate.
- Screening should be done at triage, be brief and employ validated tools.
- Asking about suicide or assessing suicidality does not increase a patient's risk of suicide.[4]
- Use a screening tool to *detect* risk (e.g., "The Ask Suicide-Screening Questions (ASQ)[5] which takes 20 seconds to administer, 98% sensitive for detecting suicide risk").[6]

<table>
<tr><th colspan="3">Ask Suicide-Screening Questions (ASQ) [5]</th></tr>
<tr><th>Questions</th><th>Responses</th><th>Outcomes</th></tr>
<tr><td>1.In the past few weeks, have you wished you were dead?</td><td>Yes/No</td><td rowspan="2">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.</td></tr>
<tr><td>2.In the past few weeks, have you felt that you or your family would be better off if you were dead?</td><td>Yes/No</td></tr>
<tr><td>3.In the past few weeks, have you been having thoughts about killing yourself?</td><td>Yes/No</td><td rowspan="2">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.</td></tr>
<tr><td>4.Have you ever tried to kill yourself?</td><td>Yes/No</td></tr>
<tr><td>If a patient answers 'yes' to any of these questions, a 5th question is asked to determine risk acuity:</td><td></td><td rowspan="2">Negative: A patient who answers 'no' to questions 1-4.
» The patient does not require a further suicide risk assessment in the emergency department.</td></tr>
<tr><td>5.Are you having thoughts of killing yourself right now?</td><td>Yes/No</td></tr>
</table>

Step 2: Comprehensive Suicide Risk Assessment

- Perform a suicide risk assessment for patients who screen positive in Step 1.
- The assessment should obtain detailed information from the patient and parents/caregivers to inform safety planning and identify specific risk factors that can be addressed with targeted interventions.
- Part of the interview should be conducted privately with the patient.
- Inform the patient of the limits of confidentiality, including your obligation to inform appropriate people about immediate safety concerns.
- Establish rapport by making eye contact, using the patient's name, and explaining the purpose of the assessment.
- Demonstrate empathy by actively listening.
- There are no currently available assessment tools that can reliably predict future suicidal behaviour.[6,7]
- Validated interview tools for ages 6 and up (e.g., HEADS-ED available at www.HEADS-ED.com) can be used to structure the assessment.[8]

The HEADS-ED has 7 domains for organizing the detailed information collected:
1. Home (*e.g., How does your family get along with each other? Can probe for child protection issues, family violence*)
2. Education and Employment (*e.g., How is your school attendance? Are you working?*)
3. Activities and peers (*e.g., What are your relationships like with your friends? Can probe for bullying*)
4. Drugs and alcohol (*e.g., How often are you using drugs or alcohol? Cigarettes and/or vaping?*)
5. Suicidality (*e.g., Do you have thoughts of wanting to kill yourself? When do you have these thoughts? How and when would you do it?*)
6. Emotions, behaviours, thought disturbance (*e.g., How have you been feeling lately? Can assess for agitation*)
7. Discharge or current resources (*e.g., Do you have a mental health care provider or are you waiting to receive help?*)

Step 3: Safety Planning/Management

- Identify *potentially modifiable* and *non-modifiable* risk factors to understand the patient's background and current life circumstances to inform safety planning and recommended resources.[9]
- Identify *immediate* risk factors associated with suicide.

Potentially modifiable risk factors	Immediate Risk Factors
- Mental illness, including depression, substance use disorders, bipolar disorder, psychotic disorders - Impulsivity - Family conflict - Living outside of home (e.g., homeless, group home, correctional facility) - Social isolation	- Intoxication* - Agitation* - Recent stressful life event *If present, suicide risk assessment should be repeated once the patient's intoxication and/or agitation has resolved.
Non-modifiable risk factors	
- Previous deliberate non-suicidal self-injury or suicide attempt - Family history of suicide - History of adoption - History of bullying - History of abuse and/or trauma - Identification as transgender	

The purpose of this document is to provide healthcare professionals with key facts and recommendations for the screening and assessment of suicidal risk in children in the emergency department. This summary was co-produced by the suicidal risk screening and assessment content advisors for TREKK, Dr. Matthew Morrissette of the University of Alberta, Dr. Amanda Newton of the University of Alberta, Dr. Stephen Freedman of the Cumming School of Medicine, University of Calgary, and Dr. Laurence Katz of the Winnipeg Health Sciences Centre (HSC), and content advisors for EIIC, Dr. Susan Duffy of the Alpert Medical School, Brown University, and Dr. Vera Feuer of the Cohen Children's Medical Center, and uses the best available knowledge at the time of publication. However, healthcare professionals should continue to use their own judgment and take into consideration context, resources and other relevant factors. The TREKK Network and EIIC are not liable for any damages, claims, liabilities, costs or obligations arising from the use of this document including loss or damages arising from any claims made by a third party. The TREKK Network and EIIC also assumes no responsibility or liability for changes made to this document without its consent. This summary is based on:

1. Statistics Canada. Table 13-10-0394-01 Leading causes of death, total population, by age group. Ottawa: Statistics Canada; 2021. [cited 2021 April 6]. Available from: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310039401
2. National Center for Health Statistics. Adolescent Health. USA: National Center for Health Statistics. [cited June 29, 2021]. Available from: https://www.cdc.gov/nchs/fastats/adolescent-health.htm
3. Lanzanillo EC, Horowitz LM, Wharff EA, et al. The importance of screening preteens for suicide risk in the emergency department. *Hosp Pediatr*. 2019;9(4):305-307.
4. DeCou CR, Schumann ME. On the iatrogenic risk of assessing suicidality: A meta-analysis. Suicide and Life-Threatening Behavior. 2018;48(5):531-543.
5. Newton AS, Soleimani A, Kirkland SW & Gokiert RJ. A systematic review of instruments to identify mental health and substance use problems among children in the emergency department. *Acad Emerg Med*. 2017;24(5):552-568.
6. Cwik MF, O'Keefe VM & Haroz EE. Suicide in the pediatric population: screening, risk assessment, and treatment. *Int Rev Psychiatry*. 2020;32(3):254-264.
7. Carter G, Milner A, McGill K, et al. Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. *Br J Psychiatry*. 2017;210(6):387-395.
8. Cappelli M, Gray C, Zemek R, et al. The HEADS-ED: A rapid mental health screening tool for pediatric patients in the emergency department. *Pediatrics*. 2012;130(2): e321–7.
9. Shain B & American Academy of Pediatrics Committee on Adolescence. Suicide and suicide attempts in adolescents. *Pediatrics*. 2016;138(1): e20161420.