Provincial Clinical Knowledge Topic
Suicide Risk Assessment, Adult – Inpatient
(Non – Psychiatric)
Version 1.0

Revision History

Version	Date of Revision	Description of Revision	Revised By
1.0	June 4, 2018	Topic Completed	See Acknowledgements

Important Information Before you Begin

The recommendations contained in this knowledge topic have been provincially adjudicated and are based on best practice and available evidence. Clinicians applying these recommendations should, in consultation with the patient, use independent medical judgment in the context of individual clinical circumstances to direct care. This knowledge topic will be reviewed periodically and updated as best practice evidence and practice change.

The information in this topic strives to adhere to Institute for Safe Medication Practices (ISMP) safety standards and align with Quality and Safety initiatives and accreditation requirements such as the Required Organizational Practices. Some examples of these initiatives or groups are: Health Quality Council Alberta (HQCA), Choosing Wisely campaign, Safer Healthcare Now campaign etc.

Guidelines

This topic is based on the following guidelines:

- Centre for Addiction and Mental Health (CAMH) Suicide Prevention and Assessment Handbook
- Ontario Hospital Association – Suicide Risk Assessment Inventory: A Resource Guide for Canadian Health Care Organizations
- For information on the Alberta Health Services – Addiction and Mental Health Suicide Risk Assessment Documentation Guidelines, please access via the AHS Insite page http://insite.albertahealthservices.ca/assets/policy/clp-calgary-amh-gpc-suicide-risk-assess-doc-s-1.pdf

Keywords

- Suicide
- Suicidal
- Self-harm
- Violence
- Aggression
- Elopement

Rationale

AHS has recognized suicide as an important safety concern. Key recommendations have been put forward regarding policy, practice and research related to patient safety, including the standardization of care practices related to suicide risk screening, assessment and documentation. Suicide in health care settings is a serious adverse event. National quality assurance and accreditation organizations have recognized the need for consistent assessment and documentation of suicide risk. Suicide risk assessment should be viewed as a part of the therapeutic process that creates an opportunity for discussion between the clinician, the person and their family and other supports. Levels of risk of suicide should be clearly identified and available for clinicians and provide guidance on creating a safety plan for the person.

In Alberta deaths by suicide between 2014 and 2016 were between 542 and 662[1] (Figure 1). Studies have shown that 90% of people who die by suicide have been diagnosed with serious mental illness; psychiatric disorders and substance abuse problems and have consistently been identified with risk factors for suicide and suicidal ideation.[2]

Accreditation Canada has recommended a regular assessment of suicide risk of all persons as a required organizational practice (ROP) when providing inpatient mental health services in a hospital setting or a mental health facility. This is a requirement for addressing the immediate and ongoing safety needs of those identified as being at risk for suicide. Suicide Risk Assessment should be conducted on admission to an inpatient or outpatient area.

Figure 1 *Suicides Rates for Alberta 2006-2016* [1]

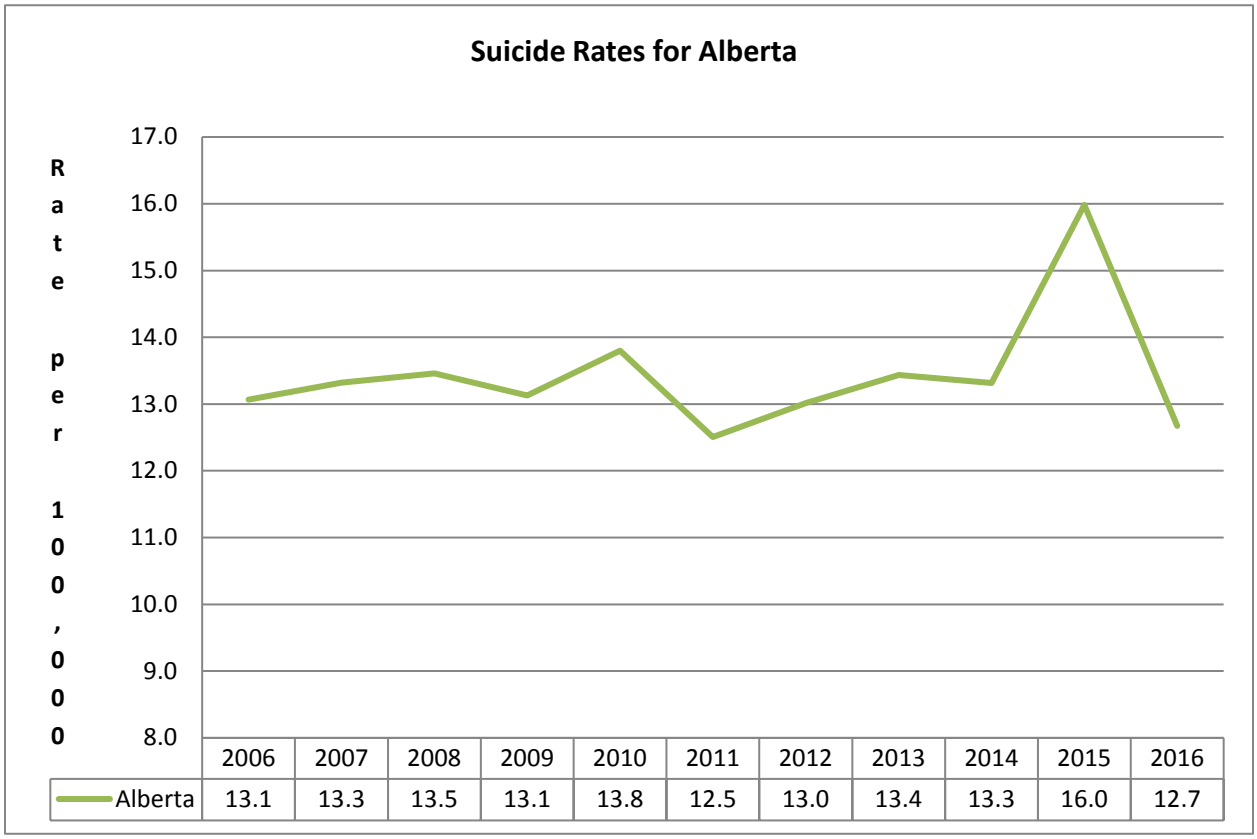


Figure 2 *Number of Suicides by Age and Gender 2014-2016 (Alberta)* [1]

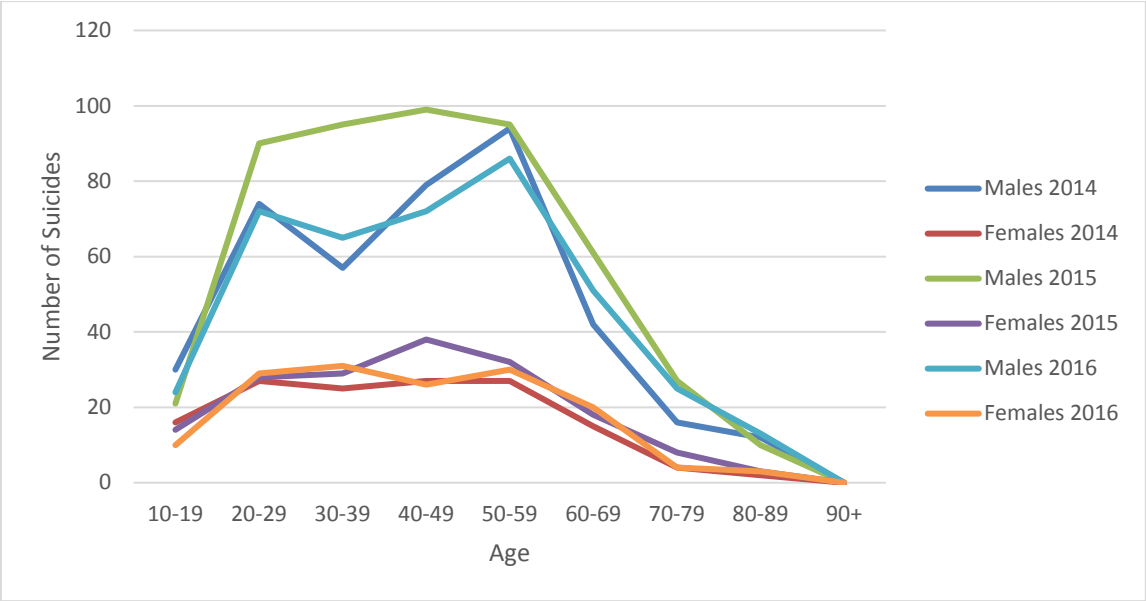


Table 1 *Number of Suicides 2014-2016 (Alberta)* [1]

Gender	2014	2015	2016
Male	402	493	408
Female	140	169	153
Total	**542**	**662**	**561**

Goals of Management

Definitions

Suicide – the act of killing oneself deliberately or consciously initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome[3]

Attempted suicide – potentially self-injurious behavior with a non-fatal outcome, for which there is evidence that the person intended to kill themselves, a suicide attempt may or may not result in injuries[3]

Suicidal ideation – having thoughts about killing oneself[3]

Suicide intent – the degree to which an individual is resolved to take their own life as well as what the person wants to achieve by the suicidal act(s) e.g. to influence another[3]

Risk factors – characteristics that make it more likely that an individual may engage in suicidal behaviors, they may encompass biological, psychological, or social factors in the individual, family and environment[3]

Key Principles

Improve the health care provided to patients with suicidal behavior

Provide recommendations to health professionals around screening, assessment and treatment

Provide adequate training for Health Care professionals to enable evaluation of the presence of risk factors for suicidal behavior

Levels of suicide risk are clearly defined and available for clinicians

Concurrent disorders are assessed for those deemed ‘at risk’ of suicide

Address immediate safety needs of clients, identified as being at risk of suicide

Improve communication between health professionals and patients with suicidal behavior and their families

Identify appropriate interventions for clients at risk of suicide

Identify patients who are at risk for elopement

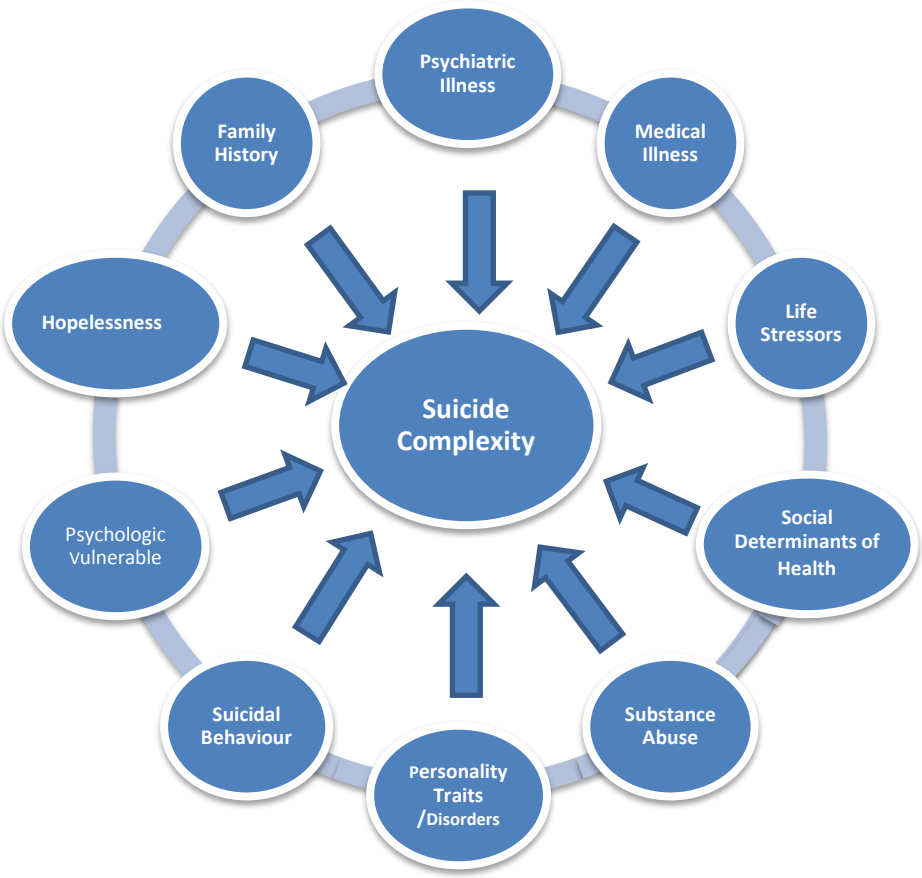
Strategies, procedures are in place for the disposition, transfer of patients from one level of care to another level of care

Indicators developed to assess and evaluate the quality of care for those at risk of suicide

Complexity of Suicide

Suicide risk should be reassessed at various points throughout treatment, as an individual's risk level will increase and decrease over time. Suicide is a complex phenomenon, determined by multiple factors intersecting at one point in the life of the individual.

Figure 3 *Suicide Risk Factors*[2]



Adapted from CAMH Suicide Assessment and Prevention Handbook

Risk Factors for Suicide

In performing a suicide risk assessment the clinician identifies risk factors and distinguishes those that can be modified and those that cannot be changed.

Table 2 *Risk Factors for Suicide* [2]

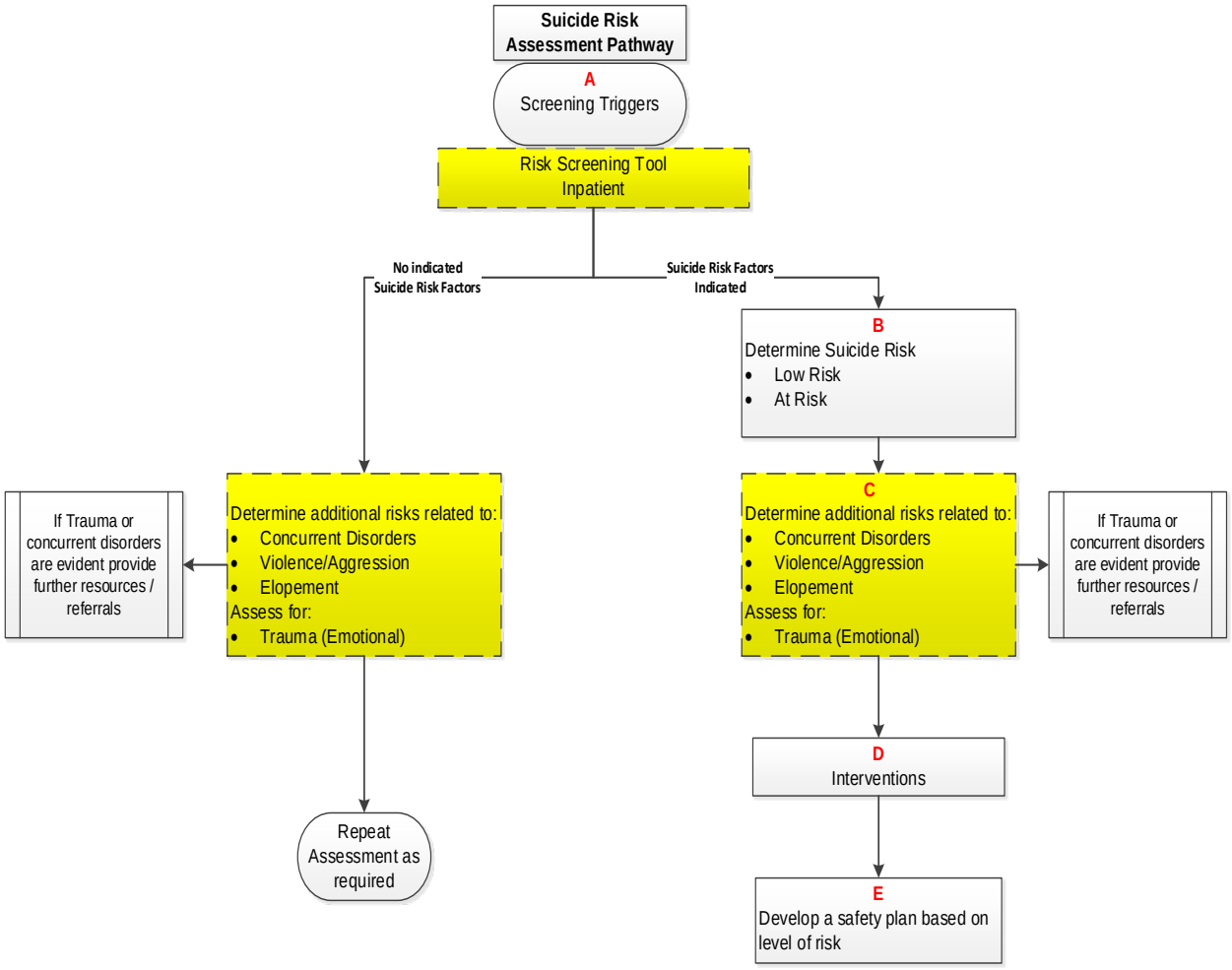
Risk	
Demographic	• Risk Increases with age; rates of suicide increase after puberty and in adults over age 65 • The number of suicide attempts is greater for females than males. • The number of deaths by suicide are greater for males than females.
Access to lethal means	• Possession of fire arms • Access to large doses of medications
Psychosocial	• Recent severe, stressful life events such as interpersonal loss or conflict, job loss, financial problems, legal problems
Psychiatric	• Mood disorders, particularly depression • Anxiety disorders, especially those co-occurring with mood disorders • Schizophrenia • Borderline personality disorder • Eating Disorders
Substance Use	• Intoxication • Use of multiple substances • Withdrawal from substances • Extended use of sedatives
Medication Use	• Changes in medication (including OTCs and herbal use) temporarily associated with increased suicidal thinking • Medications with a known risk of increased suicidal thinking or depression. Refer to Lexicomp List of Medications that cause suicide ideation, and Micromedex *(Search "Drugs that cause suicidal behavior" and "Drugs that cause suicidal")*
Physical Illness	• Malignant neoplasms, HIV/AIDS, peptic ulcer disease, hemodialysis • Chronic medical illness are a common factor in suicides over 60 years • Complicating factor for those who request medical assistance in dying
Psychological Dimensions	• Hopelessness, psychological pain, anxiety, decreased self-esteem • Psychological turmoil, perfectionism, psychosis
Behavioral Dimensions	• Impulsivity, aggression, severe anxiety • Prior suicide attempt: dramatically increases future risk
Cognitive Dimensions	• Thought restriction • Polarized thinking
Adverse Childhood Experiences (ACE)/ Trauma	• Sexual/Physical/Emotional Abuse • Neglect, parental loss/separations
Genetic and Familial	• Family History of suicide, mental illness or abuse

Note: In Table 2, the examples listed are for illustration

Components of Suicidal Ideation[2]

- Intent: subjection, expectation, and self-destructive behaviour act to end in death
- Lethality: objective danger to life associated with a suicide method or action. Lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous. (Important in estimating risk of death, not necessarily aligned with intent)
- Degree of ambivalence: wish to live, wish to die
- Intensity
- Frequency
- Rehearsal
- Availability of method
- Making a final arrangements, putting one's affair in order

Figure 3 **Suicide Risk Assessment Pathway**



A. Screening Triggers

Patients with risk factors for suicide should be assessed upon admission or intake to an area, and at regular intervals or as the need changes based on clinical indicators. Patient's behaviour and attitude, appearance, anxiety, mood and thought processes are indicators that should be paid attention to and alert clinicians to performing a risk screening assessment.

- Known history of self-harm, suicidal ideation, suicide attempts
- Appearance – patient's appearance along with behaviour and attitude also provide clues that they should have a screening assessment.
- Behaviour and attitude – patients who make poor eye contact, display verbal or physical aggression or are uncooperative/avoidant.
- Anxiety – have anxiety levels increased or is the anxiety being displayed in a different way.
- Mood – patient's mood such as those who are sad, crying, depressed, guarded, or irritable.

The following 3 questions should be asked upon admission or intake to an area or at regular intervals as the need changes:
Screening Trigger Questions:
Questions: In the last 30 days:

1. Have you **wished** you were dead or wished you could go to sleep and not wake up?
2. Have you had any actual **thoughts** of killing yourself?
3. Have you **done** anything, started to do anything, or prepared to do anything to end your life?

If the patient answers yes to any of the above questions then the next step would be to determine the risk level for suicide.

Refer to Appendix A – Sample Suicide Risk Screening Tools

B. Determine Suicide Risk Level

The following table provides a reference for suicide risk determination. The following should be considered when assessing a patient's suicide risk level: suicidal ideation, suicide plan formed, and presence of suicidal intent.

Table 3 **Risk Determination Reference**

Low Risk	At Risk
Suicide Self Harm	
• Suicidal ideation of limited frequency, intensity, or duration • No identifiable plans • No intent • Good self-control • Hope for the future • Actively seeking help/support • Presence of several protective factors (See protective factors)	• Suicidal ideation of increased frequency, intensity or duration • History of previous suicide attempt • Specific plan to harm or kill themselves • Access to means to follow through with plan • Emotional distress or despair • Feelings of hopelessness • Feeling rejected, unconnected and without support • Pessimistic, vague or negative future plans • Questionable impulse control • Increased risk taking behaviors • Few protective factors (See protective factors)
Violence/Aggression	
• Non-aggressive • Good self-control	• Evidence of impaired control • Aggressive behavior observed, reported or threatened
Elopement	
• No risk factors identified • Engaged in care	• Occurrences of prior elopement/wandering/LAMA • Cognitive Impairment • Cravings related to substances • Impulsive behavior • Pressing responsibilities at home/work • Restlessness or agitation

For those who are deemed to be at risk a more detailed risk determination should be completed by a practitioner who this falls within their scope of practice.

The following components should be included in suicide risk assessment[4]:

- Presence of suicidal ideation, previous suicide attempts
- Presence of addiction and mental health disorders, substance use and specific symptoms such as hopelessness, anxiety, agitation as well as stressful events and the availability of methods
- Risk factors associated with physical illness, chronicity, pain or disability, family history of suicide, social and environmental factors and a history of suicide in their environment
- The level of violence/aggression and risk of elopement based on risk determination
- Risk determination can be found on the AHS Addictions and Mental Health Suicide Risk Screening, Assessment and Management Policy. For non-Addictions and Mental Health areas, the policy can be used as reference. This can only be access via the AHS Insite page http://insite.albertahealthservices.ca/assets/policy/clp-amh-ahs-inpt-suicide-risk-screening-assess-mgmt-pol-amh-02.pdf

Protective Factors

Protective factors are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities that help people deal more effectively with stressful events and mitigate or eliminate risk in patients and families. By reviewing protective factors it assists the patient/family to determine where their strengths reside.

The following are protective factors that can be reviewed with the patient:

- Strong connections to family and community support
- Skills in problem solving, coping and conflict resolution
- Sense of belonging, sense of identity, and good self-esteem
- Cultural, spiritual, and religious connections and beliefs, immorality of suicide
- Identification of future goals
- Constructive use of leisure time (enjoyable activities)
- Willingness to access support through ongoing medical and mental health care relationships
- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal means of suicide
- Fear of death or dying due to pain or suffering
- Responsibility to family, pets or others; living with family
- Supportive social network or family
- Engaged in work or school
- Additional factors as determined by the patient/family

C. Additional Risk Factors

(Concurrent disorders that may warrant further assessment)

Addiction and Mental Health issues cannot be separated. In determining that there is a risk of suicide the patient should also be assessed for concurrent disorders such as:

Mental Health Issues

- Does the patient have any history of mental health issues e.g. history of depression, bipolar disorder, schizophrenia, obsessive compulsive disorder etc.

Substance Use

- Does the patient use substances, how much, how often and what type of substances? (e.g. alcohol)
- Do they have a history of suffering withdrawal?
- Does the patient have any concerns about their addiction(s), or symptoms of withdrawal?
- Have they ever attended treatment for addiction or has it been suggested to them that they attend?

Gambling

- Does the patient gamble, how frequently?
- Is it a problem? (e.g. financial)

Other behaviours that are poorly controlled which is cause for distress

- Level of violence/aggression should also be considered. Does the patient have a known history of aggression and/or violence towards others?
- The risk of patient elopement must also be factored in and a safety plan put in place particularly for those who are determined to be moderate or high/imminent risk for suicide

Assessing for Trauma (Emotional) including Adverse Childhood Experiences (ACE)

Trauma can have physical and emotional impacts on a patient. It is important to factor this into an assessment for suicide risk. The focus should shift from what is wrong with the patient to "'what has happened to them". Ask the patient if they are comfortable sharing information about difficult life events. An approach to discussing this and helping the patient to open up about any trauma could be to state "I know these things can be hard to talk about, but this can affect your physical health and working relationships with health care personnel…you don't have to discuss this with me if you don't want to…but if you do, I can work with you to ensure you are comfortable when you see me and to get the help you need"

If the patient has agreed to continue the conversation the following questions can then be asked:

1. Have you experienced a traumatic event which continues to affect you emotionally?
2. Is there someone in the community that you are being supported by?
3. Do you require a connection with counselling, social support services or Mental Health Services?

Trauma Informed Care resources are available for AHS staff. Please access via AHS My Learning Link page http://mylearninglink.albertahealthservices.ca/elearning/bins/index.asp

C. Develop a Safety Plan

A carefully laid out safety plan needs to be developed based on the assessed suicide risk level for the patient. The communication of the plan is another critical piece to the development of the plan.

Table 4 **Safety Plan Development**

Low	At Risk
• Refer to Health Link (811) and request Addiction and Mental Health and/or trauma resources • Refer to local Addiction and Mental Health office or other community agency • Repeat risk screening as required based on patient assessment • Engage family/significant others to support care/safety as appropriate • Patient or support person provided a copy of: o AHS Staying Safe & Healthy at Home Addiction-and-mental-health-safety-brochure.pdf o Preventing Suicide Preventing-Suicide-brochure-2014-web.pdf o Coping with Suicidal Thoughts Coping-with-Suicidal-Thoughts.pdf • Additional Instructions provided to the patient to promote safety: _____ _____ Referral Availability MyHealth.Alberta.ca • AMH Health Link (811) • Mental Health Helpline	• Provide Personal Safety Plan form (form #18600) • Search Safety Intervention as per AHS Policy • Change into hospital clothing • Remove unsafe articles • Secure patient belongings • Utilize safe/quiet room If available • Increase visibility of the patient • Assign a care space nearer to a highly visible area • Utilize safe quiet room if available • Open curtains/door • Increase frequency of observation of the patient • Receive order for constant care • Request staff or security for 'patient watch' of the patient – see Patient Watch Services Guideline • Assign every 15 – 30 minute rounds • The observation record Form-20909 can be utilized to assist with documentation. Please access this form via the AHS Insite page http://insite.albertahealthservices.ca/frm-20909.pdf • Provide accompaniment to diagnostic tests • Consider admission/transfer to a higher level of care • Seek consultation with other services as required • Alert Nutrition and Food Services re safe tray requirement • Initiate restraints if required adhering to principles of least restraint AHS policy • Request physician examination for consideration of Form 1 (*Mental Health Act*)

Additional Forms available:

- A personal safety plan form is also available to access through the AHS Insite page http://insite.albertahealthservices.ca/frm-19367.pdf
- Patient Watch Services Guideline: Please access via the AHS Insite page http://insite.albertahealthservices.ca/assets/policy/clp-protective-services-patient-watch-services-guideline-ps-63-01.pdf

E. Suicide Risk Assessment Interventions

Safety and security precautions should be in place based upon the level of risk for elopement and/or self-harm

An urgent referral to mental health services for a patient with suicidal ideation is recommended in the following cases:

- Presence of severe mental illness
- Recent suicidal behavior or escalating self-harm behavior
- A prepared suicide plan
- Expression of suicidal intent
- Social and family situation at risk or lack of support
- If in doubt about the severity of ideation or the risk in near future

Interventions

- Assess risk factors
- Monitor on going suicide risk
- Ensure appropriate observation level
- Implement physical safety precautions
- Review and apply safety plan
- Reinforce healthy coping skills
- Review protective factors with the patient
- Provide additional resources, as appropriate

Additional interventions associated with the level of suicide risk:

At Risk –

- Assessment of patients medical stability
- Increase patient's level of observation status – refer to AHS AMH Inpatient Observation Levels Policy for assistance with determining the observation components. This can only be accessed via the AHS Insite page http://insite.albertahealthservices.ca/assets/policy/clp-amh-ahs-inpt-use-obs-levels%20pro-amh-01-01.pdf
- Implement elopement precautions
- Body/belongings search
- Assess physical environment for risk potential (e.g. bathroom)
- Pharmacological management of behaviour if required
- Psycho-education (coping skills, stress management, symptom management)
- Safety Plan – consider the physical environment, focusing on limiting access to methods. A Safety Plan form can be accessed via the AHS Insite page http://insite.albertahealthservices.ca/frm-19367.pdf
- Urgent referral to Addiction Mental Health Services

Note: AHS AMH Policies above can be used as a reference for non-Addiction and Mental Health areas

Low – (use as clinically appropriate)

- Provide education about warning signs
- Referral for Psychotherapy
- Psycho-Education (coping skills, stress management, symptom management)
- Pharmacotherapy management of behavior if required
- Refer to Primary Care Physician for on-going care
- Provide Addiction and Mental Health referral options MyHealth.Alberta.ca
  - Refer to AMH Health Link
  - Mental Health Helpline
- Engagement with family members or significant other

Suicide Risk Assessment Adult Inpatient (non-psychiatric) Order Set

Order Set Restriction: For patients admitted to a non-psychiatric unit/area
Order Set Keywords: Suicide, suicidal, self-harm, violence, aggression, and elopement
Risk Assessment / Scoring Tools/Screening: Risk Screening Tool (In-Patient Non-Psychiatric)

Patient Care

- ☐ Clinical Communication:
  - ☐ Secure Patient belongings – remove any unsafe items
  - ☐ Change into hospital clothing (based on risk level)
  - ☐ Completion of a safety plan for those at risk

Diet

- ☐ Regular Diet
- ☐ Clinical communication: Provide safe tray *(for those at risk)*

Activity

- ☐ Activity as Tolerated
- ☐ Clinical communication:
  - Provide accompaniment for any off unit visits, diagnostic tests
  - Bathroom supervision
- ☐ Other _____

Monitoring

- ☐ Clinical Communication:
  - Increase visibility of the patient (based on level of suicide risk) (e.g. keep privacy curtains open, room close to nursing station)
  - Utilize safe/quiet room if available
  - Review physical environment for risks to patient care (e.g. Patient bathroom, access to hand sanitizer)
- ☐ Assess Suicidality Daily for those deemed to be at risk of suicide
- ☐ Observe patient:
  - ☐ Every 2 hours
  - ☐ Every 60 minutes
  - ☐ Every 15 minutes
  - ☐ Every _____minutes
  - ☐ Constant

Consults and Referrals

- ☐ MD Consult: Psychiatrist on call
- ☐ Social Work Referral
- ☐ Consult _____

Relevant Guidelines, Procedures, and Clinical Knowledge Topics

Note: AHS AMH polices/guidelines listed below can be used as a reference for non-Addiction and Mental Health areas

Procedures

- Inpatient Observation Levels. Please access via the AHS Insite page http://insite.albertahealthservices.ca/assets/policy/clp-amh-ahs-inpt-use-obs-levels%20pro-amh-01-01.pdf
- Suicide Risk Screening, Assessment and Safety Planning. Please access via the AHS Insite page http://insite.albertahealthservices.ca/assets/policy/clp-amh-ahs-inpt-suicide-risk-screening-assess-safety-plan-pro-amh-02-01.pdf

Additional Guidelines

- Suicide Risk Assessment Guide Ontario Hospital Association Suicide Risk Assessment Guide- OHA.pdf
- Public Health Post-Partum Depression Screen

Clinical Knowledge Topics

- Tobacco Reduction, Adult – Inpatient Clinical Knowledge Topic. Please access via the AHS Insite page http://insite.albertahealthservices.ca/assets/klink/et-klink-ckv-tobacco-reduction-adult-inpatient.pdf

Learning Modules

The following learning modules are available as a learning resource for health care professionals on the AHS external web site.

Suicide Prevention and Risk Assessment Modules (SPRAM)
http://www.albertahealthservices.ca/info/Page14579.aspx

- Pre-Competency Assessment
- Introduction Module
- Prevention Module
- Initial Risk Assessment Module
- Focused Risk Assessment Module
- Integrated Risk Assessment Module
- Management Module
- Suicide and Self-Care Module
- Post Competency

References

1. Data provided by Centre for Suicide Prevention. Provincial and Territorial Suicide Statistics Accessed November 2016
2. Centre for Addiction and Mental Health (CAMH). *Suicide Prevention and Assessment Handbook* 2015. Toronto, Ontario
3. Perlman C, Neufeld E, Martin L, Goy M, & Hirdes J. *Suicide Risk Assessment Inventory: A Resource Guide for Canadian Health care Organizations.* 2011. Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute
4. National Guideline Clearing House. *Clinical Practice Guideline for the prevention and treatment of suicidal behavior.* 2012; National Guideline Clearing House. Rockland Maryland.
5. Centre for Suicide Risk Assessment. *Columbia Suicide Severity Rating Scale.* Columbia University Medical Centre. New York (NY). http://cssrs.columbia.edu/

Appendix A- Sample Suicide Risk Screening Tools

Table 5 **Risk Screening Tool** *(SAMPLE)*

Suicide/Self Harm	
Suicide/Self Harm in the last 30 days – *Provide a culturally sensitive patient/client advisor/translator and include family members where possible and appropriate*	
1. Have you **wished** you were dead or wished you could go to sleep and not wake up?	☐ Yes ☐ No ☐ Unable to answer ☐ Declined
2. Have you had actual **thoughts** of killing yourself?	☐ Yes ☐ No ☐ Unable to answer ☐ Declined
3. Have you **done** anything, started to do anything to end your life?	☐ Yes ☐ No ☐ Unable to answer ☐ Declined
Risk Determination for Suicide/Self Harm	☐ At Risk ☐ Low Risk
If patient answers yes to any of the Suicide/Self Harm questions above, complete the full AHS Suicide Risk Assessment Form # 18519 and continue with this tool.	
Concurrent Disorders	
Use Substances such as alcohol? ☐ Yes ☐ No ☐ Unable to answer ☐ Declined	How often? Describe - _____
Gamble ☐ Yes ☐ No ☐ Unable to answer ☐ Declined	How often? Describe - _____
Have a history of suffering withdrawal ☐ Yes ☐ No ☐ Unable to answer ☐ Declined	How often? Symptoms - _____
Have any concerns about their substance use? ☐ Yes ☐ No ☐ Unable to answer ☐ Declined	What? Which?
Ever attended addictions treatment ☐ Yes ☐ No ☐ Unable to answer ☐ Declined	When? Where?
Ever had anyone suggest they get help for their potential substance use? ☐ Yes ☐ No ☐ Unable to answer ☐ Declined	What? Which?
Violence/Aggression	
Does the patient have a known history of aggression and/or violence towards others?	☐ Yes ☐ No ☐ Unable to answer ☐ Declined
Risk Determination for Violence Aggression	☐ At Risk ☐ Low Risk
Based on the assessment thus far, check all the appropriate risk factors related to elopement.	
Elopement	
☐ Cognitive Impairment ☐ Cravings related to substances (e.g. nicotine, alcohol, drugs) ☐ Personal or family history of mental illness or suicide/self-harm ☐ History of leaving against medical advice (LAMA) ☐ History of wandering/elopement	☐ Impaired insight/judgement or poor impulse control related to potential admission ☐ Legal issues Describe: _____
	☐ Personal financial crisis ☐ Recent Loss ☐ Responsibilities at home/work ☐ Restless easily agitated ☐ Other _____
Risk Determination for Elopement	☐ At Risk ☐ Low Risk

Patients who have been deemed to be at risk of suicide should continue to have a daily shift screen by the health care provider. Based on the responses to the risk screening the following questions should be asked per shift/or daily of the patient:

- **Patients with suicidal thoughts**:
  - Since you were last asked have you actually had thoughts about killing yourself?

- **Suicidal Thoughts** (with method):
  - Have you been thinking about how you might do this?

- **Suicidal Intent** (without specific plan):
  - Have you had these thoughts and had some intention of acting on them?

- **Suicide Attempt** (with specific plan):
  - Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

Appendix B - Columbia-Suicide Severity Rating Scale (C-SSRS)

Screener with triage for Emergency Departments

Guidelines for Triage Using the C-SSRS

Screener – Since Last Contact

Acknowledgements

We would like to acknowledge the contributions of the Provincial Clinical Knowledge Working Group members as follows. Your participation and time spent is appreciated.

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