



Suicide Risk Assessment Guide

A Resource for Health Care Organizations

Disclaimer

The *Suicide Risk Assessment Guide: A Resource for Health Care Organizations*, was prepared by the Ontario Hospital Association (OHA) in partnership with the Canadian Patient Safety Institute (CPSI) as a general guide to help health care organizations with understanding and standardizing the practice of high-quality suicide risk assessment.

The research findings, tools and other materials in this resource guide are for general information only and should be utilized by each health care organization in a manner that is tailored to its circumstances. This resource reflects the interpretations and recommendations regarded as valid at the time of publication based on available research, and is not intended as, nor should it be construed as, clinical or professional advice or opinion. Health care organizations and individuals concerned about the applicability of the materials are advised to seek legal or professional counsel. Neither the OHA nor CPSI will be held responsible or liable for any harm, damage, or other losses resulting from reliance on, or the use or misuse of the general information contained in this resource guide.

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Suicide Risk Assessment Guide: A Resource for Health Care Organizations

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Executive Summary

BACKGROUND

Suicide is a tragic and distressing phenomenon. The negative effects on families, friends and communities following a suicide reinforce the urgency for a better understanding and prevention of suicide. In Canada, Statistics Canada reported that 3,500 people died by suicide in 2006. Globally, the World Health Organization (WHO) has reported that the rate of suicide has risen since 1950, as much as 268% among men aged 15 to 24 (WHO, 2003). In addition to the rise in rates of persons who have died by suicide, even more persons have been hospitalized due to attempted suicide, as many as 23,000 hospitalizations in Canada in 2001 (Canadian Institute for Health Information [CIHI], 2004).

For these reasons, suicide risk assessment has been identified in Canada, and internationally, as a fundamental safety issue among health care organizations. A lack of information on and documentation of suicide risk has been identified as a common issue in reviews of cases where persons have died by suicide in inpatient mental health settings (Mills, Neily, Luan, Osborne, & Howard, 2006). In a review of national suicide prevention strategies among 11 countries, including Canada, Martin and Page (2009) found that standardized suicide risk assessment was not a major component in any of the strategies. A joint Ontario Hospital Association (OHA) and Canadian Patient Safety Institute (CPSI) report identified the need for risk assessment tools related to patient safety including suicide (Brickell, Nicholls, Procyshyn, McLean, Dempster, Lavoie, et al., 2009). Focusing on suicide risk assessment is a first step in improving suicide prevention.

THE NEED FOR SUICIDE RISK ASSESSMENT

The OHA and CPSI have recognized suicide as an important patient safety concern. Numerous gaps in Canadian research on patient safety in mental health care, including suicide, were identified in a report commissioned by the OHA and CPSI (Brickell, Nicholls, Procyshyn, McLean, Dempster, Lavoie, et al., 2009). This report included a number of key recommendations for policy, practice and research related to patient safety, including the standardization of care practices across mental health settings and improvements to incident reporting. The report also highlighted the need to identify and evaluate

This resource guide is intended to help standardize suicide risk assessment practice across Canadian health care organizations. Its goal is to highlight all factors that should be considered for performing high-quality suicide risk assessment to ensure the safety and well-being of care recipients.

risk assessment tools related to patient safety. As a result, the OHA and CPSI commissioned the development of a resource guide related to suicide risk assessment and prevention for use in Canadian health care organizations.

It is important to acknowledge that, similar to other medical conditions such as heart attacks, not all suicides are entirely preventable. However, suicide in health care settings is a serious adverse event. Public health and the health system should promote safety and quality of care through high-quality risk assessment, intervention, and documentation. National quality assurance and accreditation organizations have recognized the need for consistent assessment and documentation of suicide risk by integrating these processes into their evaluation frameworks.

Suicide risk assessment should be viewed as an integral part of a holistic therapeutic process that creates an opportunity for discussion between the person and care provider, and his or her family and other supports.

Accreditation Canada is now in its second year of implementing a regular assessment of suicide risk of all persons in mental health service settings as a “Required Organizational Practice” (ROP). This is now a standard requirement for addressing the immediate and ongoing safety needs of persons identified as being at risk, and appropriately documenting risks and interventions in the person’s health record (Accreditation Canada, 2011). While accreditation and quality monitoring organizations mandate the use of suicide risk assessment, it is important to recognize that this process should not occur simply to mitigate liability in response to such mandates (Lyons, Price, Embling, Smith, 2000). Instead, suicide risk assessment should be viewed as an integral part of a holistic therapeutic process that creates an opportunity for discussion between the person and care provider, and his or her family and other supports.

THIS GUIDE

This resource guide was developed based on an environmental scan of peer-reviewed, best practice, and policy literature on suicide risk assessment processes, principles, and tools. The methodological approach that informed this resource guide can be found in Appendix A. Interviews were also performed with 21 expert stakeholders representing different cultural, ethnic, geographic, demographic, health sector, and professional backgrounds. The interviews complemented the environmental scan and added specific contextual considerations for guiding risk assessment in different situations and with persons from varied backgrounds.

The environmental scan and interviews led to the development of four sections:

- I. The first section presents an overview of suicide risk assessment principles, processes, and considerations to help guide risk assessment in a variety of health settings.
- II. The second section consists of an inventory of suicide risk assessment tools that includes information on their psychometric properties and recommendations for their use.
- III. The third section provides a framework for suicide risk assessment, including application of risk assessment tools and recommendations for monitoring the quality of the risk assessment process.
- IV. The fourth and last section provides resources for hospitals including key concepts, tips and diagrams which may be reproduced and posted in the organization. Additionally, more detail on the project methodology is given as well as references to cited works.

Together, these sections create the foundation of the suicide assessment resource guide. In Canada, this guide is anticipated to be a first step in standardizing the process of suicide risk assessment for health care professionals, and hopefully, will help advance a national strategy on suicide prevention. We also hope that this resource guide will be used to educate health care professionals and policy decision-makers and improve quality initiatives in suicide risk assessment, by offering much-needed insight into the reduction and prevention of suicide.



Section I

Overview of Suicide Risk Assessment Principles, Processes, and Considerations

The goal of a suicide assessment is not to predict suicide, but rather to...appreciate the basis for suicidality, and to allow for a more informed intervention”

- (Jacobs, Brewer, & Klein-Benheim, 1999, p. 6).

In this section:

1. The Content of Suicide Risk Assessment

- Identifying and evaluating warnings signs as well as risk and protective factors
- Explaining why certain demographics like age and sex are excluded as risk factors
- Discussing issues such as mental illness and chronic suicidality that compound risk assessment

2. The Principles that Guide the Assessment Process

- The therapeutic relationship
- Communication and collaboration
- Documentation
- Cultural awareness

3. Applying the Principles – Special Considerations in Given Care Settings and Populations

- Primary care
- Emergency settings
- Mental health settings
- Youth
- Older adults
- First nations communities
- Lesbian, gay, bisexual, transgender, queer communities
- Military personnel

It is recommended that readers consult the cited works for a more in-depth overview of each of the concepts presented. A list of all references can be found in Appendix J.

Suicide risk assessment is a multifaceted process for learning about a person, recognizing his or her needs and stressors, and working with him or her to mobilize strengths and supports (protective factors). While suicide risk assessment tools are a part of this process, these should only be used to support the assessment process, rather than to guide it.

1. The Content of Suicide Risk Assessment

The assessment of suicide risk is commonly based on the identification and appraisal of warning signs as well as risk and protective factors that are present. Information relevant to the person's history, chronic experience, acute condition, present plans, current ideation, and available support networks can be used to understand the degree of risk.

Suicide risk assessment is a multifaceted process for learning about a person, recognizing and addressing his or her needs and stressors, and working with him or her to mobilize strengths and supports. While suicide risk assessment tools are a part of this process, these should be used to support the assessment process, rather than to guide it. There are many other types of resources available to support the suicide risk assessment process, for example, clinical guides (e.g., Jacobs, 1999; Rudd, Joiner, & Rajab, 2004) and best practice guidelines (e.g., American Psychiatric Association, 2003; Heisel & Flett, 2006; Registered Nurses' Association of Ontario [RNAO], 2009).

Understanding of suicide risk is challenged by the difficulty in establishing how well the presence or absence of these factors actually predict suicide, given the rarity of suicide and variations in the timeframes used to appraise risk (Baldessarini, Finklestein, & Arana, 1988). For example, timeframes for measuring suicide outcomes range from 1 to 20 years (e.g., Brown, Beck, Steer, & Grisham, 2000). Longer timeframes speak to the chronic nature of suicide risk based on certain risk factors, but these same factors may not be clinically meaningful to assessing risk in the short term (i.e., minutes and days; Rudd, Berman, Joiner, et al., 2006).

It is important to keep these challenges in mind when reviewing the abundance of literature on the identification and clinical interventions associated with suicide risk and behaviours (e.g., Jacobs, 1999; Joiner, 2005; Rudd et al., 2004).

THE DIFFERENCE BETWEEN SUICIDE AND SELF-HARM

As an introductory point, it is good to distinguish between the terms “self-harm” and “suicide”. Often the terms “self-harm” and “suicide” are used interchangeably, yet they are different on both a conceptual and treatment level.

Suicide is an intentional, self-inflicted act that results in death. The difficulty in distinguishing suicidal behaviours from purposeful self-harm is in determining the person’s intent. For example, was the intention of the behaviour to end the person’s life, a call for help, or a means of temporary escape? Suicidal behaviours that do not result in death are considered “non-fatal,” or more commonly, “suicide attempts”.

Self-harm is an intentional and often repetitive behaviour that involves the infliction of harm to one’s body for purposes not socially condoned (excluding culturally accepted aesthetic modifications such as piercing) and without suicidal intent (see Neufeld, Hirdes, Rabinowitz, 2011). It may be very difficult to distinguish between self-harm and suicide-related behaviour as both are self directed and dangerous. However, the majority of individuals who engage in self-harm do not wish to die. Rather, they use self-harm as a coping mechanism that provides temporary relief from psychological distress. Although seemingly extreme in nature, these methods represent an effective form of coping for some individuals. Though most people will know when to cease a session of self-harm (i.e., when their need is satisfied), accidental death may also result for example, if the person cuts into a vein and cannot stop the bleeding. Such cases of self-harm may be mistakenly labelled as a suicide or non-fatal suicide attempt by health care professionals.

The distinction between self-harm and suicidal behaviour is important as there are appropriate and different treatment options for both.

THE APPRAISAL OF UNDERLYING FACTORS THAT INDICATE SUICIDE RISK: WARNING SIGNS, RISK FACTORS, AND PROTECTIVE FACTORS

Warning signs and risk factors

For suicide risk assessment, it is important to make the distinction between the extent to which factors are known to be correlated with suicide (i.e., potentiating risk factors; Jacobs et al., 1999) and the extent to which they are known to actually increase risk of suicide (i.e., warning signs; Rudd et al., 2006).



Definition

Potentiating risk factors are associated with a person contemplating suicide at one point in time over the long term.

Warning signs are factors that may set into motion the process of suicide in the short term (i.e., minutes and days)

FACT: *In general, there is consensus that it is the combination of warning signs and potentiating risk factors that increases a person's risk of suicide (Jacobs et al., 1999).*

Risk factors may be associated with a person contemplating suicide at one point in time over the long term, whereas warning signs are those factors that, in the immediate future (i.e., minutes and days), may set into motion the process of suicide (Rudd, 2008). Warning signs present tangible evidence to the clinician that a person is at heightened risk of suicide in the short term; and may be experienced in the absence of potentiating risk factors.

It is important to recognize that risk may still be high in persons who are not explicitly expressing ideation or plans, searching for means, or threatening suicidal behaviour. Persons who may be truly intent on ending their lives may conceal warning signs. Thus, it is vital that all warning signs are recognized and documented during the risk assessment process. In Section III of this guide, we will discuss ways in which suicide risk assessment tools can assist in detecting incongruity between a person's level of distress and his or her stated level of intent regarding suicide.

The presence of potentiating risk factors may predispose a person to higher risk of suicide, but this risk is established by the presence of warning signs. For instance, not all persons who are unemployed are at risk of suicide. However, if an unemployed person becomes increasingly hopeless about his or her future, possibly due to extreme debt or inability to support family, and begins to express thoughts that others would be better off without him or her, then that person is at heightened risk of suicide.

Figure 1 illustrates how a person's risk of suicide increases with the presence of warning signs, as well as with the number and intensity of warning signs. It is important to note that Figure 1 does not necessarily present an exhaustive list of all potentiating risk factors and warning signs. For instance, Wingate and colleagues (2004) identify over 75 potential risk factors associated with suicide. Instead, Figure 1 focuses on the key risk factors and warning signs identified in the literature and supported by interviews with experts that contribute to a heightened risk of suicide.

A pull-out reference is available in Appendix C.



Figure 1. Illustration of the Accumulation of Potentiating Risk Factors and Warning Signs on Risk of Suicide (Warning Signs adapted from Rudd et al., 2006).

In essence, identified potentiating risk factors may become focal points for targeting interventions once risk is abated. For example, experiences such as prior traumatic events, chronic illness and disability, social isolation and extreme loss (i.e., financial, personal, social) are important for understanding the origins of risk. Potentiating risk factors in the absence of warning signs may represent a less immediate risk of suicide. And by focusing treatment interventions on these kinds of potentiating factors, care providers may actually avert a person's future progression into warning signs. Therefore, though warning signs indicate the person's level of risk, the potentiating risk factors present areas of focus for interventions.

FACT: *The determination of suicide risk should not rest on demographic characteristics such as age or sex. Instead, these characteristics should be considered when determining the most appropriate intervention approach once risk has been established based on potentiating risks and warning signs.*

The exclusion of certain demographic characteristics as key risk factors

A number of demographic characteristics associated with suicide risk in the literature have been excluded from the key risk factors proposed in this guide, in particular age and sex.

Age

Interviews with experts have indicated that age alone should not be included as a potentiating risk factor as it tells nothing about risk of suicide without the presence of other potentiating risk factors (e.g., see Figure 1 (p.5)). Instead, age may be related to suicide through an interaction with other factors such as impulsivity or life circumstances. For instance, older adults may develop suicide risk as a result of a long-standing physical illness or pain. Age is still an important factor to consider in the risk assessment process, but not as a risk factor. See page 29 where specific considerations related to lifespan and traumatic life experience are discussed.

Sex

With respect to sex, differences in the rates of suicide between men and women have been consistently observed in Canada and worldwide. Typically, rates of suicide among men are higher than rates among females, though some report that the rate of attempted suicide is higher among females (Murphy, 1998). It is believed that such attempts may be used as a call for help by women, whereas men are less inclined to openly discuss distress or vulnerability (Murphy, 1998; Pearson et al., 1997). Therapeutic interventions among men and women in distress therefore require early and increased vigilance to verbal and behavioural cues for warning signs.

Appraisal of underlying factors of risk is not a straight-line exercise

There are two compounding issues which must also be considered when trying to assess factors that might indicate suicide risk; they are mental illness and chronic suicidality.

Suicidality and mental illness

Not all persons with mental illness will develop suicidal thoughts and behaviours. For instance, it is estimated that about 5% of persons with schizophrenia died by suicide (Palmer, Pankratz, & Bostwick, 2005). However, it is estimated that up to 50% of persons with schizophrenia consider suicide at some point in their lifetime (Radomsky, Haas, Mann, & Sweeney, 1999). In fact, 90% of persons who have died by suicide in the United States had depression, substance abuse, and other mental illnesses (Moscicki, 2001). A history of mental illness has been found to be a much stronger predictor of suicide than socioeconomic variables (e.g., unemployment, low income, marital status; Mortensen, Agerbo, Erikson, Qin, & Westergaard-Nielsen, 2000).

Suicide risk is not necessarily a symptom of mental illness and is based on specific symptoms or circumstances experienced by persons with mental illness.

- *Hopelessness* has been found to be a stronger predictor of suicide ideation than *depression* diagnosis (Beck, Steer, Beck, & Newman, 1993).
- Among persons with *schizophrenia*, it is important to review whether persecutory or command hallucinations are contributing to a person's suicidal ideation or desire to die (Heila, Isometsa, Henriksson, Heikkinen, Marttunen, & Lonngvist, 1997). In addition, recency of onset of schizophrenia, frequency of hospitalizations, and despair, sadness, or hopelessness (even in the absence of a depressive syndrome) may also contribute to suicide risk in this group (Mamo, 2007).
- *Persons who abuse alcohol or other substances* may also be at increased risk of suicide, particularly as inhibitory control is reduced and impulsivity is increased (Wilcox, Conner, & Caine, 2004). Several interviewees also indicated that life circumstances and onset of depression following



Definition

Predicament suicide refers to “suicide that occurs when the individual without mental disorder is in unacceptable circumstances from which they cannot find an acceptable alternative means of escape”. (Pridmore, 2009, p 113)

recovery from addiction may also contribute to a sense of isolation, guilt, hopelessness, and other despair that may increase suicidal thoughts or behaviours.

- Intense negative emotional states, impulsivity, and persistence of illness often lead to a high number of suicide behaviours, attempts, and deaths among persons with *borderline or antisocial personality disorder* (Zaheer, Links, & Liu, 2008).

It is also important to recognize that suicide may occur in the absence of a diagnosed mental illness, or in the presence of a relatively non-specific diagnosis (e.g., adjustment disorder).

The concept of *predicament suicide* is used to describe “suicide that occurs when the individual without mental disorder is in unacceptable circumstances from which they cannot find an acceptable alternative means of escape” (Pridmore, 2009, p. 113). This may be related, but not limited, to persons who experienced extreme financial loss, persons who may feel excessive guilt, humiliation or shame, or persons who have experienced loss of a close personal relationship. These experiences, or potentiating risk factors, may manifest into warning signs if the person is not able to cope or reason with the situation, or if he or she feels there is nowhere to go or no one to turn to for support. Recognizing the potential for such experiences to manifest into warning signs is particularly important in primary care and other such gatekeeper settings where early screening and interventions are possible.

Chronic Suicidality

Occasionally, health care professionals will encounter persons that are considered “chronically suicidal”; that is, they experience suicidal ideation on a daily basis with fluctuating intensity and persistence of these thoughts. A chronically suicidal person must be assessed for acute risk and his or her intention to die. However, if the person repeatedly entertains suicidal ideas and frequently threatens suicide, it can occasionally invoke ambivalent feelings (e.g., ‘this person is just trying to get attention’) which threaten the therapeutic relationship. People with chronic suicidality may have an underlying mental health condition (e.g., borderline personality disorder), are frustrated with a lack of response to ongoing interventions or treatment, or are using suicidality as a way of communicating distress (Kutcher & Chehil, 2007; Paris, 2002).

In contrast to persons with acute suicidality (with or without major depressive episodic symptoms), the management of chronically suicidal persons requires a different set of principles. Clinical approaches for treating acute suicidality among persons with mood disorders are rarely appropriate for chronic suicidality. Unless in a psychotic state or following a serious suicide attempt, hospitalization of chronically suicidal persons *has little value* in preventing suicide in this population, and *may have unwanted negative effects* (e.g., cycle of repeat admissions; Paris, 2002). Partial hospitalization in a highly structured day program is an effective alternative where access to a specialized psychiatric team is possible, and at the very least, provides respite to the family and any outpatient therapists (Bateman & Fonagy, 1999). Dialectical behavioural therapy (DBT) has also been shown to be an effective intervention for managing persons with recurrent suicidal behaviour in the community (McMain, Links, Gnam, Guimond, Cardish, Korman, Streiner, 2009).

Recommendations from the literature and from stakeholder interviews suggest that it may also be necessary for mental health professionals to tolerate suicidality over extended periods and allow (with good clinical judgement) persons to remain in the community under a ‘certain degree of risk’ (Maltzberger, 1994; Paris, 2002). This balance should err on the side of caution, be grounded in an established therapeutic relationship, and use ongoing monitoring to assess for heightened acute risk.

The establishment, reliance, and ongoing review of a person-centred safety plan are particularly important for persons with chronic suicidality. In the short term, hospitalization of a person with chronic suicidality may be a means to establish immediate safety and a treatment plan; however, over the long-term, establishing and addressing underlying causes for chronic suicidality (on an outpatient basis) may assist in developing alternative solutions to the problems underlying the suicidality. As demonstrated in treatment of persons with borderline personality disorder, once treatment begins to work, chronic suicidality gradually remits (Najavits & Gunderson, 1995).

Protective factors

Protective factors are those that may mitigate risk of suicide (Nelson, Johnston, & Shrivastava, 2010; Sanchez, 2001); see Box 1 below.

Box 1. Examples of Protective Factors (Sanchez, 2001; United States Public Health Service, 1999)

- 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
- Identification of future goals
- Constructive use of leisure time (enjoyable activities)
- 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 seeking help
- Restricted access to highly lethal means of suicide

The identification of protective factors is a necessary component of suicide risk assessment in order to identify potential strengths and resiliency that can be used to buffer suicide risk. Recognizing protective factors can be a means to encourage hope among persons at risk. Responsibility and love for one's family or children, strong ties to friends or the community, or personal hobbies or interests may foster a sense of self-worth and should be considered during suicide risk assessment. However, the protective nature of some factors may be temporary (e.g., a person may not attempt suicide while their children are still living at home). Protective factors should never supersede evidence of warning signs when assessing risk. The presence of protective factors does not reduce the risk associated with the presence of severe warning signs. Instead, these factors should be used in the care process with the person to attempt to alter risk.

The mere absence of warning signs and potentiating risk factors can also be thought of as a protective factor

It is important to recognize that the absence of these factors can be strengths which may assist in coping with other risk factors or warning signs. In fact, several experts interviewed emphasized the use and leverage of protective factors in a strengths-based approach to assessing and monitoring risk of suicide, particularly for persons receiving community-based care (See Reason for Living Inventory in Section II for an example of a tool that can help gather information on protective factors). Further, it is important to discuss both the available internal (e.g., person’s skills, coping mechanisms) and external (e.g., strong family or community supports, cultural or religious networks; Grotberg, 2002) supports. Asking the person to identify with positively worded statements (e.g., “I can take care of myself”, “I have people I can talk to”, etc.) might also help to shift the focus from the person’s distress and suicidal ideation to areas of strength and support.

2. The Principles that Guide the Assessment Process

Providers need to recognize, organize and act on potentiating risk factors and warning signs. This process is complicated by the context and complexity of providing care to persons at risk of suicide. For example, in almost all health care settings, care providers are faced with numerous challenges including:

- time available to appropriately assess a person;
- the availability, experience, and support of other care providers or clinical team members;
- the sophistication of health information systems;
- the availability of appropriate services for high-risk persons;
- ongoing management of admissions and discharges; and
- staff shift changes and internal transitions in care.

These challenges are compounded by the urgency and consequences associated with the person’s condition. Timely, informed decisions need to be made regarding a person’s safety and the risk that the person may pose to himself or herself while in the care environment as well as when outside of that environment.

The primary principle for maintaining a person-centered risk assessment is the establishment of a therapeutic relationship with the person, based on active listening, trust, respect, genuineness, empathy, and response to the concerns of the individual.

PRINCIPLE ONE – THE THERAPEUTIC RELATIONSHIP

The danger emerging from the challenges briefly described in the preceding paragraph is that the suicide risk assessment process may become automated, or focused solely on triage or service need rather than on recognizing and intervening with the person's distress. Therefore, the primary principle for maintaining a person-centered risk assessment is the establishment of a therapeutic relationship with the person (APA, 2003). This relationship should be based on active listening, trust, respect, genuineness, empathy and responding to the concerns of the person (RNAO, 2009). Maintenance of openness, acceptance, and willingness to discuss his or her distress can help minimize feelings of shame, guilt, and stigma that the person may experience.

The way that questions are asked may help convey a sense of empathy and normalization, and help the person feel more comfortable. This may be particularly important among youth, who may be afraid to disclose their feelings for fear of repercussions. One approach is to let the person know that it is not uncommon for some people to think about hurting themselves when in distress, and then ask him or her if that is how he or she feels. The person may then feel reassured that he or she is not alone in his or her feelings, and that the clinician is there to listen and provide support.

Establishing a good therapeutic rapport can improve the suicide risk assessment process

The development of a therapeutic relationship may take time and span multiple visits, although this rapport begins to be established at first contact. Several strategies can be carried out to develop therapeutic rapport with the person to improve the suicide risk assessment process (Heaton, 1998).

Box 2. Successful strategies for building the therapeutic rapport (Heaton, 1998)

- Ask the person how he/she wants to be addressed
- Provide the person with an explanation of your role and the purpose of the assessment which will minimize feelings of uncertainty and anxiety
- Listen empathetically
- Take the time to consider the person's story
- Highlight the person's strengths
- Meet the person in a comfortable and private environment

The clinician should:

- Listen empathetically to the person and use a calm tone of voice in conversation. Often, when in crisis, the person may not know how to act. Therefore, modeling behaviour (e.g., quiet and even tone of voice) may help the person understand what is expected, as well as assist in de-escalating the situation;
- Take the time to consider the person’s story so that he or she does not feel dismissed. It is helpful for clinicians to remember that the person in crisis is more than a cluster of behaviours; consequently he or she should be seen as a person first, and as a person in crisis second; and
- Help the person to see his or her strengths (e.g., reinforce that the choice to seek help was a good one), validate his or her feelings, and help him or her to regain control.

Building rapport should begin in the first moments of contact between the clinician and person and continue throughout the risk assessment process; this can reassure the person and improve his or her engagement.

The setting in which the assessment is completed should be comfortable and private to help the person feel safe and open to discussion. External stimuli during a crisis can be overwhelming. A waiting area with some privacy, away from noise and perceived scrutiny, can assist in decreasing any anxiety and distress. If the person is so distressed that he or she is crying, ask the person if a curtained area or a place that is safe (i.e., free of environmental risks) and relatively quiet would be more comfortable, allowing the person time and privacy once moved. Checking in to ensure that the person is comfortable with the immediate physical surroundings will not only help to de-escalate the situation, but also increase the therapeutic rapport (Bergmans et al., 2007).

PRINCIPLE TWO – COMMUNICATION AND COLLABORATION...

Effective communication and collaboration are crucial for ensuring that suicide risk assessment remains thorough, consistent, and effective in addressing a person’s risk throughout his or her journey through the system (e.g., from the emergency room to the community, from one professional to another). Communication and collaboration are essential for obtaining collateral information about a person’s distress and maintaining his or her safety. To support the person throughout his or her recovery process, it is essential to maintain good communication and collaboration:

- With the person;
- With the person’s informal support network; and
- Within and between the care teams supporting the person.

...With the person

Many persons seeking mental health services and coming into contact with mental health staff feel that their experience was negative. Cerel and colleagues (2006) reported that among persons in the emergency department following a suicide attempt, fewer than 40% felt that staff had listened to them or taken their injuries seriously; more than half felt directly punished or stigmatized by staff.

FACT: *The perceived poor attitudes from staff regarding suicide-related behaviour may discourage individuals at risk from seeking help. Less than 12% of persons with a history of suicide considered the mental health system as a first line of help in times of crisis (Alexander and colleagues (2009)). Critical attitudes from staff can increase the level of distress. For instance, a negative experience in hospital can lead to further self-harm, in addition to attempts by individuals to self-treat wounds in order to avoid the emergency department experience altogether (Harrison (1995)).*

Providing care and treatment for persons with suicide-related behaviour is emotionally demanding and care providers should keep in mind that they themselves might require support. Some health care professionals may have intense personal reactions to a potential suicide, making it difficult to remain empathetic, accepting, and open-minded. Persons who engage in repetitive self-injury can provoke frustration in the inability to “cure the person” (Bergmans et al., 2007). Understanding one’s own personal views on suicide and self-harm will assist in maintaining a caring, respectful and non-judgemental attitude (Pompili, 2011), while understanding the perspective of the person at risk can aid in developing more meaningful, person-centered interventions.

Though larger systemic issues can also affect the therapeutic relationship, it is essential that clinicians remain aware of how their personal feelings of being overwhelmed or frustration may impact that relationship. Where care providers experience these feelings, they should seek help and support. These coping strategies will ensure that the person at risk continues to feel supported and to feel heard.

...With the informal support network

Families, friends, and other informal supports provide an invaluable resource for persons in distress. When appropriate and with the person’s permission, family, friends, and others should be involved in risk assessment and treatment of self-harm and suicide-related behaviour. Families and other informal supports may also be a source for collateral information through their suspicions or spotting of signs of suicide-related behaviour prior to the formal involvement of mental health treatment. Communication to families of all aspects of risk, assessment, monitoring, and interventions is essential for maintaining a person’s safety. The family should be involved in the monitoring of the person, preventing access to means, and encouraging compliance with the treatment recommendations.

While efforts to include informal supports in the process of risk assessment and treatment can enhance the overall care provided, this involvement is not always maximized. Some family members describe having very little opportunity for genuine participation in mental health care and treatment at either a systemic or individual level, and have little encouragement to do so (Goodwin & Happell, 2007). However, a person-centered approach to the treatment of suicide-related behaviour views family members as partners in providing care for the person (Buila & Swanke, 2010).

In other instances, family members may be in denial about the experience and hope that it will go away. Thus, where appropriate and available, family members should be included in discussions about safety management and crisis situations that emphasize non-judgement and normalizes their feelings, and acknowledges that support is available.

The involvement of family and informal support during suicide risk assessment is determined by several factors. If a person is acutely suicidal, the first responsibility is to protect his or her safety, which may involve breaching confidentiality as required by law and ethical codes of conduct. These laws and codes may be established by the governing jurisdiction, professional practice, and organizational policy. A breach of confidentiality may be required to share information with family or gather information from family to ensure the safety of the person (APA, 2003). This is a very complex situation that should be carried out in consultation with legal, ethical, and risk management experts. While carrying out consultations on breaching confidentiality, implement a strategy for promoting the person's safety within current means.

In some circumstances, the risk for self-harm or suicide is perpetuated by conflicted family relationships (e.g., an abusive parent, divorce, bullying) or a dysfunctional home environment. In this context, the person's safety should be the main priority which may require (depending on the severity of the circumstances) the involvement of children and youth protection services, the temporary removal of the person from their home environment, or a simple referral to a family therapist for counselling. Occasionally, a person's culture or religion will hinder or prohibit the discussion of suicide, creating a challenge for familial involvement in suicide risk assessment. Under these circumstances, the person's right to privacy should be respected and balanced against the need for safety if the risk of suicide is present.

Documentation is key to suicide risk assessment.

Clear notes are needed for:

- Level of risk (based on warning signs, potentiating risk factors and protective factors);
- Person's thoughts and observed behaviours;
- Psychiatric history;
- Previous treatments;
- Plans for treatment and preventive care;
- Concerns expressed by the informal support network; and
- Current and previous suicidal behaviour (timing, method, level of intent and consequences).

This is by no means an exhaustive list.

As well, organizations should develop standard protocols for identifying the location of information in the person's record related to suicide risk.

...Within and between the care teams supporting the person

Communication and collaboration in suicide risk assessment and prevention are fundamental processes both within and between care settings. The documentation and sharing of information within and between clinical units and care settings should be a standardized process to improve the ease of information flow and consistency in knowledge about a person's risk.

Discussion among care providers within settings should include a formal review of the person's status, levels of distress, and determination of risk. Information yielded from this review should be documented and clearly communicated among all persons involved in the person's care. Granello (2010) indicates that care teams should use collaboration, corroboration, and consultation in the risk assessment process. Collaborating with other team members and persons aware of the person's status will help ensure key information about risk is not missed. Corroboration of the risk assessment information with others familiar with the person's status will help inform the level of risk by providing information on the prior frequency of mental status, suicide thoughts, and behaviours. Consultation with other team members or clinical experts is important for making a final designation of risk and determining appropriate actions for risk mitigation. Even among expert clinicians, collaboration with others is an essential process of risk determination.

Communication and collaboration is also essential for understanding risk and preventing suicide at points of transition between shifts, programs, and care settings (sometimes called "hand offs" or "transitions in accountability"), a time when suicide risk may be highest (Ho, 2003). In Norway, national guidelines on suicide recommend a chain of care that includes ongoing assessment and communication of suicide risk be developed for persons transitioning between care environments following a suicide attempt. However, few organizations actually meet these guidelines (Mork et al., 2010). Thus, it is important at the level of care settings to establish specific processes to ensure communication of suicide risk and prevention within and between care settings.

PRINCIPLE THREE – DOCUMENTATION IN THE ASSESSMENT PROCESS

Documentation is a key process for ensuring the efficacy of suicide risk assessment. After initial and ongoing assessments, chart notes should clearly identify the person's level of risk (based on warning signs, potentiating factors,

and protective factors) and plans for treatment and preventive care. Chart notes should be augmented with structured assessments, including relevant risk assessments, previous psychiatric history, previous treatment received, and concerns expressed by family or friends. In settings where behaviours can be easily observed (e.g., hospital), documentation should also include information about the person's specific thoughts and behaviours to further help appraise risk.

Documentation should include information about current and historical suicidal and purposeful self-harming behaviour. Even if the behaviour occurred several years previously, it is necessary to explore the circumstances around that incident and the person's reaction to it, in case a similar situation arises. For both current and historical suicidal behaviour, details about timing, method, level of intent, and consequences of the behaviour should be documented.

A pull out reference is available in Appendix E.

Documentation should include:

1. The overall level of suicide risk

The level of risk should be clearly documented along with information to support this assertion. This can include information about:

- The types of assessment tools used to inform risk assessment;
- Details from clinical interviews and details from communication with others (e.g., the person's family and friends, other professionals);
 - i. The circumstances and timing of the event;
 - ii. Method chosen for suicide;
 - iii. Degree of intent; and
 - iv. Consequences.

2. Prior history of suicide attempt(s) and self-harming behaviour.

This should include:

- The prior care plan/intervention plan that was in place;
- The length of time since previous suicide attempt(s) or self-harming behavior(s);

- The rationale for not being admitted to a more intensive environment or discharged to a less restrictive environment, and what safety plans were put into place; and
 - Details about family concerns and how these were addressed.
3. **Details about all potentiating risk factors, warning signs, and protective factors**
 4. **The degree of suicide intent**
The degree of intent may include, for example, what the person thought or hoped would happen.
 5. **The person's feeling and reaction following suicidal behaviour**
For example, sense of relief, regret at being alive.
 6. **Evidence of an escalation in potential lethality of self-harm or suicidal behaviours**
Document whether the person has begun to consider, plan, or use increasingly lethal means (e.g., from cutting to hanging, seeking a gun).
 7. **Similarity of person's current circumstances to those surrounding previous suicide attempt(s) or self-harming behaviour(s)**
 8. **History of self-harm or suicidal behaviour(s) among family or friends or significant loss of family or friends**
This should include anniversary dates of these events as risk may be elevated at these anniversary points.

Organizations should also develop standard protocols for identifying the location of documentation regarding suicide risk within the persons' record. The location of documentation should be consistent and easily identified by others within the organization or those involved in the care of the person.

Documentation during transitions

Studies have shown that persons who have been discharged from in-patient psychiatric care are at particularly higher risk of suicide than the general population (Ho, 2003; Hunt et al., 2009; Goldacre et al., 1993). The transition from the safety of the hospital setting back into the community is a vulnerable period. Discharge planning may improve this transition to the community and reduce the risk for suicide once the person has left in-patient psychiatric care.

Box 3. Key aspects of documentation during transitions

- Risk indicators that immediately inform care providers of the person's heightened risk
- Use of physical or virtual indicators (e.g., brighter chart, warning on electronic record) that indicate the person's heightened risk
- Information on prior monitoring, assessment timelines, and recommendations for future monitoring (which are based on knowledge of the person and understanding of his or her chronic and acute needs)
- Information on plans to mitigate risk that have been established between the person and his or her care team (i.e., crisis plan, supports and safety plan, and concerns or considerations of the informal support network). This allows providers in different care environments to follow a consistent risk prevention strategy

A thorough suicide risk assessment is essential when considering the timing of discharge.

If the crisis has not been addressed, the person has not fully de-escalated, or the person cannot (or will not) agree to formulate a safety plan, try to negotiate a safety plan with the person. Suicidal ideation, low mood or hopelessness should not be present at time of discharge. Offer concrete choices (e.g., “Do you think staying in hospital would be helpful, or would returning home with a family member feel safer?”) to provide autonomy to the person to choose the treatment/discharge option that feels most safe for him or her. Relying on how the person has previously managed in the community (or while in hospital) is not a fail-safe indicator of how he or she will respond when back in the community. The person will need preparation for reintegrating, crisis contact numbers, and a timely appointment with a professional to address these items. Persons who self-discharge following a suicide crisis should be red-flagged for close monitoring. Follow-up appointments should incorporate the same suicide risk management practices as those used for discharge planning (Bergmans et al., 2007; Hunt et al., 2009).

Persons in hospital or the emergency department for suicidality should be discharged with a specific safety plan on how to stay safe once he or she returns to the community. Strategies for staying safe, early warning signs, grounding techniques, coping strategies and crisis contact numbers that were discussed during the intervention should be included in the safety plan.

Writing this plan on paper with the person will help them avoid returning into crisis once they leave the safety of the hospital (Bergmans et al., 2007) and also provides something tangible to review if feelings of distress begin to mount. Support persons, such as family or friends, should also be involved in the details of the safety plan with clear documentation of who needs to be contacted if a crisis seems imminent. Sharing the safety plan with the person's care team will also increase collaboration and continuity of care in the event of a re-admission.

PRINCIPLE FOUR – CULTURAL AWARENESS

Clinicians and health care professionals performing suicide risk assessments need to be aware of culture and its potential influence on suicide. In some cultures for instance, suicide is considered taboo and is neither acknowledged nor discussed. This creates a challenge not only for the clinician assessing for suicidality, but also for the person of that culture who may be struggling with suicidal thoughts and unable to discuss or disclose those thoughts or feelings to members of their same ethnic community. It should be considered a sign of strength for persons whose culture does not accept or discuss suicide to disclose suicidal ideation.

Intra-cultural beliefs regarding suicide can be further confounded by age (e.g., youth, adult, elder), sex, and/or religious beliefs. It is important to consider and be aware of this diversity in beliefs and the potential impact on risk of suicide. Whenever possible, talking with the person, family, or others about specific cultural beliefs toward suicide will aid the risk assessment process and help develop an approach to prevention with the person that is in line with his or her beliefs.

SUMMARY OF KEY PRINCIPLES

The principles outlined above, and others, can be used to help overcome some of the challenges associated with conducting a thorough suicide risk assessment. Granello (2010) developed a set of principles for maintaining a thorough person-centred assessment that can incorporate the use of a suicide risk assessment tool, clinical interview, or both (see Table 1 on next page).

A pull out reference is attached in Appendix F.

Table 1. Guiding Principles for Suicide Risk Assessment (adapted from Granello, 2010).

Suicide Risk Assessment:	Explanation
1. Is Treatment and Occurs in the Context of a Therapeutic Relationship	<ul style="list-style-type: none"> • The process of the risk assessment, itself, could be a therapeutic process for persons, helping them feel that their story can be heard in a safe and confidential environment. • Empathy and helping the person feel valued in the assessment process is important. • This process can help establish the therapeutic relationship with the person.
2. Is Unique for Each Person	<ul style="list-style-type: none"> • Regardless of risk profile a person may have unique circumstances that precipitate suicide ideation or behaviours. • To help the person, it is important to learn about these circumstances from the person's perspective.
3. Is Complex and Challenging	<ul style="list-style-type: none"> • Suicide thoughts or behaviours may be an attempt to escape distress rather than a direct desire to seek out death. • The distinction between wanting to escape vs. wanting to die may create opportunities for intervention. • Each person may have their own specific reasons for escape or distress that may fluctuate over time.
4. Is an Ongoing Process	<ul style="list-style-type: none"> • Ongoing assessment is needed due to the fluctuations of risk factors and warning signs over time. • Important assessment points include times of transition, elevated stress, and changes to supports. • Assessments can use brief questions about frequency and timing of ideations (e.g., last day, week, month, etc.) to determine the acuity or chronicity of ideation.
5. Errs on the Side of Caution	<ul style="list-style-type: none"> • Assessment of risk needs to balance between identifying all possible persons at risk of suicide (sensitivity) while identifying only persons actually at risk of suicide (specificity). • While over estimating persons who may be at risk (false positives) may be burdensome, underestimating those actually at risk (false negatives) can be detrimental. • Risk factors and warning signs are to be used to balance this assessment, but cautious clinical judgement is required to ensure safety.
6. Is Collaborative and Relies on Effective Communication	<ul style="list-style-type: none"> • Multiple sources of information can provide corroboration to the risk assessment. • Collaboration and consultation with other clinical team members as well as others familiar with the person in different environments (e.g., at home, school, or work) can inform this process. • Communication of risk factors and warning signs among all persons involved in care is essential to monitoring and preventing risk.

Suicide Risk Assessment:	Explanation
7. Relies on Clinical Judgement	<ul style="list-style-type: none"> • Assessment tools help inform decisions but never provide exact answers. • Assessment requires a combination of experience and training taking into account all sources of information, including the use of risk assessment tools.
8. Takes All Threats, Warning Signs, and Risk Factors Seriously	<ul style="list-style-type: none"> • Threats and warning signs may represent a cry for help and must always be recognized as potential risks to a person’s safety. • Therapeutic rapport is essential for distinguishing between ideation and behaviours consistent with chronic suicidality and warning signs representing acute risk.
9. Asks the Tough Questions	<ul style="list-style-type: none"> • Rather than using indirect words (e.g., “not around anymore”) use direct language specifically referring to “suicide” or “death” to avoid miscommunication. • Communicate that it is okay to talk about suicidal thoughts and behaviours. • Open-ended questions also allow for persons to express their thoughts about their intentions or behaviours, particularly if their main intentions are not to die. • Multiple questions may be more effective than one question that simply asks “Have you ever felt suicidal?”
10. Tries to Uncover the Underlying Message	<ul style="list-style-type: none"> • Three forms of messages typically represent a person’s reason for wanting to end his or her life: <ul style="list-style-type: none"> – Communication of unbearable distress or pain; – Control over one’s life, fate, or the actions of others; – Avoidance of impending physical or emotional pain when all other options have been exhausted (e.g., unavoidable legal or financial hardship).
11. Is Done in a Cultural Context	<ul style="list-style-type: none"> • Be aware that anyone, regardless of racial or cultural context, may experience suicidal ideation. • In some cultures or religious groups where negative attitudes are held about suicide (e.g., disrespectful to family, religion) persons may not be willing to divulge information about suicidal thoughts. • Cultural empathy and sensitivity to risk assessment is important.
12. Is Documented	<ul style="list-style-type: none"> • Thorough documentation of details regarding all aspects of the suicide risk assessment (i.e., risk factors, warning signs, underlying messages, level of risk, and recommendations for intervention) should be completed in the person’s health record. • The detail and availability of this information between clinical staff members and care settings (e.g., from acute to community health settings) is crucial for the ongoing monitoring and safety of the person.

3. Applying the Principles – Special Considerations for Given Care Settings and Populations

While the principles outlined above apply to all care environments and populations, there may also be specific concerns or considerations for the risk assessment process within certain care settings and among certain sub-populations.

CARE SETTINGS

In this section, special considerations for primary care, emergency, mental health, and long term care settings are highlighted, as are general concerns related to the care environment.

Primary care

As the first point of contact with the health system for most people, primary care settings (e.g., family physicians, nurse practitioners or clinicians, and private practice counselling) have the potential to identify, reduce, and prevent the risk of suicide. However, screening for suicide risk is not a routine practice among most primary care physicians (Fenkenfield, Keyl, Gielen, Wissow, Werthamer, & Baker, 2000), and a number of barriers exist that hinder the professional's ability to recognize and adequately address suicidality. In particular, time constraints during appointments mean that persons have very little time in which to discuss their mental health concerns. When feeling 'rushed', persons may not feel comfortable or encouraged to disclose thoughts of suicide (Cole & Raju, 1996; Denneson, Basham, Dickinson, Crutchfield, Millet, Shen, & Dobscha, 2010). Unless the persons are questioned directly on the state of their emotional health, it is common for them to withhold information on psychological distress (Mellor, Davison, McCabe, et al., 2008). Clinicians in primary care settings can encourage disclosure of mental health issues through effective communication and a supportive patient-centered environment.

Methods that increase screening or improve identification of suicide risk in primary care settings

- Education
 - This is a key strategy to improve mental health awareness and reduce stigmatizing attitudes and discomfort among professionals around sensitive topics such as suicide (Costa-von Aesch & Racine, 2007; Saarela & Engestrom, 2003). Mann, Apter, and Bertolote and colleagues (2005) found that among primary care physicians who received education about screening for suicide risk, patient suicide rates fell between 22% and 73%.
- Education coupled with a skills-training component
 - This strategy, which can include training on the use of a suicide screening instrument, also increases primary care clinician’s ability to recognize and manage underlying mental health issues (Botega, Silva, Reginato, et al., 2007; McCabe, Russo, Mellor, et al., 2008).
 - Emerging evidence provides support for the utility of brief screening for the early identification of suicide risk in primary care. Gardner, Klima, Chisolm, and colleagues (2010) found that among 1500 youth who completed a brief computerized screen given in the waiting room that asked about suicide ideation and behaviours, only 44 refused to answer while 209 indicated suicide thoughts or behaviours and were triaged for further assessment and care.
- Collaborative care approaches
 - Collaborative care approaches in primary care for the treatment of mental health issues have also been proven to be effective (Chang-Quan, Bi-Rong, Zhen-Chan et al., 2009; Gilbody, Bower, Fletcher et al., 2006). The principles of collaborative care generally allow primary care clinicians to focus on medical diagnoses while other specialists and allied health professionals work with patients to manage their condition and improve their health habits. In other words, a greater number of specialists (e.g., nurse case managers, social workers, psychologists, etc.) work in a team approach to augment primary care services. As more health professionals are involved in the person’s care, the likelihood of uncovering underlying psychological distress or suicidal ideation is greatly increased.

Emergency settings

Assessment of the risk of suicide in emergency settings is a time sensitive process that involves evaluating the degree of risk of harm to self, mitigating acute risk, and determining the appropriate level of care for the person (Dawe, 2008). Persons who may be at risk of suicide in an emergency department setting may present immediately following an attempt to commit suicide, at a point where an attempt was imminent; or they may present for reasons other than suicidal thoughts or behaviours but still be at risk. In order to establish risk and triaging for next steps for care, the assessment of suicide risk in emergency settings involves:

- 1) Determining the person's actual level of intent, (i.e., whether or not the person actually wants to die).
 - In this situation it is vital to determine the depth and severity of mood symptoms and hopelessness combined with the degree of ideation, methods, plans, and intentions to attempt suicide. In these situations it was identified that risk assessment tools can be used as an adjunct to gauge the degree of symptom severity and inquire about future intent.
- 2) Evaluating whether the person is telling the truth, either about wanting or not wanting to die by suicide.
 - It may be that some persons have secondary motives and do not actually intend to end their life. In these situations, it is very important to take all thoughts, plans, or threats of self-harm seriously, paying attention to information that may represent some level of distress;
 - Assessment for psychosis should be carried out to determine if symptoms such as command hallucinations are related to suicide ideation or intent;
 - A key question in determining a person's motive and level of intent is to ask questions related to the person's future orientation. For example, asking about whether the person has plans for education, employment, entertainment, or social outings in coming days and weeks may help identify whether the person is actually at risk of ending his or her own life; and

- Persons concealing their true level of intent may be identified in the risk assessment process by the incongruence between their level of distress, agitation, and symptom severity and their stated thoughts, intentions, and plans regarding suicide.
 - In these situations a brief assessment tool that may not entirely focus on suicide intentions but asks about plans to attempt suicide in the future combined with other symptoms such as depression or hopelessness may be helpful (for example, the Beck Depression Inventory; Beck, Ward, Mendelson, 1961). Observational tools may also be useful for providing an indication of risk to the clinician based on combinations of prior history, current symptom severity, current ideations and behaviours expressed by the person. See Section II for more information on tools.

In many instances, the person may arrive at the emergency setting accompanied by ambulance attendants, police, or family/friends. These accompanying persons should be consulted regarding their accounts, observations, and discussions with the person at risk. Ask anyone who may have brought the person to the emergency department whether the person had spoken about suicide or wanting to die, had attempted suicide in the past, and whether any other warning signs were observed.

Mental health settings

In mental health settings, suicide risk assessment is more prevalent than in other care settings. In both inpatient and community mental health care, suicide risk assessment is a continual process and part of the therapeutic process with the person. In these settings, high quality initial screening, global assessment of care needs, and ongoing assessment are essential. The initial screening needs to be brief but sensitive enough to detect persons who may be experiencing warning signs, particularly at points of transition within and between settings. A risk assessment process that involves screening, monitoring, intervention, and follow-up needs to be completed and reviewed on an ongoing basis to inform initial care and therapeutic opportunities, progress in treatment, and changes to levels of care.

Long-term care settings

Suicide in long-term care (LTC) settings has received less attention in the literature and is less well understood. Generally, suicide attempt or death by suicide in LTC nursing home settings is less common than other care settings such as mental health care settings (Conwell, Pearson, & DeRenzo, 1996). However, lower rates of suicide does not mean persons in LTC nursing home settings do not encounter distress and ideation of suicide. Instead, it is suspected that risk factors of suicide such as mental illness often go unrecognized or under-treated in LTC and that lower rates are, instead, related to less access to lethal means and higher rates of daily supervision (Conwell et al., 1996; Scocco, Fantoni, Rapattoni, et al., 2009). Therefore, suicide risk assessment and monitoring is an important process in the care of persons in LTC.

Wanting to die, feeling worthless or living without purpose are common observations made of some LTC residents (Adams-Fryatt, 2010). Major medical illnesses and the loss of personal relationships may also make the older adult wish that their life would end, but they may not be suicidal.

Indirect self-destructive behaviours are actions that are not generally regarded as suicidal, but could still endanger the life of the older adult (Conwell, Pearson, & DeRenzo, 1996). These actions include a wide range of behaviours, such as refusing to eat or drink, failing to take medications, or treatment non-compliance (Brown, Bongar, & Cleary, 2004). Such behaviours are more common in LTC settings where access to lethal means of suicide (e.g., firearms) is more restricted than it is in the community.

An important distinction is whether these self-destructive behaviours are a result of the person's intent to die, or of his or her right to refuse care in an environment where personal autonomy is often restricted. In this sense, control over death may hold a more critical meaning to LTC residents. As any type of self-injurious behaviour places an older adult at risk for premature death, indirect self-destructive behaviours and suicide risk should be equally assessed. Gauging the older adult's level of suicide intent by normalizing the feeling of a loss of purpose may be a first step of risk assessment. For example, one can ask: "Sometimes people with the kinds of medical problems you have had start to feel like life does not have any purpose. Have you ever felt that way?" Additional probing questions, as well as a reflection on the older adult's protective factors, can assist in determining the level of risk.

Making sure that all types of care settings are safe

It is essential that care environments for persons at acute risk of suicide are safe and free of hazards that could be used to attempt or facilitate suicide. The presence of environmental safeguards, policies and best practices about care environments, are essential for preventing persons from being able to inflict harm upon themselves or others (Tishler & Reiss, 2009).

FACT: *Common hazards in care settings:*

- *Anchor points on walls that can support a person's weight;*
- *Materials that could be used as weapons, such as drawers, cords, mouldings, loose tiles, flatware, plastic trash can liners, poisonous cleaning agents; and*
- *Possibility of elopement from a secure unit.*

Hanging and jumping from a window or roof were the most common methods used in inpatient suicide in the U.S., with most hangings occurring in the bathroom (Tishler & Reiss, 2009). Among veterans' mental health hospitals in the United States, a study on environmental risks in care settings identified up to 64 hazards per hospital, with an average of 3 hazards per bed (Mills, 2010). The most common hazard was anchor points on walls that could support the weight of a person attempting to hang him or herself, followed by material that could be used as weapons, and issues regarding potential elopement from secured units. Following an assessment, 90% of the hazards were abated. Doors and wardrobe cabinets that accounted for almost half of all anchor points were removed or altered. The study also found that drawers, cords, mouldings, tiles, flatware, and other small objects could be used as weapons and were also accessible. Less common, but potentially more lethal were suffocation risks such as plastic trash can liners and poisons found in cleaners accessible through unlocked storage closets were identified on secure units.

Clearly, cost is always a consideration when improving the safety of an environment. However, most of the hazards identified, with the exception of changes to structures such as doors and walls, were abated simply with removal, improved education of staff, and changes to the use or availability of certain materials in care units.

The care setting also needs to maintain a comforting and therapeutic environment rather than an authoritarian style (Bostwick, 2009). In this sense, sensitivity should be used when removing personal items from patients that could pose a risk to safety (Lieberman et al., 2004). Rather than simply taking items from the person, explain that the items are being removed for the person's safety and will be kept in a safe and secure storage area.

CONSIDERATIONS RELATED TO LIFESPAN AND TRAUMATIC LIFE EXPERIENCES

Just as the type of care setting can impact the application of general suicide risk assessment principles, so too can considerations such as stage of life and sexual orientation. In this section, special considerations for youth, older adults, First Nations, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities, and military personnel are discussed.

Youth

Suicide risk assessment among youth needs to consider specific approaches for conducting the risk assessment interview to help them feel comfortable and open to discussion.

When asking questions about wanting to die, it is also important to normalize the youth's thoughts or feelings to further encourage disclosure. This can be done by explaining how other youth have expressed certain feelings (e.g., sadness, hopelessness) and tried to die, followed by asking the youth if this is how he or she feels.

- For example, “I know that some kids might feel lonely or hurt and want to try to hurt themselves. Is this how you feel?”

The contagion effect

Occasionally among youth, clusters of persons who die by suicide may occur at similar times or locations – more than would normally be expected in a given community (e.g., multiple persons who die by suicide in a high school over 1 school-year; CDC, 1998). This may reflect a “contagion” effect; that is, persons are believed to end their life because they have been influenced by or are imitating the suicidal behaviour of others.

The evidence supporting the contagion effect of suicide is mixed. Certainly, the emotionally charged atmosphere of a suicide cluster heightens the perception of the contagion effect (O’Carroll & Mercy, 1990). Other factors that account for the occurrence of suicide clusters include individually based risk factors in the face of an unexpected negative life event, as well as friendships that are exposed to shared extremes of stress (Anestis, 2009). Occasionally, suicide in a community or suicide of a celebrity will receive coverage in the media that romanticizes or dramatizes the description

Asking direct questions related to ‘wanting to die’ rather than ‘wanting to commit suicide’ are more appropriate among youth. Ask: “Have you tried to die before?”, “When was the last time you tried to die?”, and “Have you tried to hurt yourself without wanting to die?”

of suicidal deaths (Sudak & Sudak, 2005). The evidence regarding the influence this has on suicide among susceptible youth is also mixed, although the concern for contagion still exists (CDC, 1998). If a suicide cluster is suspected in a community, the Centers for Disease Control and Prevention recommends a community response plan for the prevention and containment of suicide clusters (see <http://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm>).

As some evidence exists that an increase in suicidal behaviour by family members is associated with an increase in deaths by suicide among youth (Ali, Dwyer & Rizzo, 2011), clinicians should consider:

- Whether the youth knows someone who has contemplated, attempted or died by suicide;
- The recency of this/these event(s); and
- How the youth is coping with this knowledge.

In terms of specific risk factors and warning signs among youth, awareness of heightened impulsivity is important to consider, particularly when other risk factors or warning signs are present (e.g., prior abuse, family or caregiver conflict, hopelessness) (Kutcher & Chehil, 2007). Suicide ideation in youth is also related to victimization through bullying, as well as the ability to communicate feelings, negative attachment to parents or guardians, and presence of deviant peers (Peter, Roberts, & Buzdugan, 2008). It is also important to ask the youth and his or her family if there are lethal means in the home environment, such as hunting weapons, anchor points, or toxic substances.

FACT: *Globally, men and women over 74 years of age have the highest rates of death by suicide (WHO, 2005); however, men over 84 years have the highest rate of suicide across all age groups (Canadian Coalition for Seniors Mental Health [CCSMH], 2006). Compared to younger persons, older adults with suicidal ideation are much less likely to turn to suicide prevention centres, crisis telephone lines, or other kinds of mental health services (Glass & Reed, 1993).*

Older adults

Older adults who do see a physician prior to their suicide tend to report somatic symptoms (e.g., insomnia, weight loss, etc.) or despair, and generally do not volunteer thoughts of suicide unless directly questioned. Waern and colleagues (1999) reported that three quarters of older adults who had died by suicide had spoken to relatives or friends about ideation in the year preceding the act, though only one-third had discussed such thoughts with a health care professional.

The Canadian Coalition for Seniors Mental Health (CCSMH) has developed a guideline on the “Assessment of Suicide Risk and Prevention of Suicide” that outlines specific issues to consider among older adults (Heisel et al., 2006).

Again, these guidelines emphasize that older adults may downplay or under-report risk factors or thoughts related to suicide, and that they often present with somatic symptoms (e.g., pain that is not relieved, difficulty sleeping). Continual monitoring is recommended due to variations in the expression and severity of thoughts related to suicide among older adults.

Suicide risk assessment among older adults needs to combine the development of a therapeutic relationship with specific psychometric training prior to using suicide risk assessment tools. This ensures that the assessment is done professionally in a warm and empathetic environment. Improper administration of a tool – for example, using a check-list approach in the absence of a therapeutic relationship, may further contribute to the underestimation of suicide risk in this population (Heisel & Duberstein, 2005). During the assessment process it is also important for professionals to avoid a “moralistic attitude or an aversion to suicide” to encourage openness between the older adult and the assessor (Heisel et al., 2006, p. 568).

First Nations communities

A common misperception is that all suicide rates are uniformly higher across all First Nations and Inuit communities. Based on aggregate statistics, the rate of suicide in Canada is higher among First Nations communities compared to the rest of the population. The Government of Canada (2006) has reported that the rate of suicide among First Nations in Canada was 24 per 100,000 in the year 2000, while the rate among the general population was 12 per 100,000. Inuit communities in Nunavut have experienced a drastic increase in the rate of suicide over the last 25 years, from about 35 per 100,000 in 1981 to almost 120 per 100,000 in 2007 (Nunavut Suicide Prevention Strategy Working Group - SPSWG, 2010). *However, while some First Nations communities experience very high rates of suicide, it is important to recognize that suicide is not a uniform phenomenon across all communities (Bagley, Wood, & Khumar, 1990; Bohn, 2003).* In British Columbia, for instance, Chandler & Lalonde (1998) reported suicide rates as high as 800 times the national average among youth in some First Nations communities. In contrast, in other First Nations communities, rates were closer to 0. Therefore, suicide cannot be considered uniformly across all First Nations and Inuit communities. Instead, it is important to understand specific community and cultural factors in addition to person-level factors during the risk assessment process.

FACT: Older adults tend to:

- *Downplay or under-report risk factors or thoughts related to suicide;*
- *Report somatic symptoms or despair;*
- *Withhold thoughts about suicide unless directly questioned; and*
- *Have spoken with family or friends about suicidal ideation prior to an attempt.*

FACT: *The Government of Canada (2006) reported that the rate of suicide among First Nations in Canada was 24 per 100,000 in the year 2000, while the rate among the general population was 12 per 100,000.*

FACT: *In this population, some of the warning signs exhibited may stem from traumatic personal experiences or multi-generational trauma.*

Factors that may influence suicide risk in First Nations include personal and socio-cultural factors that are to be considered in risk assessment and intervention planning. Many of the immediate warning signs discussed in previous sections are the same among First Nations people. However, the root cause of person-level risk is often related to colonization and historical events and inter-generational trauma. At the personal level, specific warning signs to consider include a low sense of self-esteem and self-worth, loss of identity, alcohol and substance use, binge drinking, social isolation, hopelessness, feelings of anger and rage, and a sense of community discontentment and disconnectedness. The presence of any of these factors, particularly in combination, may indicate that the person may be at a higher risk of suicide. A substantial socio-cultural potentiating risk factor for suicide among First Nations people in Canada is cultural continuity (Chandler & LaLonde, 1995; Chandler & LaLonde, 2004). Cultural continuity needs to be considered in addition to person-level risk factors, warning signs, and protective factors.

Cultural continuity

Cultural continuity refers to the process of maintaining or preserving ownership over past and future traditions, belief systems, and culture. This sense of ownership or connection is lost and cultural identity fractured when development or socio-cultural circumstances undermines or interrupts the continuity from past through present to future.

The institution of residential schools that existed from the mid 1800's to as recently as 1996, is a glaring example of how cultural continuity can be fractured (Indian and Northern Affairs Canada [INAC], 1998). This system removed children from their homes and communities in an attempt at assimilation (Aboriginal Healing Foundation, 2002; INAC, 1998). Similarly, following World War II Canadian Government policies coerced Inuit to move from traditional seasonal camps into new communities based around non-Inuit values, education, governance, and laws (NSPSWG, 2010). Disconnected from their heritage and without means to engage their culture, these experiences left many from First Nations communities with feelings of extreme loneliness, abandonment, loss of culture, lack of self-respect and dignity, and problems with personal relationships.

During the risk assessment process, it is important to consider the community context and cultural continuity of the person. Communities that do not have a strong sense of their own culture and historical identity are not able to provide resources for vulnerable community members to help them through periods

of identity confusion and discontinuity (Chandler & LaLonde, 1995). Thus, the potential protective nature of supportive community may be absent where cultural continuity has been fractured.

It is also important to recognize that not all First Nations communities lack cultural continuity. Actions by some First Nations communities to regain or strengthen cultural continuity actually protect against suicide risk. For instance, First Nations communities in British Columbia that implemented efforts to regain legal title to traditional lands, re-establish forms of self-government, reassert control over education and other community and social services, and preserve and promote traditional cultural practices, had the lowest suicide rates compared to communities that did not engage in these activities (Chandler & Lalonde, 1998).

Therefore, during the risk assessment process it is important to attempt to engage community members or others who are familiar with the person's community and cultural context. Interviews with experts revealed that programs such as the Aboriginal Critical Incidence Response Team (AS CIRT) of the inter Tribal Health Authority, a program servicing 29 member nations throughout Vancouver Island and parts of Coastal BC (www.intertribalhealth.ca), work to educate First Nations communities on traditional values, and to empower them to establish community resources, and recognize and discuss risk as a responsibility of communities. Persons outside of First Nations communities who may be involved in the risk assessment of persons from within these communities should consult professionals from programs such as AS CIRT, referenced above, to incorporate the community and cultural context experienced by the person.

Lesbian, gay, bisexual, transgender, queer (LGBTQ) communities

It is important to recognize the significance and impact of life experiences such as taunting, discrimination, harassment, marginalization, and victimization of persons from LGBTQ communities in the risk assessment process.

In the risk assessment process, it is important to recognize that the person's orientation is not the root cause of suicide risk. Instead, suicide risk may stem from the distress caused by external traumatic life experiences ranging from parental neglect or exclusion, to public discrimination or harassment. Assessment approaches using understanding, empathetic, and non-judgmental approaches that respect the person's privacy are essential.

The person's orientation is not in and of itself the root cause of suicide risk.

FACT:

- *Hatzenbuelher (2011) reported that*
 - *Lesbian, gay, and bi-sexual (LGB) youth (i.e., over 31,000 grade 11 students) were significantly more likely to attempt suicide compared to heterosexual youth (21.5% vs. 4.2%);*
 - *Among LGB youth, the risk of attempting suicide was 20% greater in unsupportive environments compared to supportive environments.*
- *O'Donnell, Meyer, and Schwartz (2011) found that the risk of suicide was even higher among ethnic, minority LGB youth compared to Caucasian LGB youths.*

Military personnel

Persons with experience serving as military personnel may have experienced traumatic events or have developed other mental health conditions that may contribute to risk of suicide. The lifetime prevalence of suicide attempt among active Canadian military has been estimated at 2.2% for men and 5.6% for women (Belik, Stein, Asmundson, & Sareen, 2009). Recent findings have indicated that there were no differences between suicide ideation over the year prior to the study between military personnel and civilians; and that the prevalence of suicide attempt was lower among military personnel compared to civilians (Belik, Stein, Asmundson, & Sareen, 2010).

However, there may be specific risk factors and warning signs that should be considered for military personnel. After controlling for mental illness and socio-demographic factors, interpersonal trauma (e.g., rape, sexual assault, physical and emotional abuse) has been found to be significantly related to suicide attempt among military personnel (Belik et al., 2009).

While many of the risk factors and warning signs may be similar to civilians, specific occupational risk factors for active military personnel include:

- Access to lethal means;
- Timing of assigned duty/shift (i.e., morning duty, late evening duty); and
- Recent changes to duty status for medical reasons (i.e., medical downgrading; Mahon et al., 2005).

Assessment of suicide risk among military personnel should consider the impact of traumatic life experiences that may or may not be related to their military experience, as well as specific aspects of a person's duty status. Clinicians involved in the medical downgrading process should be particularly vigilant in monitoring risk as the person makes this transition.



Section II

Inventory of Suicide Risk Assessment Tools

Risk assessment tools are only one aspect of the risk assessment process. They should be used to inform, not replace, clinical judgment. These tools should be incorporated into the clinical interview and administered once a therapeutic rapport has been established.

In this section:

1. The Use of Tools in Suicide Risk Assessment

- The technical considerations in the selection of suicide risk assessment tools

2. Inventory of Risk Assessment Tools

- Critical review of 15 suicide risk assessment tools identified in the literature review and interviews
- A quick reference table with tool characteristics (Table 2, page 58)
- Authorship and copyright information for each of the suicide risk assessment scales presented (See Table 3, page 59)

3. Evaluating and Using Risk Assessment Tools

- Difficulties associated with the evaluation risk assessment tools
- How professionals can use scores generated by risk assessment tools

1. The Use of Tools in Suicide Risk Assessment

Clearly, suicide risk assessment is a complex process involving consideration of a multitude of factors and contexts. Clinical experience is an asset in navigating this process because ultimately, the designation of risk is a clinical decision. However, a number of tools have been designed to assist in the suicide risk assessment process. Therefore, tools are to be regarded as one aspect of the risk assessment process that informs, but does not replace, clinical judgement of risk (Barker and Barker, 2005). *The use of tools within the risk assessment process must remain person-focused and be incorporated into the clinical interview; these tools can be administered when a therapeutic rapport has been established.*



Definition

Psychometric properties refer to the statistical properties that describe how well a tool has been constructed.

TECHNICAL CONSIDERATIONS FOR THE SELECTION OF SUICIDE RISK ASSESSMENT TOOLS

There are many factors which should be considered when evaluating the suitability of risk assessment tools. These include details about the psychometric properties of the tools as well as other technical issues describing their utility.

Properties such as reliability and validity should be reviewed and considered in order to understand the trustworthiness, meaning and application of the data obtained from an assessment tool.

Box 4 provides a brief description of the main psychometric and technical criteria used to evaluate risk assessment tools.

Box 4. Psychometric and Technical Considerations for Evaluating Suicide Risk Assessment Tools

Correlation	The extent of an association between variables (e.g., tool scores), such that when values in one variable changes, so does the other. A correlation can range from -1.0 to 1.0. The closer the score is to -1.0 or 1.0, the stronger the relationship between variables. Negative correlations indicate that as the value in one variable increases the value in the second variable decreases. Correlation is often used in the validation process when examining how well a tool's score relates to other indicators or suicide risk or distress.
Reliability	The degree to which a risk assessment tool will produce consistent results (e.g., internal consistency) at a different period (e.g., test-retest), or when completed by different assessors (e.g., inter-rater). A common statistic reported for internal consistency is the Cronbach's alpha (or α). This statistic, like a correlation, ranges from 0 to 1.0. A higher score means the items consistently measure the construct of interest. Typically, a score of 0.7 or higher indicates good reliability.
Validity	The degree to which a risk assessment tool will measure what it is intended to measure or forecast into the future. Convergent, concurrent, and construct validity may be established by looking at the correlation between a tool's score and scores of other instruments, measures, or factors already know to measure or indicate the construct of interest (e.g., suicide risk assessment tool should correlate with other gold standard instruments for measuring suicide risk or factors related to suicide risk such as severe depression). Face validity can be established when the content of the instrument is in agreement with the accepted theory or clinical dimensions of the construct of interest. Predictive validity refers to how well a score on a suicide risk tool can predict future behaviour.
Sensitivity	A component of validity, sensitivity of a risk assessment tool is the ability of the instrument to identify correctly persons who are at risk.
Specificity	A component of validity, specificity of a risk assessment tool is the ability of the instrument to identify correctly those who are not at risk.
Factor Analysis	A statistical approach that can be used to analyze interrelationships among a large number of items on a tool and to explain these relationships in terms of their common underlying dimensions (factors). Usually, this analysis is done to determine how items in an instrument measure a similar factor.
Threshold Scores	A threshold score is the minimum score that denotes a level of risk on an assessment instrument. Falling within a high range of points, for example, may suggest higher risk for suicide. Note that not all threshold scores are validated across populations/settings and their use may result in increased false negatives (i.e., incorrectly labeling a person not at risk of suicide). To adopt a threshold score for identifying high risk of suicide, evidence of strong sensitivity and specificity, as described above, is required.
Modes of Administration	Several approaches to risk assessment exist, such as a clinical interview or through a self-report questionnaire. Advantages of self report include the opportunity for screening prior to a visit, particularly in primary care or use as a break in the clinical interview and an opportunity for corroboration. Disadvantages include the potential for perceived disconnect between the assessor and person and the impersonal nature of completing the form.

FACT: *Symptom assessment* refers to the use of a tool to identify specific symptoms or conditions that are known to be related to risk factors or warning signs for suicide (e.g., Beck Hopelessness Scale).

Tools that assess **resilience factors** assess the person's motivation or determination to live or die (e.g., Reasons for Living Inventory). Some tools may combine both symptom assessment and resilience factors into assessment.

2. Inventory of Risk Assessment Tools

COMMONLY USED SUICIDE RISK ASSESSMENT TOOLS

In this section, a critical review of fifteen of the most commonly used suicide risk assessment tools is presented (in alphabetical order). The focus of the tools range from **symptom assessment** (e.g., hopelessness) to **resilience factors** (e.g., reasons for living).

Although not an exhaustive list of suicide risk assessment tools, the list is based on recommendations from the literature and interviews with experts. A pull out summary reference of the assessment tools is provided in Appendix H.

TRAINING IN THE USE OF EACH SUICIDE RISK ASSESSMENT TOOL IS ADVISED.

THE SCALES

Beck Hopelessness Scale

What it Measures:

The Beck Hopelessness Scale (BHS; Beck & Steer, 1988) was designed to measure negative attitudes about one's future and perceived inability to avert negative life occurrences.

Format:

Twenty true/false questions measure three aspects of hopelessness:

- Negative feelings about the future;
- Loss of motivation; and
- Pessimistic expectations.

Each of the 20 statements is scored 0 or 1. A total score is calculated by summing the pessimistic responses for each of the 20 items, with higher scores indicating greater hopelessness. The published cut-off score for the BHS is greater than 9 (Beck, Steer et al., 1985).

Potential setting/Population:

The BHS can be used with psychiatric and non-psychiatric (general population) samples, as well with older adults (Neufeld et al., 2010). It may be used in a forensic setting, where a cut-off score of greater than 5 has been identified for suicide risk (McMillan et al., 2007).

Psychometric properties:

The BHS has been found to produce reliable scores with reported internal consistency scores ranging from a Chronbach's alpha score of $\alpha = .82$ to $\alpha = .93$ among samples of persons with mental illness (Beck & Steer, 1988) and $\alpha = .88$ in a non-psychiatric sample (Steed, 2001). When comparing BHS scores and clinical ratings of hopelessness, moderate correlations have been found between BHS responses and ratings of hopelessness in a general practice sample ($r = .74$) and in a suicide-attempt sample ($r = .62$) (Beck et al., 1974).

Other considerations:

It has been suggested that the BHS would make a good initial screener to identify people who are in need of a more intensive clinical risk assessment (McMillan et al., 2007). The BHS is not supported for use in identifying individuals at high risk of repetitive, non-suicidal self-injury, nor is it supported for use in emergency settings (Cochrane-Brink et al., 2000).

Beck Scale for Suicide Ideation (BSS®)

What it Measures:

The Beck Scale for Suicide Ideation (BSS®: Beck et al., 1979) measures the current and immediate intensity of attitudes, behaviours and plans for suicide-related behaviour with the intent to end life among psychiatric patients.

Format:

The scale consists of 21 items that are rated on a 3-point scale of suicidal intensity (e.g., 0 to 2). Five screening items assess the patient's wish to live or die, including the desire to attempt suicide. If any active or passive suicide-related ideation is noted, the remaining scale items are administered to assess the duration and frequency of ideation and the amount of preparation involved in a contemplated suicide attempt. Two items assess previous suicide-related behaviour. The BSS® requires specific training and professional qualification for use. See publishers for more details on training (<http://www.pearsonassessments.com>).

Potential setting/Population:

The BSS® has been validated among a number of populations, including psychiatric inpatients and outpatients, primary care patients, emergency room patients, adolescents, college students, and older adult clinical populations (Beck et al., 1985; Beck et al., 1997; Clum & Curtin, 1993; Holi et al., 2005; Mireault & de Man, 1996).

Psychometric properties:

The BSS® reports moderately high internal consistency with Cronbach alphas ranging from $\alpha = .84$ to $\alpha = .89$. Responses to the SSI have been significantly associated with the Beck Depression Inventory and Hamilton Rating Scale for Depression (Brown, 2002). The BSS® is one of the few assessment tools to have documented predictive validity for death by suicide. In a 20-year prospective study, patients considered at high risk were seven times more likely to die by suicide than those patients considered at lower risk (Brown et al., 2000). Predictive validity of the BSS® for acute suicide was not found in the literature.

Other considerations:

The BSS® is one of the most widely used measures of suicide-related ideation and has been extensively studied. It has been shown to differentiate between adults and adolescents with and without a history of suicide attempts (Holi et al., 2005; Mann et al., 1999). It has also been translated into multiple languages, including French (de Man et al., 1987), Norwegian (Chioqueta & Stiles, 2006), Chinese (Zhang & Brown, 2007) and Urdu (Ayub, 2008).

The BSS® can either be clinician-administered or done through self-report using paper and pencil or on a computer (Chioqueta & Stiles, 2006). Factor analysis of the scale has revealed different dimensions of suicidality, depending on the population being sampled and the factor-analytic methods used. The original factor analysis revealed three factors: active suicidal desire; passive suicidal desire; and preparation (Beck et al., 1979). More recently, a two-factor model of motivation (e.g., wishes, reasons, desires) and preparation (e.g., planning and acting) was established among a sample of female suicide attempters (Holden & DeLisle, 2005).

Columbia-Suicide Severity Rating Scale

What it Measures:

The Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2008) assesses a full-range of suicide-related ideation and behaviour, as well as the intensity of the ideation. Training is required to administer the C-SSRS.

Format:

This scale is a questionnaire developed for use in clinical drug trial research, with applicability in clinical practice.

Potential setting/Population:

Three versions of the C-SSRS are used in clinical practice to optimize patient safety and management and monitor improvements or worsening of suicidality.

- The *Lifetime/Recent* version gathers lifetime history of suicidality, as well as recent suicide-related ideation and/or behaviour. This version is appropriate for use as part of the person's first interview.
- The *Since Last Visit* version prospectively monitors suicide-related behaviour since the person's last visit, or the last time the C-SSRS was administered.
- The *Risk Assessment* version is intended for use in acute care settings as it establishes a person's immediate risk of suicide. Suicide-related ideation and behaviour is assessed over the past week and lifetime through a checklist of protective and risk factors for suicidality. Mundt et al. (2010) tested and validated a computer-automated version of the C-SSRS and found it well correlated to the Beck Scale for Suicide Ideation ($r = .61$).

Other considerations:

Information about the reliability and validity of the C-SSRS was not available at the time of publication of this guide.

Geriatric Suicide Ideation Scale

What it Measures:

The Geriatric Suicide Ideation Scale (GSIS; Heisel & Flett, 2006) is a multidimensional measure of suicide-related ideation developed for use with older adults.

Format:

The GSIS is composed of 31 questions with scores ranging from 31 to 165. Participants provide responses on a 5-point Likert-type scale ranging from strongly disagree (1) to strongly agree (5). The GSIS was initially validated with institutionalized and community-dwelling seniors over 64 years of age (Heisel & Flett, 2006). The GSIS has four factors:

- Suicide ideation (e.g., “I want to end my life.”);
- Perceived Meaning in Life (e.g., “Life is extremely valuable to me”, reverse keyed);
- Loss of Personal and Social Worth (e.g., “I generally feel pretty worthless”); and
- Death Ideation (e.g., “I often wish I would pass away in my sleep”); and one additional item (e.g., “I have tried ending my life in the past”).

Potential setting/Population:

Older Adults.

Psychometric properties:

Test-retest reliability of responses by a sample of 32 nursing home residents was $r = .86$ (one to two months between points of measurement), and $r = .77$ for a sample of 13 nursing home residents (1 to 1.5 years between points of measurement; Heisel & Flett, 2006). Cronbach’s alpha for responses to the GSIS ($\alpha = .90$) and its subscales ($.74 \leq \alpha \leq .86$) suggest acceptable to good internal consistency (Heisel & Flett, 2006). Responses to the GSIS have exhibited strong concurrent validity vis-à-vis the Beck Scale for Suicide Ideation ($r = 0.62$) and the Geriatric Depression Scale ($r = 0.77$; Heisel, Flett, Duberstein, & Lyness, 2005). Further positive features include its sensitivity to suicide-related ideation across a range of functioning and subscales that focus on maladaptive and protective factors.

interRAI Severity of Self-harm Scale (interRAI SOS)

What it Measures:

The interRAI Severity of Self-harm (SOS Scale) measures risk of harm to self (suicide and self-harm) based on historical and current suicide ideation, plans, and behaviours as well as indicators of depression, hopelessness, positive symptoms, cognitive functioning, and family concern over the person's safety. The SOS Scale uses hierarchical scoring algorithm producing scores ranging from 0 (no risk) to 6 (extreme or imminent risk). Persons scored at the highest risk level (6) include those with observed or reported suicide ideation in the last 24 to 76 hours, who previously attempted suicide, and have a high number of current depressive symptoms.

Format:

The interRAI SOS is a scale embedded within three interRAI assessment instruments for mental health settings, the interRAI Mental Health, the interRAI Community Mental Health, and the interRAI Emergency Screener for Psychiatry (www.interrai.org). The interRAI Mental Health (interRAI MH) is an assessment system that includes information on socio-demographic characteristics of the person, indicators of mental and physical health status, patterns of substance use, aggressive and disruptive behaviour, harm to self and others, diagnoses, cognitive performance, functioning with daily activities, social and family relationships, vocational functioning, and service utilization (Hirdes et al., 2000). A compatible instrument to the interRAI MH, the interRAI Community Mental Health (CMH) is designed for use among persons receiving outpatient mental health services. About 60% of the items on the interRAI CMH are the same as the interRAI MH with the remaining items designed to address issues of specific relevance to community mental health services (e.g., financial issues, expanded substance use items, involvement with criminal justice, etc.). The interRAI Emergency Screener for Psychiatry (ESP) is a brief screening instrument that includes items from the interRAI MH and CMH designed to assess ability to care for self and risk of harm to self and others in emergency room settings.

The interRAI MH and CMH are completed at admission, every 90 days, upon a change in status, and at discharge. The interRAI ESP is completed within the first 24 hours of a person entering an emergency health setting. Each of these assessments is completed by the clinical care team based on observation as well as consultation with other team members, family, and the person. The interRAI MH and CMH are based on a three-day observation period, while the ESP uses a 24-hour observation period.

Potential Setting/Population:

Adult inpatient, community, and emergency mental health settings.

Psychometric properties:

The interRAI MH has been found to have good inter-rater reliability with an average level of agreement on item ratings of over 80% between assessors (Hirdes et al., 2002). The SOS scale was derived using over 1,000 interRAI ESP assessments collected from 10 Ontario hospitals with inpatient mental health beds. To assess validity, clinicians completing the ESP were also asked to rate the level of risk of harm to self each person posed on a five point scale, from minimal to very severe/imminent risk. Strong relationships were found between the SOS scores and clinician

continued...

ratings of risk where the SOS scores matched clinician ratings 85% of the time. Further, 98% of patients with a score of 0 on the SOS were rated as minimal or mild risk by clinicians while 80% with an SOS score of 6 were rated as moderate to very severe/imminent risk.

Other considerations:

In Ontario and other jurisdictions (e.g., Finland, Iceland), the interRAI MH is used to assess all persons admitted to an inpatient mental health bed.

The SOS Scale is also used as a basis for the Suicidality and Purposeful Self-harm Clinical Assessment Protocol (CAP). Once the full interRAI MH, CMH, or ESP is completed, the clinical team is alerted to persons at minimal to mild (0 to 2), moderate to severe (3 to 4), and very severe risk of harm to self (5 to 6). The CAP provides a list of initial considerations, guidelines, and interventions that the clinical team can use in care planning to address immediate and long-term safety issues to prevent future self-harm and suicide. Thus, the interRAI assessment instruments combine risk assessment with guidelines to support care planning. In jurisdictions such as Ontario, the SOS Scale is administered for every person admitted to an inpatient mental health bed allowing for embedded screening and an opportunity to identify persons in need of more in-depth assessment of suicide risk using a clinical interview.

Mental Health Environment of Care Checklist

What it Measures:

The Mental Health Environment of Care Checklist (MHECC) focuses on the factors in the physical care environment that contribute to patient and staff safety. It does not determine whether a person is at risk of suicide.

Format:

The checklist provides detailed guidelines to identify environmental hazards and improve environmental safety. There are 114 potential hazards that are rated across severity (i.e., negligible to catastrophic) and mishap probability (i.e., likely to occur immediately to unlikely to occur). Each hazard is rated using a 5-point risk assessment code (RAC) that combines the elements of hazard severity and mishap probability (i.e., negligible to critical). For example, an RAC of 5 is a situation that requires immediate attention, such as an open window in a patient's room that is high above the ground. The MHECC is mandatory in all U.S.A. Veteran Affairs mental health units responsible for treating persons known to be at risk for suicide. In terms of effectiveness and ease of implementation, multidisciplinary safety inspection teams at 113 facilities implemented the checklist and identified 7,642 hazards with 5,834 (76.4%) of these hazards having been eliminated after one year of implementation (Mills et al., 2010).

Potential setting/Population:

Inpatient care settings.

Other considerations:

The Mental Health Environment of Care Checklist (MHECC; Mills, 2010) was developed following the results of a study on the relationship between inpatient suicide and the physical environment. A committee of senior leaders and frontline staff in mental health, senior mental health nurses, chief engineers and architects with expertise in mental health facility design and construction, as well as senior inpatient safety and fire safety personnel developed this environmental checklist for use in all Veteran Affairs Mental Health Units for the purpose of reducing environmental factors that contributed to inpatient suicides and self-injury.

Modified Scale for Suicide Ideation

What it Measures:

The Modified Scale for Suicide Ideation (SSI-M; Miller, Bishop & Dow, 1986) was designed to screen at-risk patients in clinical settings in a format that can be used by paraprofessionals and laypeople. Thus, the SSI-M identifies those at highest risk for suicide within a specific high-risk population (e.g., psychiatric patients suspected of suicidal ideation) and can be administered by non-clinically trained staff (Pettit, Garza, Grover et al., 2009; Rudd & Rajab, 1995). The SSI-M assesses several aspects of suicidal ideation and behaviour, such as ideation frequency, duration and severity; identifiable deterrents to an attempt; reasons for living/dying; degree of specificity/planning; method availability/opportunity; expectancy of actual attempt; and actual preparation (Rudd & Rajab, 1995).

Format:

The scale consists of 18 questions that are scored from 0 to 3. Total scores range from 0 to 54. A total score based on the sum of all items is calculated to estimate the severity of suicidal ideation. For efficiency purposes, the first four items of the scale are designated as screening items (e.g., patients reporting a moderate or strong wish to die) to warrant the administration of the entire scale.

Potential setting/Population:

The SSI-M has been used across adult populations and among adolescents aged 13 to 17 years.

Psychometric properties:

Reported internal consistency of SSI-M responses range from $\alpha = .87$ to $\alpha = .94$ (Clum & Yang, 1995; Miller, et al., 1986; Rudd & Rajab, 1995). Correlations between the SSI-M and the SSI ($r = .74$) Beck Depression Inventory ($r = .39$); BHS ($r = .46$); and Zung Depression Scale ($r = .45$) establish the scale's construct validity. The SSI-M shows some support for establishing risk over time (e.g., six months), however there is limited evidence for its predictive validity.

Other considerations:

The Modified Scale for Suicide Ideation (SSI-M; Miller, Morman, Bishop, & Dow, 1986) is a revised version of Beck's Scale for Suicidal Ideation (BSS®; Beck et al., 1979). An advantage of the SSI-M is its ability to effectively discriminate between suicide ideators and attempters at intake.

Nurses' Global Assessment of Suicide Risk

What it Measures:

The Nurses' Global Assessment of Suicide Risk (NGASR; Cutcliffe & Barker, 2004) is a nursing assessment tool used to identify psychosocial stressors that are reported to be strongly linked with suicide.

Level of Expertise Required:

The NGASR is recommended for use as a guide in the assessment of suicide risk, and is appropriate for entry-level health care staff with little experience in suicide assessment.

Format:

Fifteen items assess the patient's level of risk, as well as corresponding levels of engagement and support for the patient needs. Five of the 15 items have a weighting of 3, as these items are considered critical indicators of suicide risk (e.g., hopelessness, having a suicide plan). The remaining ten items have a weighting of 1. Risk is attributed to four possible categories: very little risk; intermediate degree of risk; high degree of risk; or extremely high risk of suicide. The higher the level of risk indicated, the more intensive level of engagement required.

Potential setting/Population:

Psychiatric inpatient and outpatient settings. Adults.

Psychometric properties:

There are no wide-scale validation studies testing the psychometric properties of the NGASR. A recent Dutch study using the NGASR on a crisis resolution ward reported low internal consistency ($\alpha = .42$), but high user-satisfaction (Veen, 2010). This satisfaction among health professionals using the NGASR has been echoed elsewhere (Mitchell et al., 2005), including among nurses who are novice with suicide assessments. The tool receives widespread use among nurses in Canada, Ireland, Japan, New Zealand and the UK.

Other considerations:

Barker & Barker (2005) incorporate the NGASR as a key component of suicide risk assessment and monitoring in their Tidal Model of mental health care; a theory-based approach to mental health nursing that emphasizes a therapeutic patient-empowering relationship.

Reasons for Living Inventory

What it Measures:

The Reasons for Living Inventory (RFL; Linehan et al., 1983) assesses potential protective factors among persons who report ideation of suicide. It may be used to explore differences in the reasons for living among individuals who engage in suicide-related behaviour and those who do not (e.g., “I believe that I could cope with anything life has to offer”).

Format:

The RFL is a 48-item self-report questionnaire. Each item is rated on a 6-point Likert-type scale ranging from 1 (not at all important) to 6 (extremely important). The RFL consists of six subscales and a total scale: survival and coping beliefs (24-items); responsibility to family (7-items); child-related concerns (3-items); fear of suicide (7-items); fear of social disapproval (3-items); and moral objections (4-items). The six subscales were based on four separate factor analyses performed on two samples of normal adult volunteers (Linehan et al., 1983). Subsequent confirmatory factor analysis, however, only found moderate support for the six-factor solution in psychiatric patients (Osman et al., 1999).

Potential setting/Population:

The RFL has been demonstrated for use with both clinical and non-clinical samples, as well as older adult populations (RFL-OA; Edelstein et al., 2009) and young adults (RFL-YA; Gutierrez et al., 2002; Linehan et al., 1983; Malone et al., 2000; Osman et al., 1993).

Psychometric properties:

Good internal reliability is reported with Cronbach alphas ranging from $\alpha = .72$ to $\alpha = .92$ for each subscale. A robust internal consistency is reported for the RFL-OA ($\alpha = .98$). The RFL had moderate negative correlations with the SSI ($r = -.64$) and the BHS ($r = -.63$) in a college student sample (Brown, 2002). Responses on the RFL-OA were also significantly correlated with the SSI ($r = -.40$) and BDI-II ($r = -.43$). No evidence is available for the predictive validity of the RFL.

Other considerations:

Reports indicate that the RFL takes approximately 10 minutes to administer, however the 48-items are cumbersome for some populations such as psychiatric or forensic inpatients (Brown, 2002; Range & Knott, 1997).

An advantage of the RFL is its positive wording that may, in part, act as a buffer against suicide-related behaviour for those completing the assessment. Assessment of reasons for living, either with this instrument or through clinical interview, should be included in the evaluation of suicidal individuals (Malone et al., 2000). While it is a self report instrument, clinicians interested in using the RFL may want to incorporate the items into a clinical interview approach or give very thorough instructions to the person as to why he or she is being asked to complete the RFL. Simply distributing the items to gather a score may appear cold and take away from therapeutic engagement. Once the RFL is completed it is important to discuss the items with the person and review his or responses as part of therapeutic intervention.

SAD PERSONS and SAD PERSONAS Scales

SAD PERSONS

What it Measures:

The SAD PERSONS Scale (Patterson et al., 1983) is a simple mnemonic to assess major suicide-related risk factors (Patterson et al., 1983).

Format:

The letters in SAD PERSONS are associated with demographic, behavioural and psychosocial risk factors. A positive endorsement of each letter is weighted with 1-point, to a maximum of 10 points. A cut-off score of greater than 5 is the suggested risk level when hospitalization (either voluntary or involuntary) of the at-risk patient is necessary. However, limited evidence is available to support the validity of this cut-off. The items include:

- S = Sex (male) 1-point
- A = Age (25-34); (35-44); (65+) 1-point
- D = Depression 1-point
- P = Previous attempt 1-point
- E = Ethanol abuse 1-point
- R = Rational thinking loss (psychosis) 1-point
- S = Social support lacking 1-point
- O = Organized suicide plan 1-point
- N = No spouse (for males) 1-point
- S = Sickness (chronic/severe) 1-point

Each item is scored as present/not present to a maximum of 10 points. Patterson et al., (1983) recommends that for scores of 3 to 4, clinicians should closely monitor status, for 5 and 6 clinicians should “strongly consider hospitalization”, and scores of 7 to 10 should hospitalize for further assessment. Juhnke & Hovestadt (1995) found that clinicians who used the SAD PERSONS were better able to identify persons with suicide ideation than a control group who did not use the SAD PERSONS.

Potential setting/Population:

All health care settings with all populations.

Psychometric Properties:

A small number of studies have examined the validity of the SAD PERSONS. Bullard (1993) found that the score may underestimate suicide risk compared to clinical interview. Herman (2006) found that the cut off score of 5 failed to identify 14% of persons considered by clinicians to be actively suicidal and had a false positive rate of 87%.

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Other considerations:

While the SAD PERSONS does include a number of factors considered risk and warning factors (e.g., substance abuse, loss of rational thinking, and presence of a suicide plan) it also includes a number of epidemiologic factors that may be more distal in terms of risk. More importantly, the risk factors are not organized in any hierarchical manner suggested by literature on warning signs (Rudd, 2008). For instance, a 40 year old single male with diabetes would score higher than a 40 year old female with depression and an organized plan for suicide. Thus, clinicians may be faced with high numbers of false positives.

SAD PERSONAS

A **modified version** of the SAD PERSONS, the **SAD PERSONAS** (Hockberger & Rothstein, 1998) was developed to incorporate a weighting system and modify several items:

S = Sex (male) 1-point

A = Age (<19 or >45 years) 1-point

D = Depression or hopelessness 2-point

P = Previous suicide attempts or psychiatric care 1-point

E = Excessive alcohol or drug use 1-point

R = Rational thinking loss 2-point

S = Separated, divorced or widowed 1-point

O = Organized or serious attempt 2-point

N = No social supports 1-point

A = Availability of lethal means 2-point

S = Stated future intent 2-point

Potential setting/Population:

All health care settings with all populations.

Psychometric properties:

Hockberger & Rothstein (1998) found 31% sensitivity and 94% specificity for the modified version of the SAD PERSONAS in predicting hospitalization among persons in an emergency department. Cochrane-Brink et al. (2000) found the modified SAD PERSONAS was not as effective in predicting hospitalizations due to risk of harm to self compared to other measures of risk including the Suicide Probability Scale.

Other considerations:

While the modified scale makes improvement in weighting risk factors that are consistent with more specific warning signs for acute suicide, there is still a lack of predictive validity for clinical decision-making. The assessment does provide an easy to remember checklist of potential risk factors to guide initial screening, particularly among those not as experienced in clinical risk assessment.

Scale for Impact of Suicidality – Management, Assessment and Planning of Care

What it Measures:

The Scale for Impact of Suicidality–Management, Assessment and Planning of Care (SIS-MAP; Nelson, Johnston & Shrivastava, 2010) is a comprehensive suicide assessment tool to aid in the prediction of suicide risk, as well as the development of a care and management plan.

Format:

The items in the SIS-MAP are balanced between risk and resilience (protective) factors, in addition to factors that contribute to suicide from a wide variety of domains. Current level of suicide risk is measured from eight domains: (1) demographics; (2) psychological; (3) co-morbidities; (4) family history; (5) biological; (6) protective factors; (7) clinical ratings/observations; and (8) psychosocial/environmental problems.

The SIS-MAP scale is composed of 108 items across the above domains. Despite the number of items, the scale can be administered in a relatively short period of time. The majority of items require a simple checking of ‘yes’ or ‘no’ to the presence or absence of items under each domain (‘yes’ items have a value of 1; ‘no’ items have no value). Authors of the scale recommend that persons with a score of 33 or above are considered “serious risk” of suicide and should be admitted to a psychiatric facility while persons with scores between 13 and 33 are still considered at risk requiring clinical judgement for appropriate care settings (Nelson et al., 2010). Scores of less than 13 are not likely to require follow-up, but should be subject to appropriate clinical judgement. Unlike other risk assessment tools that offer little in the way of treatment implications, the SIS-MAP provides clinical cut-offs in order to facilitate a level of care decision based on the patient’s score.

Potential setting/Population:

Adult inpatient and outpatient psychiatric settings as well as non-psychiatric care settings.

Psychometric properties:

The resilience items on the SIS-MAP showed moderate association with admission to inpatient hospital ($r = -.33, p < .05$), suggesting that individuals with a higher degree of protective factors are less likely to be admitted to hospital. The SIS-MAP also correctly differentiated between individuals who did not require admission (i.e., specificity rate of 78.1%) and those that required admission (i.e., sensitivity rate of 66.7%). The false positive rate was 33.3%, with 21.9% of cases resulting in a false negative (Nelson et al., 2010). Although additional psychometric and validation studies are required, the SIS-MAP shows preliminary evidence as a valid, sensitive, and specific tool for assessing suicide risk.

Suicidal Behaviors Questionnaire

What it Measures:

The Suicidal Behaviors Questionnaire (SBQ; Linehan, 1981) is a self-report assessment for suicidal thoughts and behaviours in adults. The SBQ measures the frequency and intensity of suicidal ideation, past and future suicidal threats, past and future suicide attempts and non-fatal self-harming behaviour. Items are rated according to the past several days, the last month, the last four months, the last year and over a lifetime. Behaviours are scored using a weighted summary score across each time interval. Suggested cut-off scores for a general adult population is >7 ; and >8 for adult inpatient psychiatry.

Format:

The Suicidal Behaviors Questionnaire is a self-report questionnaire that can be completed using a 14-item version (SBQ-14; Linehan, 1996) and a 4-item version (SBQ-4; Linehan & Nielsen, 1981).

Potential setting/Population:

The SBQ has been validated for use in multiple populations, including adults in community and psychiatric populations, and youth in correctional facilities.

Psychometric properties:

Internal consistency has been established for both versions, ranging from $\alpha = .76$ to $\alpha = .87$ (Osman et al., 2001). Correlations between the SBQ-14, the Scale for Suicide Ideation, the Beck Depression Inventory and the Beck Hopelessness Scale ($r = .55$ to $r = .62$) establish the scale's construct validity (Linehan & Addis, 1990).

Other considerations:

The self-report format of the SBQ allows opportunity to obtain information from individuals who may have difficulty revealing suicidal thoughts or previous suicide-related behaviour during an interview situation (Osman et al., 2001). Due to the wording in the SBQ-4, a broad range of suicidal behaviour can quickly be assessed. Clinicians may prefer the abbreviated 4-item version to the 34- or 14-item versions, which have been used more often for research purposes.

Suicide Intent Scale

What it Measures:

The Suicide Intent Scale (SIS; Beck, Schuyler, & Herman, 1974) is largely used as a research instrument to assess circumstantial and subjective feelings of intent following a specific attempt to die by suicide.

Format:

The SIS includes 15 items scored for severity from 0 to 2 with a total score ranging from 0 to 30, with higher scores indicating a greater degree of intent. The SIS is typically administered as an interview. The first part of the SIS (items 1-8) assesses objective circumstances surrounding the suicide attempt including items on preparation and manner of execution of the attempt, the setting, as well as prior cues given by the patient that could facilitate or hamper the discovery of the attempt. The second part of the SIS (items 9-15) covers the attempter's perceptions of the method's lethality, expectations about the possibility of rescue and intervention, the extent of premeditation, and the alleged purpose of the attempt.

Recently, a four-factor structure has been identified among adults that include conception (e.g. purpose and seriousness of attempt), preparation (e.g., degree of planning), precautions against discovery (e.g., isolation), and communication (e.g., act to gain help) (Misson et al., 2010). For instance, the item on the degree of meditation prior to the attempt is scored 2 if the person contemplated suicide for more than three hours prior to an attempt, 1 if the person contemplated suicide for less than three hours, and 0 if the person did not contemplate suicide but acted impulsively (Beck, Schuyler, & Herman, 1974).

Potential setting/Population:

Health care settings with persons who may have recently attempted to die by suicide.

Psychometric properties:

The SIS has been found to be a reliable measure of suicide intent as it has been found to have strong internal consistency ($\alpha = .95$) and inter-rater reliability ($r = 0.95$; Beck, Schuyler & Herman (1974)). Convergent validity of the SIS is limited following inconsistent results regarding the relationship between the SIS and other measures of suicide-related intent (Freedenthal, 2008). The SIS has been found to have low to moderate predictive validity. Two, 10-year prospective studies for completed suicide for patients who were hospitalized after attempting suicide found that the SIS was not predictive of death by suicide (Beck & Steer, 1989; Tejedor, Diaz, Castillon & Pericay,

continued...

1999). Other studies have found inconsistent results for the predictive validity of the SIS for subsequent nonfatal suicide attempts. Beck, Morris, & Beck, 1974 found that the SIS was related to subsequent attempted suicide while Tejedor, Diaz, Castillon & Pericay (1999) did not find a relationship between the SIS score and subsequent suicide attempt.

Other considerations:

The SIS has been translated into a number of languages and has shown to be reliable in different cultures (Gau et al., 2009). *The SIS might best serve as a research tool or brief screening tool to help understand, retrospectively, the reasons why a person attempted suicide* (Harriss & Hawton, 2005; Sisask et al., 2009). The first section on objective ratings could even be completed through medical chart review by researchers following a person's death (Freedenthal, 2008). However, given the inconsistencies and lack of predictive power, the SIS is not a useful screening tool to assess for future risk of suicide.

Suicide Probability Scale

What it Measures:

The Suicide Probability Scale (SPS; Cull & Gill, 1988) measures current suicide ideation, hopelessness, negative self-evaluation and hostility.

Format:

The SPS includes 36 self-report items. Questions about the frequency of emotions and behaviours are answered on a 4-point scale ranging from 1 (“None or a little of the time”) to 4 (“Most or all of the time”). The SPS scale takes approximately 10 to 20 minutes to complete and requires a fourth grade reading level.

Three summary scores can be derived from the SPS including:

- A suicide probability score;
- A total weighted score; and
- A normalized T-score.

Using the suicide probability score (range = 0 to 100) cut off scores have been created representing persons in inpatient facilities (e.g., high risk = 50 to 100), persons in outpatient clinics (e.g., intermediate risk = 25 to 49), and persons in the general population (e.g., low risk = 0 to 24). The total weighted score ranges from 30 to 147 with a weighted score of 78 published as the cut-off for high risk.

The SPS is based on six factors:

- Suicide Ideation (6 items);
- Hopelessness (12 items);
- Positive Outlook (6 items);
- Interpersonal Closeness (3 items);
- Hostility (7 items); and
- Angry Impulsivity (2 items) (Cull & Gill, 1988).

However, four subscales were recommended for the SPS:

- Hopelessness,
- Suicidal Ideation,
- Negative Self-Evaluation (combining positive outlook and interpersonal closeness), and
- Hostility (including angry impulsivity).

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The existence of these different dimensions allows clinicians to identify specific factors that may be contributing to a person's risk of suicide.

Potential setting/Population:

The SPS has been used in adolescent and adult samples of men and women. Normative scores have been developed based on samples from the general population, persons receiving inpatient mental health services, and persons who have attempted suicide (Cull & Gill, 1988). Each of these samples included persons of White, Hispanic, and African-American racial backgrounds. The SPS has also been applied to adult prison inmate populations where the higher total probability scores were found to have low to moderate sensitivity and specificity in discriminating among inmates who would later engage in suicidal behaviour (Naud & Daigle, 2010). The SPS has also shown to be reliable among university students, adolescents, and male prison inmates (Labelle et al., 1998).

Psychometric properties:

Among adult populations, the SPS has shown strong reliability with Cronbach's alphas of $\alpha = .93$, and ranging from $\alpha = .62$ to $\alpha = .93$ for the four clinical subscales (Cull & Gill, 1988, Bisconer & Gross, 2007). The SPS has also demonstrated good convergent validity correlating well with other measures of suicide risk, hopelessness, and depression. Test-retest reliability with a correlation of $r = .92$ has been established over a three-week period. Predictive validity of the SPS has not been extensively studied in adult populations. In a small sample of adult inpatients admitted as either a danger to self (high risk group) or danger to others (low risk group) the total suicide probability score cut off of 50 on the SPS was able to correctly identify persons in the high risk group (sensitivity) 52% of the time, while correct identification of those not in the high risk group (specificity) occurred in 78% of cases. These results warrant further investigation before recommendations of the use of a cut-off score can be made.

Other considerations:

The SPS is reliable and valid for use among adolescent psychiatric inpatients, although the original factor-structure identified in adults was not consistently identified among adolescents (Eltz et al., 2006). Among hospitalized adolescents, the total weighted SPS score strongly predicts suicide attempts post discharge (Huth-Bocks et al., 2007). In the same study, the sensitivity of the cut-off score of 78 was moderate at 65%, as was the specificity at 64%. Lowering the cut-off to 61 greatly improved the sensitivity to 90% but drastically reduced the specificity to 38%, indicating that a high number of false positives would be expected.

Tool for Assessment of Suicide Risk

What it Measures:

The Tool for Assessment of Suicide Risk (TASR; Kutcher & Chehil, 2007) was designed to assess imminent suicide risk. The TASR is a short and succinct tool intended for use as part of regular mental health assessment. It was designed to assist in clinical decision-making regarding the ‘burden of risk’ for suicide (Kutcher & Chehil, 2007) by ensuring that the most pertinent individual, symptom and acute risk factors have been addressed by the clinician.

Format:

The TASR is divided into four sections with corresponding items in each section. Each section is given a weighting ‘star’ (*) to denote the items’ significance to suicide risk. Clinicians either check ‘yes’ (applies to patient) or ‘no’ (does not apply) to each item listed.

- (1) **Individual Risk Profile (section 1)** – identifies age and demographic risk factors, as well as pertinent family history, personal medical history and psychosocial history. This section has a weighting of one star as many individuals have many of the demographic risk factors but are not suicidal.
- (2) **Symptom Profile (section 2)**– addresses the current presence of psychiatric symptoms that are associated with increased suicide risk (e.g., depression symptoms, impulsivity). This section has a weighting of two stars.
- (3) **Interview Profile (section 3)** – addresses acute factors identified during the clinical interview that may place an individual at high risk of suicide (e.g., suicidal intent, suicide plan) whether accompanied or unaccompanied by factors listed in sections 1 and 2. This section has a weighting of three stars.
- (4) **Overall Rating of Risk (section 4)** – rates the individual’s risk for suicide (e.g., high, moderate, low) based on the clinician’s impression of the overall assessment.

Potential setting/Population:

The TASR has been used with adults in emergency rooms, hospitals and community outpatient settings. The TASR is also available in a version for youth – The Tool for Assessment of Suicide Risk for Adolescents (TASR-A). It is similar to the TASR for adults, with items specific to risk factors for suicide in younger populations.

Psychometric properties:

No information is available about the validity and reliability of the TASR. Kutcher and Chehil (2007) note that the TASR is not designed as a predictive or diagnostic tool; rather, the TASR is intended as a means for clinicians to summarize their assessment of a patient who may be exhibiting risk of suicide.

Table 2. Characteristics of Suicide Risk Assessment Tools

Scale	Administration		# of Items	Predictive Validity	Reliability	Potential Utility		Population Setting			Population Specific [^]			
	Self-Report	Interview/Observation				Global Assessment	Screening	Psychiatric	Non-Psychiatric	Adults	Children & Youth	Older Adults		
								In	Out	ER				
BSS®	X	X	21	X	X	X	X	X	X	X	X	X		
BHS		X	20		X	X	X	X	X		X	X		X
C-SSRS		X				X	X	X	X	X	X	X		
GSIS	X	X	31		X		X	X	X	X	X			X
interRAI-SOS		X	varies*		X	X	X	X	X	X		X		
MHECC			114			X	X							
NGASR		X	15			X	X	X				X		
RFL	X		48		X	X	X	X	X		X	X		X
SAD PERSONAS		X	10			X	X	X	X		X	X		
SIS-MAP		X	108		X	X	X	X	X		X	X		
SSI-M		X	18		X	X	X	X	X		X	X		X
SBQ	X		34		X	X	X	X	X		X	X		X
SIS		X	15	X	X		X	X	X		X	X		
SPS	X		36	X	X	X	X	X	X		X	X		X
TASR			26			X	X	X	X		X	X		X

Note. **BSS®** = Beck Scale for Suicide Ideation; **BHS** = Beck Hopelessness Scale; **C-SSRS** = Columbia-Suicide Severity Rating Scale; **GSIS** = Geriatric Scale for Suicide Intent; **RAI-MH SOS** = interRAI Mental Health Severity of Self-harm Scale; **MHECC** = Mental Health Environment of Care Checklist; **NGASR** = Nurses Global Assessment of Suicide Risk; **RFL** = Reasons for Living Inventory; **SIS-MAP** = Scale for Impact of Suicidality – Management, Assessment and Planning of Care; **SSI-M** = Modified Scale for Suicide Ideation; **SBQ** = Suicidal Behaviours Questionnaire; **SIS** = Suicide Intent Scale; **SPS** = Suicide Probability Scale; **TASR** = Tool for the Assessment of Suicide Risk.

*The interRAI SOS scale is embedded in a larger mental health assessment system based on three different instruments. The number of items in each instrument varies as does the time to complete the entire assessment.

[^] Adults (18-64), Older Adults (65+), Children & Youth (8-18)

Table 3. Authorship and copyright information for suicide risk assessment scales.

Scale	Main Author	Contact Info	Copyright	Fee
Beck Scale for Suicide Ideation (BSS®)	Aaron T. Beck, Gregory K. Brown & Robert A. Steer	University of Pennsylvania Department of Psychiatry Room 2032 3535 Market Street Philadelphia, PA 19104-3309 abeck@mail.med.upenn.edu	Yes	\$115 (Pearson) www.pearsonassessments.com
Beck Hopelessness Scale (BHS)	Aaron T. Beck & Robert A. Steer	University of Pennsylvania Department of Psychiatry Room 2032 - 3535 Market Street Philadelphia, PA 19104-3309 abeck@mail.med.upenn.edu	Yes	\$115 (Pearson) www.pearsonassessments.com
Columbia Suicide – Severity Rating Scale (C-SSRS)	Kelly Posner	New York State Psychiatric Institute 1051 Riverside Drive, Unit 78 New York, NY 10032 Tel: (212) 543-5504 Fax: (212) 543-5344 Posnerk@childpsych.columbia.edu	Yes	No Contact author for permission to use
The Geriatric Suicide Ideation Scale (GSIS)	Marnin Heisel & Gordon Flett	Department of Epidemiology and Biostatistics University of Western Ontario London, ON Canada N6A 5C1 Tel: (519) 685-8500, ext: 75981 Fax: (519) 667-6584 Marnin.heisel@lhsc.on.ca	Yes	No Contact author for permission to use
InterRAI Mental Health Assessment Tools: Severity of Self-harm Scale (interRAI SOS)	John Hirdes and interRAI group	For information about interRAI tools contact: Mary James Institute of Gerontology University of Michigan 300 North Ingalls, Ann Arbor, Michigan 48109-2007 USA Tel: +1 734/936-3261 Fax: +1 734/936-2116 Mljames@umich.edu	Yes	No Contact interRAI for licensing

Scale	Main Author	Contact Info	Copyright	Fee
The Mental Health Environment of Care Checklist (MHECC)	Peter Mills	Field Office of the National Center for Patient Safety - Veterans Health Administration White River Junction, VT USA Peter.mills@va.gov	No	No
Modified Scale for Suicide Ideation (SSI-M)	Ivan W. Miller, William H. Norman, Stephen B. Bishop & Michael G. Dow	Ivan W. Miller Box G-RI Brown University Providence, RI 02912-G-RI	Yes	No (General Practice South) www.gpsouth.com
Nurses' Global Assessment of Suicide Risk (NGASR)	John Cutcliffe & P. Barker	John Cutcliffe University of Northern British Columbia 3333 University Way Prince George, BC Canada V4N 4Z9 Cutclifi@unbc.ca	Yes	No
Reasons for Living Inventory (RLS)	Marsha M. Linehan	Behavioral Research & Therapy Clinics Department of Psychology, Box 351525 University of Washington Seattle, WA 98195-1525 Linehan@u.washington.edu	Yes	No Contact author for permission to use
SAD PERSONS Scale	William M. Patterson, Henry H. Dohn, Julian Bird & Gary A. Patterson	Birmingham Research Group, Inc. 2120 Lynngate Drive Birmingham, AL 35216 Tel: (205) 823-0766 Fax: (205) 823-9410 Brg_wmp@bellsouth.net	No	No

Scale	Main Author	Contact Info	Copyright	Fee
Scale for Impact of Suicidality – Management, Assessment and Planning of Care (SIS-MAP)	Amresh Srivastava & Charles Nelson	Operational Stress Injury Clinic Parkwood Hospital, Hobbins Building 801 Commissioners Road East 3rd Floor, Room H-3015 London, ON Canada N6C 5J1 Tel: (519) 685-4567, ext 42235 Charles.nelson@sjhc.london.on.ca Dr.amresh@gmail.com	Yes	No Contact author for permission to use
Suicidal Behaviors Questionnaire (SBQ)	Marsha M. Linehan	Behavioral Research & Therapy Clinics Department of Psychology, Box 351525 University of Washington Seattle, WA 98195-1525 Linehan@u.washington.edu	Yes	No Contact author for permission to use
Suicide Intent Scale (SIS)	Aaron T. Beck, D. Schuyler & Herman	University of Pennsylvania Department of Psychiatry Room 2032 - 3535 Market Street Philadelphia, PA 19104-3309 abeck@mail.med.upenn.edu	Yes	No Contact author for details
Suicide Probability Scale (SPS)	John G. Cull & Wayne S. Gill	Western Psychological Services Publishers and Distributors 12031 Wilshire Boulevard Los Angeles, CA 90025-1251	Yes	\$99 (Western Psychological Services) www.wpspublish.com
The Tool for Assessment of Suicide Risk (TASR)	Stan Kutcher & Sonia Chehil	Department of Psychiatry Dalhousie University 5909 Veterans' Memorial Lane, 8th floor Abbie J. Lane Memorial Building QEII Health Sciences Centre Halifax, NS CANADA B3H 2E2 Tel: (902) 473-2470 Fax: (902) 473-4887 Stan.kutcher@dal.ca	Yes	No

3. Evaluating and Using Risk Assessment Tools

SUMMARY OF RISK ASSESSMENT TOOLS AND IMPLICATIONS FOR PRACTICE

There is no consensus on which is “the” most effective risk assessment tool. No tool can predict suicide; instead, certain tools provide pertinent information to inform clinical decision-making.

A number of instruments have been designed for the detection and assessment of suicide risk in a variety of settings. The scales range in purpose from brief screening and research tools to global assessments of suicide risk to be embedded in larger mental health assessments.

Based on both the review of the literature and interview with various stakeholders, no consensus was reached in terms of a single most effective or common risk assessment tool. Those interviewed ranged in perspective from fully supporting the use of risk assessment tools as a component of the risk assessment process to discouraging the use of tools in favour of clinical interview.

Since no tools can accurately predict suicide the main consensus was that risk assessment tools are useful for providing additional information and corroboration to inform clinical decision-making about risk. Evidence for most of the scales reviewed here indicates that they provide adequate to strong internal consistency and are related to other indicators of suicide risk.

Box 5. Key issues to consider for choosing a risk assessment tool

1. How much time do you have to complete the assessment?
2. How long is the risk assessment?
3. Is the risk tool easy to score?
4. Does the risk tool relate to the population you work with?
5. Are the scores meaningful?
6. Do you need the tool to help with screening, global assessment, etc.?
7. Can the person who may be at risk of suicide complete the risk tool?
8. Does the risk tool measure the domains you need?
9. Can you afford to purchase the risk scale?

A pull out reference of these considerations is provided in Appendix G.

Challenges to evaluating suicide risk assessment tools

A number of challenges exist in the evaluation of suicide risk assessment tools:

- There is no evidence to support the use of summary scores as the sole basis for decision making on acute risk.
- The ability to predict suicide based on the score (or scores) on a risk assessment tool is low. Ideally, the selection of the risk assessment tool would be based on its predictive ability – i.e., based on how someone responds to the questions in an assessment, how likely is it that he or she will actually attempt suicide?
 - The difficulty in answering this question lies in the fact that suicide, while catastrophic, is a relatively uncommon outcome in most health care settings. With so few instances where a person dies by suicide, it is difficult to evaluate its predictive value.
 - Instead, research on the predictive value suicide risk assessment tools is forced rely on proxy outcome measures such as increase in risk factors or warning signs of suicide.

The fact that suicide risk assessment tools can never be 100% accurate underscores the importance of using clinical judgement and collaboration in conjunction with suicide risk assessment tools.

How professionals can use the scores generated by suicide risk assessment tools

Interviews with experts consistently indicated that summary scores on risk assessment tools are not commonly used in practice to make firm decisions about a person’s risk of suicide. Instead, experts indicated that the scores were useful for informing users about the severity or complexity of a person’s level of distress. *The interviews revealed that summary scores generated from risk assessment instruments may be less valuable than the actual content covered in the specific items of the tools themselves.* For example, it is more important to know that a person has developed a suicide plan, than to know that his or her score is “11 out of 20”. In some instances scores indicate an accumulation of risk factors or warning signs and may be useful in informing the complexity of suicide risk. However, in practice, these scores should be cautiously interpreted. The danger is that complete reliance on a single risk score may

remove the holistic nature of clinical assessment in favour of efficiency and liability protection (Lyons, Price, Embling, & Smith, 2000). The value of suicide risk assessment tools is to enable clinicians:

- to gather additional information that can shed light on the person's degree of risk of suicide;
- to corroborate findings from clinical interviews; and
- to identify discrepancy in risk, if any.
 - For example, in some instances a person may not disclose indicators of risk in a clinical interview but may report indicators on a self-report tool.

The inclusion of risk assessment tools may be a way to improve the overall quality of the suicide risk assessment process. Risk assessment tools are particularly useful for persons with less experience in risk assessment. In this sense, the risk assessment tool presents an opportunity for standardizing the use and process of risk assessment.



Section III

A Framework for Suicide Risk Assessment and Quality Monitoring

Suicide risk assessment needs to be thorough, person-centred, and simple. It needs to incorporate multiple approaches to ascertain a person's level of distress and risk of suicide.

In this section:

1. Getting to High-Quality Suicide Risk Assessment

- Framework for the suicide risk assessment process
- The five dimensions of the framework for risk assessment

2. Suicide Risk Assessment Tools and the Risk Assessment Framework

- Use of risk assessment tools with the risk framework
- Choosing tools appropriate for the particular care setting

3. Measuring the Quality of the Suicide Risk Assessment Process

- Monitoring the quality of suicide risk assessment
- The need for development of proper quality indicators
- The need for ongoing training

4. The Way Forward

- Summary and recommendations

1. Getting To High-Quality Suicide Risk Assessment

The process of suicide risk assessment is just as important as the assessment tool used for assessing risk. It was recommended that no single tool or method should be used to assess risk of suicide (e.g., Bisconer & Gross, 2007). Instead, a high-quality suicide risk assessment needs to incorporate multiple approaches to ascertain a person's level of distress and risk of suicide.

FRAMEWORK FOR THE SUICIDE RISK ASSESSMENT PROCESS

Keep the assessment simple

A consistent concept identified from the interviews was that the suicide risk assessment needs to be thorough, person-centred, and simple. The assessor must:

- Be aware of warning signs, potentiating risk factors, and protective factors (See Section I, page 3 for further discussion);
- Use good clinical judgement as well as other sources of information about the person;
- Document all findings (See Section I, page 16 for further discussion); and
- Appropriately monitor the person.

THE FIVE DIMENSIONS OF THE FRAMEWORK FOR RISK ASSESSMENT

In the Tidal Model of mental health care, Barker and Barker (2005) describe a suicide risk assessment process that includes a *focused risk interview*, a *global assessment of risk to determine the person's care needs*, and *ongoing monitoring and re-assessment*. These dimensions present key processes for ongoing suicide risk assessment and monitoring. However, this Tidal model is based on mental health care settings where there is the assumption that the person may have already been identified to be at some level of risk of suicide.

Below is a framework for suicide risk assessment adapted from Barker and Barker (2005) that is expanded to include five dimensions (Box 6). This five dimensional framework presented in this guide is distinct from the Tidal model in two respects. First, it is applicable to care settings beyond mental health. Secondly, it can be used with persons who may come into contact with mental health and non-mental health care settings for reasons other than risk of harm to self or have yet to be assessed for suicide risk.

Box 6. The five dimensions of the framework for risk assessment

1. Initial screening for risk
2. Focused suicide risk assessment
3. Integration of risk assessment
4. Care planning, intervention implementation
5. Monitoring and reassessment

1. Initial screening for risk

During the initial screening, an attempt is made to determine if there is potential for suicide risk with the person. Initial screening may include informal clinical review of risk and formal use of screening methods to identify risk. *Virtually all health care providers may be able to provide some degree of suicide risk screening to persons seen in care. However, this process needs to begin with familiarity of potentiating risk factors and warning signs outlined in prior sections of this guide (See Section I, page 3).*

Using this knowledge, persons can be informally screened during a clinical visit for presentation of risk factors or warning signs using observation and discussion (i.e., linking statements made by the person, reports from others close to the person, and observed distress to potential suicide risk). Initiation of formal screening methods may be based on the informal clinical review or as part of standard practice in care. Formal screening should include the use of brief screening tools and a clinical interview asking directly about suicide. The considerations related to specific populations and care settings identified in Section I, page 23, may come into play during the formal screening process. At this stage documentation and corroboration are essential.

2. Focused suicide risk assessment

As explained in the Barker and Barker (2005) model, a focused risk assessment attempts to better understand the underlying factors mediating or moderating risk. At this stage, a focused, clinical interview and global assessment of risk can take place. The goal is to:

- establish an open and therapeutic rapport with the person to discuss, in detail, his or her ideations, plans, and behaviours related to suicide; and
- his or her strengths and supports available that may moderate risk.

This process should be collaborative, engaging the person as well as others aware of the person's status. This will help ensure that multiple perspectives are available to inform level of risk. During this phase, risk assessment tools may be also used to gather adjunct evidence of risk. When employing self-report assessments, care providers should reassure the person that the assessor continues to be genuinely engaged in listening and that the assessment is simply an additional way that the assessor is trying to help understand the person's needs and distress. Strong therapeutic rapport should be established before administering a self-report assessment tool.

3. Integration of risk assessment

This phase of risk assessment uses a collaborative process to determine the appropriate level of care that should be given the level of risk identified from the initial and focused assessment. Information collected from any screening tools or global risk assessments can be integrated with clinical interviews to determine overall risk. Consultations must occur with others involved in the person's care and informal supports to ensure that risk is identified as comprehensively as possible. In addition, care should be taken to make certain that all risk and protective factors have been appropriately integrated into the risk level designation.

4. Care planning and intervention implementation

Once the person's level of risk and the factors related to the immediate risk have been determined, a specific course of intervention and care plan must be implemented to support the person's safety and recovery process.

For persons not already in mental health treatment environments, the level of restriction in the care environment will increase with the severity of risk identified. For persons found to have potentiating risk factors where no warning signs are present, the restriction in the care environment may be less than persons exhibiting warning signs suggestive of high risk. Recommended care for this population may include follow-up counselling and further mental health assessment to attend to the person's distress and prevent escalation of suicide risk. When warning signs are present, immediate intervention includes engaging professional mental health services, crisis supports, and/or seeking emergency mental health services.

When developing a care plan, it is also important to keep in mind the issues of chronic suicidality and mental illness and their impact on care planning as discussed in Section I, starting on page 7.

5. Monitoring and re-assessment

Ongoing monitoring of the person's status will take place at increasing intervals as the level of risk increases. For example, persons at high risk in inpatient care settings, if not under close or constant observation, need to be monitored at brief intervals and re-assessed upon each shift change. In essence, the process of monitoring and re-assessment should incorporate the application of the prior four stages in the five-dimension framework. Specifically, monitoring includes:

- Brief screening for changes to level of risk;
- Mitigation of immediate warning signs; and
- Development or engagement in protective factors.

Monitoring and re-assessment is essential at points of transition ("hand-offs") including changes within the care environment (e.g., staff changes, prior to authorized leaves, ward changes) as well as between care environments (e.g., following discharge from hospital). Consistent and constant communication with others involved in the care of the person is vital during all monitoring.

2. Suicide Risk Assessment Tools and the Risk Assessment Framework

USE OF SUICIDE RISK ASSESSMENT TOOLS WITHIN THE RISK ASSESSMENT FRAMEWORK

Whenever possible, and only after a strong therapeutic rapport has been established, suicide risk assessment tools are to be included as part of the risk assessment interview and not given to the person to complete as a self-report.

Suicide risk assessment tools, as discussed in Section II, are one source of information that can be used to determine a person's risk of suicide. They do not replace clinical judgement (Barker and Barker, 2005). The use of tools within the stages of the risk assessment framework should remain person-focused and be incorporated using empathetic, warm, and objective assessment.

The inclusion of risk assessment tools may be a way to improve the overall quality of the suicide risk assessment process since their use helps add further summary evidence to inform and communicate risk. Many of the persons interviewed indicated that risk assessment tools are useful for informing the overall risk assessment, particularly for persons with less experience conducting a risk assessment. In this sense, risk assessment tools present an opportunity for standardizing the use and process of risk assessment. Among persons who may have difficulty disclosing feelings or emotions (e.g., adolescent males), risk assessment tools may also help provide them ways to express and describe their feelings and distress.

CONSIDERATIONS OF CARE SETTINGS WHEN CHOOSING TOOLS

Risk assessment tools will help inform the various stages outlined in the risk assessment framework. However, the type of risk assessment tool used and the approach to risk assessment taken may depend on the setting and evaluative intent (i.e. screening or monitoring or determination of risk) of the assessment.

Primary care and non-psychiatric care settings

Main goal: Determine the likelihood that a person will attempt suicide, to decide whether the person must be referred to more specialized care environment.

Role of risk assessment tool: Screening and monitoring

In this case, risk assessment tools provide a screening function that offers an efficient indication of the accumulation of risk factors, warning signs, and

protective factors. Tools that may be useful include the SAD PERSONS, (page 49) and TASR, (page 57) because they are subtle scales that can be completed by the practitioner during a general clinical interview to get a general summary of potential risk and can be used to aid in the referral process. Among persons caring for older adults (e.g., in-home care services), the GSIS, (page 42) may be useful.

The same tool (GSIS) can be used to monitor persons who may not be at high risk but have the potential to develop risk on an ongoing basis (e.g., presence of potentiating risk factor with no warning signs). If risk is determined in screening, typically persons may be referred to specialized levels of care for more in-depth suicide risk assessment and intervention.

Community mental health programs

Main goal: Determine the level of risk among persons who are newly admitted to care or to determine if a person within the program of care has experienced changes in status placing the person at a more acute level of risk. This is true in community mental health care where persons may be experiencing long-standing mental health symptoms that may include chronic suicidality (see discussion in Section I, page 8).

Role of risk assessment tool: Screening and monitoring

Issues such as a recent predicament may promote the development of warning signs among persons with or without potentiating risk factors. Risk assessment tools such as the interRAI Community Mental Health, include a global assessment of the person’s mental health status and functioning while providing a summary risk score based on the Severity of Self-Harm Scale (SOS, page 43). Almost all tools listed in Table 2, page 58, that have applications for screening could also be implemented for ongoing screening and monitoring.

The care team must rely on therapeutic rapport to judge whether a self-report screening tool can be used versus an interview-based assessment. This decision may be moderated by the person’s willingness to discuss suicide as well as his or her cognitive functioning and ability to communicate. In addition to assessment tools, screening could involve simple questions for “checking in” with the person. These questions could ask about their current thoughts of wanting to die, whether a plan is in place, and whether the person feels unsafe. If potential risk is identified, then the care team should implement a more in-depth interview and assessment tool to conduct a focused risk assessment. Tools at this stage may include SOS Scale, SIS-MAP, SPS, NGASR, RFL, or other tools with global assessment utility as listed in Table 2, page 58.

Emergency rooms

Main goal: Identify the level of risk and level of intent to decide whether a person can safely leave the hospital setting or must be referred to a more restrictive level of care for personal safety.

Role of risk assessment tool: Screening

Brief screening, as well as a clinical interview and consultation are important for this decision-making process. Tools such as the SOS scale embedded in the interRAI Emergency Screener for Psychiatry might help with this process since it provides questions of the recency of suicide ideation or attempts, intent, and other information about risk of harm to others and self care. This tool will provide a brief indicator of risk that should be accompanied by a full clinical interview and/or focused assessment of risk, particularly if any indication of risk is identified through initial screening on the SOS or other screening methods applied. Global risk assessment tools may help the emergency room clinical team gauge the person's level of intent and identify specific areas of distress in order to inform the person's next level of care (either admission to hospital or discharge to community care setting).

Inpatient mental health settings

Main goal: In inpatient mental health settings, persons may have been identified prior to admission as being at high risk or may have been admitted for reasons other than risk of harm to self. Therefore, initial screening is still important among persons where risk of harm to self may not have been immediately identified.

Role of risk assessment tool: Ongoing screening

Ongoing screening should be implemented for all persons identified at risk for harm to self that includes the use of brief screening at intervals in accordance with the person's level of risk (i.e., shorter screening intervals for persons at higher risk) as well as at all points of transition during a person's course of admission (e.g., at shift changes, prior to authorized leaves from hospital). Ongoing monitoring intervals can be modified as risk is mitigated.

3. Measuring the Quality of the Suicide Risk Assessment Process

The screening tools listed in Table 2, page 58 can be used throughout this process. However, a more in-depth risk assessment should be done at points of major transition, such as transfers between units in a hospital or prior to discharge. In Ontario, the standardized use of the interRAI Mental Health assessment automatically includes initial screening for risk of harm to self among all persons admitted to care. Using the SOS score following the completion of the interRAI assessment, care teams can identify persons who need more global assessment of suicide risk. Secondly, care teams can begin the care planning process for mitigating the identified suicide risk. The interRAI mental health assessments also include a care planning guide, the Suicidality and Purposeful Self-harm Clinical Assessment Protocol (Neufeld et al., 2011), that can provide further information to help guide the global risk assessment process and intervention planning.

MONITORING THE QUALITY OF SUICIDE RISK ASSESSMENT

Quality measurement can be complex, particularly for processes such as suicide risk assessment. This complexity is based on the current lack of standardized policies and procedures in place to encourage risk assessment, the diversity in clinical preferences for assessment methods, and the lack of common, standardized information about suicide.

There have been a number of calls for the standardization of suicide risk assessment. In Canada, Accreditation Canada has implemented suicide risk assessment as a required organizational practice (ROP). Box 7 presents information on Accreditation Canada's ROP (Accreditation Canada, 2010).

Box 7. Indicators for ROP monitored by Accreditation Canada (2010) for all mental health services, within hospital and in the community

- Each client is assessed for risk of suicide at regular intervals, or as needs change
- Clients at risk of suicide are identified
- Client's immediate safety needs are addressed
- Treatment and monitoring strategies to ensure client safety are implemented
- Treatment and monitoring strategies are documented in the client's health record

In addition to these organizational practices, the process of risk assessment is also considered a standard of care in psychiatry (APA, 2003; Simon, 2002). Simon (2002) describes risk assessment as a standard of care that should be monitored through quality assurance programs within and between organizations. As a standard of care, all information about suicide risk should be available to each person's relevant care providers. To ensure the quality of the risk assessment process, Simon (2002) suggests that the information to be monitored, documented, and made available to relevant care providers as evidence of adherence to the proper standard of care should include:

- Whether a suicide risk assessment was completed in a systematic (i.e. ongoing) process;
- The type of risk assessment;
- Evidence of specific protective factors;
- All risk factors and warning signs; and
- Actions or interventions for immediate and long-term mitigation of risk.

In implementing suicide risk assessment processes consistent with Accreditation Canada's ROP and standards of care it is vital to maintain a person-centred approach. The importance of establishing a therapeutic rapport based on trust, empathy, and understanding are essential. The communication process must focus on understanding the person's description of factors that lead to their level of distress rather than finding out what might be "wrong with" the person. The person-centred approach is about learning about a person and understanding his or her distress and not imposing a label.

Quality and the need for proper documentation

A cornerstone to the quality of a suicide risk assessment is proper documentation (see Section I, page 16). The ROP and standard of care approach rely heavily on documentation to demonstrate the quality of the assessment process. Mahal, Chee, Lee, Nguyen, & Woo (2009) assessed the quality of suicide risk assessment in psychiatric emergency settings by examining whether appropriate documentation was present for 19 specific process indicators, including documentation of risk factors, warning signs, protective factors, clinical history, and continuity of care. They found that

documentation of all 19 indicators were not complete for 100% of patients, with between three and nine indicators most commonly documented per person. Interestingly, they found that key warning signs such as current suicidal ideation, plan, history of attempts, and hopelessness were documented in less than 70% of the sample which consisted of patients being held involuntarily for current or imminent suicidal behaviour. As discussed in this guide, documentation and communication of risk are key factors for preventing future risk within care environments and at points of transition (See Section I, Page 16).

Quality and the need to develop specific quality indicators for suicide risk assessments

The relative unavailability and inability to easily collect data related to suicide risk assessment present challenges to the development and ongoing monitoring of quality indicators associated with suicide risk assessment. As one example of this problem, Mahal et al. (2009) had to use a manual chart review for scoring 19 process quality indicators among 141 persons who received services at one emergency mental health setting. Requiring that organizations undergo this kind of data collection exercise for all persons under care would be onerous and the potential cost, high. While the accreditation process involves site visits and random chart review to audit these practices, this process is carried out at broad intervals.

Mork, Mehlum, Fadum, and Rossow, (2010) suggest that evaluating the quality of one's suicide risk assessment can be done by referring to clearly defined standards written in organizational guidelines and policies. Without systematic ways to efficiently track the completion of risk assessment (e.g. electronic medical records), organizations wanting to monitor the quality of their risk assessment process, may have to rely on their demonstrated adherence to suicide risk assessment-related policies. These policies may include the principles for high-quality risk assessment outlined in this and other guides, as well as policies for the timing of risk assessments and the processes for following up on risk identification.

While future research is needed on their validity and effectiveness, other indicators of high quality organizational suicide risk assessment processes may include policies that:

- Use a specific suicide risk screening tool as part of the risk assessment process;

- Use standard guidelines and specific care planning interventions for persons identified at different risk levels;
- Detail timelines for ongoing risk assessment based on low, moderate, or high risk;
 - Include processes for reporting and reviewing adverse events, including post-suicide debriefing (for post-suicide debriefing, the policy includes steps for reviewing and acting on findings from the review and plans to mitigate risk in future); and
- Have mandatory competency-based education and training in suicide risk assessment.

More broadly, in terms of outcome, the rate of suicide has been examined as an indicator of mental health service quality. Desai, Dausey, and Rosenheck (2005) examined the use of suicide rates as a quality measure for mental health services delivered through Veterans' Affairs hospitals in the United States. In a sample of over 120,000 persons who received services, 481 suicides occurred. While suicide rates did vary across facilities, no association was found between the differences in suicide rates and other quality of care measures such as length of stay, continuity of care, timeliness of outpatient visits, rehospitalization, or hospital funding.

Desai and colleagues recommend against the use of suicide rates as a quality measure because:

- Rates are highly unstable (due to low rates);
- The difficulty in obtaining death data post-discharge; and
- The lack of association between suicide rates and other indicators of facility quality.

Further, the rate of suicide does not directly reflect the quality of the risk assessment process itself. It may be that a high rate of suicide is indicative of poor intervention planning or a lack of services for persons who are successfully identified as being at high risk for suicide.

It is clear that designing process indicators (i.e., indicators about the how the risk assessment was completed) to specifically identify poor suicide risk assessment is a challenge due to the qualitative nature of risk assessment processes. Outcome quality indicators measuring the incidence of suicide ideation, plans, or behaviours while a person is receiving care from a service

provider (e.g., admitted to a hospital) may be easier to develop. However, these indicators may reflect poor quality of care in terms of the organization, delivery, or responsiveness to treatment, rather than poor suicide risk assessment. In other words, despite having conducted a high quality suicide risk assessment, an adverse event could still occur. That fact notwithstanding, what is certain is that if the quality of the risk assessment process is not ensured, the likelihood of an adverse event occurring is exponentially higher. Thus, however challenging, specific indicators need to be developed to monitor the quality of suicide risk assessment.

Further research should examine the potential development and validity of indicators for quality suicide risk assessment. Examples of potential indicators include:

- Prevalence of suicide behaviours while in care among persons designated as low risk upon initial assessment;
- Rate of suicide attempt or death by suicide within one week of discharge;
- Rate of persons discharged as high-risk for suicide;
- Rates of change in dynamic risk factors or warning signs related to suicide risk;
- Documentation between identification of specific dynamic risk factors and implementation of a care plan specific to those factors;
- Increase in number of identified protective factors such as resiliency and coping strategies while in care;
- Incidence of environmental hazards identified in care environment;
- Number of hazards remaining in the care environment since prior assessment;
- Person/family perception of the risk assessment process; and
- Staff perceptions of the risk assessment process.

4. The Way Forward

The need for ongoing training and organizational competence to support quality improvement

Ongoing training in suicide risk assessment may be indicative of organizational competence in risk assessment. McNeil, Fordwood, Weaver, Chamberlain, Hall, & Binder (2008) found that education on the use of evidence in suicide risk assessment improved the quality of documentation of suicide risk and self-rated competence in risk detection among psychiatric and psychological trainees. Training may be a quality improvement initiative and therefore, the frequency and participation in suicide risk assessment training could be one aspect of quality measurement and monitoring. There is still a need to establish the type, methods of delivery, and intervals for delivery of education for improving suicide risk assessment.

There may also be an opportunity to develop a framework for evaluating organizational competence in suicide risk assessment using Accreditation Canada's tracer methodology process. These methodologies are exercises where accreditation surveyors observe all aspects of a clinical (e.g., infection control) or administrative process (e.g., communication) to determine if an organization adheres to standards or guidelines of care. This might include performing chart reviews, observing clinical processes, and reviewing documentation and communication processes. Instances where a care process does not meet a recommended standard of care would identify an opportunity for quality improvement.

Tracer methodologies that are applied based on Accreditation Canada's required organizational practice on suicide risk assessment as well as the concepts of suicide risk assessment discussed in this guide, may help organizations evaluate the quality of their suicide risk assessment processes. In addition to these exercises, checklists can be used to review suicide risk assessment and prevention policies, practices, and processes within organizations. For instance, the Canadian Association for Suicide Prevention (CASP) has developed a checklist for organizations to review safety related to suicide risk. This brief checklist, called "Becoming Suicide Safer: A Guide for Service Organizations" is freely accessible from the CASP (www.suicideprevention.ca). Results from tracer exercises and safety check-lists could be monitored at an aggregate level (e.g., all exercises over one year) to determine if improvements are observed in risk assessment competency.

SUMMARY AND RECOMMENDATIONS

This resource guide represents a first step in standardizing the process of suicide risk assessment. It is hoped that this guide can reduce fragmentation in the practice and assessment of suicide risk by summarizing key concepts for carrying out a high-quality risk assessment. Moreover, this guide can be used to help educate care providers and strengthen quality improvement initiatives around suicide risk assessment in Canadian health care organizations.

One of the basic principles of suicide risk assessment is to have an honest, person-centered, and empathetic approach when engaging care recipients. During the development of this report, several key factors were identified that speak to that goal.

1. **Suicide risk assessment is a process**

From interviews and research, it became apparent that suicide risk assessment is a process that involves much more than the use of instruments and an associated score. Instead, risk assessment is a crucial aspect of the therapeutic process that is, in turn, part of a person's journey to recovery.

2. **Care providers need to be appropriately trained**

Care providers should develop a good understanding of factors (potentiating risk factors and warning signs) that indicate acute risk of suicide in order to appropriately identify and mitigate risk. Positive factors in a person's life must also be explored as strengths the person can draw on in times of crisis. Identification and awareness of these factors will promote patient safety and inform specific opportunities for intervention. Whenever possible, it is also important to engage others who may be aware of the person's situation and who have a good understanding of his or her cultural context.

3. **Risk assessment tools can only assist in the process**

This guide also provided an inventory of several risk assessment tools for care providers. However, these tools can only assist with the risk assessment process by providing information that can be used, in conjunction with clinical judgment, to identify risk and to make decisions. Some tools may also be useful in screening for risk on an ongoing basis. However, evidence supporting the ability of risk assessment tools to predict suicide was scarce.

The Future

It should be noted that the scope of suicide risk is extremely broad. This guide focused only on the process of risk assessment within the context of health care organizations. It does not focus on risk assessment in non-health care contexts, and also excludes a discussion of the feasibility of integrating technology into the risk assessment process (e.g., telepsychiatry and telemedicine), interventions for mitigating risk in different care environments, or prevention strategies.

Recommendations for future investigation include:

- The suicide risk assessment and monitoring process in other contexts (e.g., public health);
- The feasibility of integrating technology into the risk assessment process (e.g., telepsychiatry and telemedicine);
- A review of interventions for mitigating risk in different care environments; and
- Suicide prevention strategies.

This resource guide represents a first step in the standardization of the suicide risk and prevention process. Development of these added resources can provide the foundation for a national strategy on suicide prevention. Such a strategy can also help generate public awareness about suicide, including factors contributing to risk, and instill a culture of understanding, acceptance, and prevention among Canadians.



Section IV

References and Resources

Appendix A: Methodological Approach to Developing the Resource Guide

The development of this resource guide included two phases:

PHASE I: ENVIRONMENTAL SCAN OF RISK ASSESSMENT TOOLS

The environmental scan included a literature review of scientific articles, clinical literature, best practice reports, and other grey literature to identify and review the process and tools available for suicide risk assessment.

A range of medical and social-sciences databases were searched to identify various suicide risk assessment strategies and tools. These included the Cochrane Library, CINAHL, PubMed (Medline), PsycINFO, Google Scholar, and Scopus. References lists from germane articles were also scanned for relevant additions to the literature search. No limiters were set on the database search criteria, although particular attention was paid to Canadian sources. The literature review began with a broad set of search terms including: “suicid*”, attempted suicide, self-harm, outcome assessment, risk assessment, psychiatric rating scale, validity, prediction (MeSH). These terms yielded over 7500 articles across search data bases. It became apparent that many articles were not relevant to suicide risk assessment and were excluded. These included pharmaceutical research on the effectiveness of medications in reducing symptoms related to suicide as well as epidemiological studies on patterns of suicide among various populations, regions, and health sectors.

Articles were then reviewed for their relevance to the following categories (number of articles identified):

- Suicide risk assessment tools/scales (99)
- Best practices in risk assessment (43)
- General research on suicide risk (52)
- Quality indicators related to suicide risk assessment (3)
- Other (15)

After a review of these manuscripts and resources, a number of manuscripts were excluded due to a lack of relevance to suicide risk assessment. Professional practice organizations such as the American and Canadian Psychiatric Associations, Registered Nurses' Association of Ontario Clinical Practice Guidelines, and others were also reviewed for resources or information on suicide risk assessment.

PHASE II: STAKEHOLDER INTERVIEWS

To supplement the environmental scan and gather information about suicide risk assessment in practice, a number of interviews were conducted. Interviewees were recruited using a convenience sampling approach, in which the Pan-Canadian Advisory Group (as listed in the Acknowledgements section), Ontario Hospital Association (OHA), Canadian Patient Safety Institute (CPSI), and the research group submitted names of potential interview candidates based on their awareness of the person's experience with the risk assessment process. The location, specialty, and experience of the interview candidates were considered to ensure breadth of experience. Specifically, the recruitment process attempted to gather persons with experience from different regions in Canada (e.g., east to west coast, urban to rural), from different health care populations (e.g., youth, older adults, First Nations), different health care sectors (e.g., emergency, community, acute care settings), and different professional backgrounds.

This sampling strategy yielded a list of 30 potential interview candidates. Email invitations were sent to candidates as well as phone calls or follow-up email invitations from Advisory Group members familiar with the person. In total, nine persons declined an interview, resulting in 21 completed interviews. A table describing each person interviewed is available in Appendix B.

The interviews used a semi-structured approach. Interviewees were asked about their:

- Background and experience;
- Recommendations for the process of conducting high-quality risk assessment;
- Familiarity, use, and recommendations for suicide risk assessment tools; and
- Familiarity and recommendations for policy, practice, and evaluation regarding suicide risk assessment.

If the person indicated a specific specialty (e.g., youth mental health), then the person was asked the questions in the context of his or her specialty (e.g., what are the key factors to consider in suicide risk assessment of youth?).

Appendix B: List of Interview Participants

Name	Name	Organization
Linda Bender	Team Leader, Community Development & Education Services	Canadian Mental Health Association, Grand River Branch, Kitchener, Ontario
Dr. Jennifer Brasch	Associate Professor, Psychiatry & Behavioural Neurosciences	McMaster University, Hamilton, Ontario
	Director, Psychiatric Emergency Service, Site Education Co-ordinator,	Department of Psychiatry, St. Joseph's Healthcare, Hamilton, Ontario
Coleen Cawdeary	Program Coordinator	Assertive Community Treatment Team, Fergus Ontario
Dr. Gary Chaimowitz	Head of Service; Forensic Service	St. Joseph's Healthcare, Hamilton Ontario
Dr. Martha Donnelly	Director, Division of Community Geriatrics, Department of Family Practice	University of British Columbia, Vancouver, British Columbia
	Director, Geriatric Psychiatry Program, Department of Psychiatry	
	Geriatric Psychiatrist, Geriatric Psychiatry Outreach Team	Vancouver Hospital, Vancouver, British Columbia
Dr. Alan Eppel	Head of Service; Community Psychiatry Services	St. Joseph's Healthcare, Hamilton Ontario
Dr. Brian Furlong	Director, Community Psychiatry Division	Homewood Health Centre, Guelph, Ontario
Dr. Laurence Y. Katz	Associate Professor of Psychiatry Post- Graduate Coordinator, Child and Adolescent Psychiatry	University of Manitoba, Winnipeg Manitoba
Denice Klavano	Member	Patients for Patient Safety Canada, Nova Scotia
Dr. Stan Kutcher	Sun Life Financial Chair in Adolescent Mental Health	IWK Health Centre, Halifax Nova Scotia
	Director, World Health Organization Collaborating Centre in Mental Health	Dalhousie University, Halifax Nova Scotia

Name	Name	Organization
Dr. Paul Links	<p>Scientist, Keenan Research Centre</p> <p>Arthur Sommer Rotenberg Chair in Suicide Studies, Mental Health Service/ Department of Psychiatry,</p> <p>Deputy Chief of Psychiatry, Mental Health Service.</p> <p>Associate Member, Faculty of Medicine, Public Health Sciences, Associate Member, Institute of Medical Science, Professor, Faculty of Medicine, Psychiatry</p>	<p>Li Ka Shing Knowledge Institute of St. Michael's Hospital, Toronto, Ontario</p> <p>St. Michael's Hospital/University of Toronto, Toronto, Ontario</p> <p>St. Michael's Hospital, Toronto, Ontario</p> <p>University of Toronto, Toronto, Ontario</p>
Dr. Peter Mills	Director, Veterans Affairs National Centre for Patient Safety Field Office	United States Department of Veterans Affairs, Burlington Vermont
Jill Mitchell	Director, Concurrent Disorders Rehabilitation and Recovery, Provincial Addiction and Mental Health	Alberta Health Services, Edmonton, Alberta
Dena Moitoso	Bereavement Counselor & Educator	Erb & Good Family Funeral Home Ltd. Kuntz House, Waterloo, Ontario
Tana Nash	Coordinator	Waterloo Region Suicide Prevention Council, Waterloo, Ontario
Crystal Norman	Quality Improvement Coordinator	Northeast Mental Health Centre, North Bay, Ontario
Kathy Payette	Assistant Director, Mental Health Services	Lutherwood, Waterloo, Ontario
Dr. Beth Reade	Psychiatrist, Homewood Addiction Division	Homewood Health Centre, Guelph, Ontario
Dr. Tracey Scott	Clinical Psychologist	Central Newfoundland Regional Health Centre, Grand Falls-Windsor, Newfoundland
Dr. Ian Slayter	Clinical Director, Adult General Psychiatry Services	Capital District Health Authority, Halifax, Nova Scotia
Lee Whittmann	Mentor, Aboriginal Suicide Critical Incident Response Team (ASCIRT)	Inter Tribal Health Authority, Nanaimo British Columbia

Appendix C: Illustration of the Accumulation of Potentiating Risk Factors and Warning Signs on Risk of Suicide



(Warning Signs adapted from Rudd et al., 2006).

Appendix D: Examples of Protective Factors

Examples of Protective Factors (Sanchez, 2001; United States Public Health Service, 1999)

- 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
- Identification of future goals
- Constructive use of leisure time (enjoyable activities)
- 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

Appendix E: Sample of Recommended Documentation

1. **The overall level of suicide risk**

The level of risk should be clearly documented along with information to support this assertion. This can include information about:

- The types of assessment tools used to inform risk assessment;
- Details from clinical interviews and details from communication with others (e.g., the person's family and friends, other professionals);
 - i. The circumstances and timing of the event;
 - ii. Method chosen for suicide;
 - iii. Degree of intent; and
 - iv. Consequences.

2. **Prior history of suicide attempt(s) and self-harming behaviour.**

This should include:

- The prior care plan/intervention plan that was in place;
- The length of time since previous suicide attempt(s) or self-harming behavior(s);
- The rationale for not being admitted to a more intensive environment or discharged to a less restrictive environment, and what safety plans were put into place; and
- Details about family concerns and how these were addressed.

3. **Details about all potentiating risk factors, warning signs, and protective factors**
4. **The degree of suicide intent**
The degree of intent may include, for example, what the person thought or hoped would happen.
5. **The person's feeling and reaction following suicidal behaviour**
For example, sense of relief, regret at being alive.
6. **Evidence of an escalation in potential lethality of self-harm or suicidal behaviours**
Document whether the person has begun to consider, plan, or use increasingly lethal means (e.g., from cutting to hanging, seeking a gun).
7. **Similarity of person's current circumstances to those surrounding previous suicide attempt(s) or self-harming behaviour(s)**
8. **History of self-harm or suicidal behaviour(s) among family or friends or significant loss of family or friends**
This should include anniversary dates of these events as risk may be elevated at these anniversary points.

Organizations should also develop standard protocols for identifying the location of documentation regarding suicide risk within the persons' record. The location of documentation should be consistent and easily identified by others within the organization or those involved in the care of the person.

Appendix F: Summary of Key Risk Assessment Principles

Key Principles to Consider When Conducting Suicide Risk Assessment

(adapted from Granello, 2011):

Suicide Risk Assessment....

1. Is Treatment and Occurs in the Context of a Therapeutic Relationship
2. Is Unique for Each Person
3. Is Complex and Challenging
4. Is an Ongoing Process
5. Errs on the Side of Caution
6. Is Collaborative and Relies on Effective Communication
7. Relies on Clinical Judgement
8. Takes all Threats, Warning Signs, and Risk Factors Seriously
9. Asks the Tough Questions
10. Tries to Uncover the Underlying Message
11. Is Done in a Cultural Context
12. Is Documented

Appendix G: Key Issues to Consider for Choosing a Risk Assessment Tool

Key issues to consider for choosing a risk assessment tool:

1. How much time do you have to complete the assessment?
2. How long is the risk assessment?
3. Is the risk tool easy to score?
4. Does the risk tool relate to the population you work with?
5. Are the scores meaningful?
6. Do you need the tool to help with screening, global assessment, etc.?
7. Can persons with whom you assess complete the risk tool?
8. Does the risk tool measure the domains you need?
9. Can you afford to purchase the risk scale?

Appendix H: Characteristics of Suicide Risk Assessment Tools

Scale	Administration		# of Items	Predictive Validity	Reliability	Potential Utility		Population Setting			Population Specific ^			
	Self-Report	Interview/Observation				Global Assessment	Screening	Psychiatric	Non-Psychiatric	Adults	Children & Youth	Older Adults	In	Out
BSS®	x	x	21	x	x	x	x	x	x	x		x	x	
BHS		x	20		x		x	x	x			x		x
C-SSRS		x				x	x	x	x			x	x	
GSIS	x	x	31		x		x	x	x					x
interRAI-SOS		x	varies*		x	x	x	x	x			x		
MHECC			114				x							
NGASR		x	15				x					x		
RFL	x		48		x		x	x	x			x	x	x
SAD PERSONAS		x	10				x	x	x			x		
SIS-MAP		x	108		x		x	x	x			x		
SSI-M		x	18		x		x	x	x			x	x	
SBQ	x		34		x		x	x	x			x	x	
SIS		x	15	x	x			x				x		
SPS	x		36	x	x		x	x	x			x	x	
TASR			26				x	x	x			x	x	x

Note. **BSS®** = Beck Scale for Suicide Ideation; **BHS** = Beck Hopelessness Scale; **C-SSRS** = Columbia-Suicide Severity Rating Scale; **GSIS** = Geriatric Scale for Suicide Intent; **RAI-MH SOS** = interRAI Mental Health Severity of Self-harm Scale; **MHECC** = Mental Health Environment of Care Checklist; **NGASR** = Nurses Global Assessment of Suicide Risk; **RFL** = Reasons for Living Inventory; **SIS-MAP** = Scale for Impact of Suicidality – Management, Assessment and Planning of Care; **SSI-M** = Modified Scale for Suicide Ideation; **SBQ** = Suicidal Behaviours Questionnaire; **SIS** = Suicide Intent Scale; **SPS** = Suicide Probability Scale; **TASR** = Tool for the Assessment of Suicide Risk.

*The interRAI SOS scale is embedded in a larger mental health assessment system based on three different instruments. The number of items in each instrument varies as does the time to complete the entire assessment.

^ Adults (18-64), Older Adults (65+), Children & Youth (8-18)

Appendix I: Dimensions of the Framework for Risk Assessment

The five dimensions of the framework for risk assessment.

1. Initial screening for risk
2. Focused suicide risk assessment
3. Integration of risk assessment
4. Care planning, intervention implementation
5. Monitoring and reassessment

Appendix J: References

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