**Screening Questions for Suicidal Thinking in Youth**

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**Suggested Script:**

| Age (or Equivalent Maturity Level) | Suicide Screening Script<br>**(the bolded question indicates the screening question)** |
|---|---|
| **12** years or older | Intro: "I'm going to ask you a few quick questions about how you are doing with respect to your mental health."<br>1. "Do you think that you have been under a lot of stress lately?"<br>2. "Have you ever felt like life is not worth living?"<br>**3. ** "In the past month, have you felt so bad that you have considered harming or killing yourself? **** |
| **10 to 12** years | Intro: "I'm going to ask you a few quick questions about how you think and feel."<br>1. "Sometimes people find that they have too much stress. Does this sound like you?"<br>**2. "Sometimes when people are very upset, they think about hurting themselves. Has this happened for you?"** |
| **If unable to communicate directly** | **To guardian: "In the past month, have you had any concerns about your child with respect to safety or self-harm?** |

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

**Why screen youth for suicide?**

Suicide is the 2nd-leading cause of death (behind accidental trauma) in Canada for all youth aged 10-24, accounting for **506 deaths in 2005.** To put this into perspective, cancer claimed 210 deaths that same year, and all medical diseases that afflict youth accounted for 578 deaths. If no youth committed suicide, it would be the **near-equivalent of curing all fatal diseases** in youth! (Statistics Canada, 2007)

Approximately **20% of adolescents contemplate suicide** in any given year, and though no specific Canadian study has been done regarding this, it can be estimated that **almost 200,000 youth in Canada plan or attempt suicide** each year, and almost **70,000** receive medical attention from it. (AACAP, 2001, extrapolated from American data) That means that almost 60% of all youth who are thinking about suicide remain hidden from our health care system.

Importantly, recent studies have shown that simply waiting for spontaneous report or detection by external sources misses a majority of youth who are experiencing suicidal thoughts. One study reported **a seven-fold increase in detection** when active screening was employed rather than waiting for spontaneous report. (Brent, 2009)

**What about the very young?**

Fortunately, **suicide in the very young is quite rare**. The rate for suicide is 1.6 per 100,000 in the 10–14-year-old age range, with 89% of these between 12 and 14 years. In the 15–19-year-old age range, the rate increases six-fold, to 10.5 per 100,000, with almost half of these occurring between 18 and 19 years old (Statistics Canada, 2007).

The youngest recorded and verified *intentional* suicide occurred in a 8-year-old boy, but unintentional self-harming deaths have been reported in children as young as six. (Black, 2010) While children younger than eight years of age generally do not understand the permanent nature of death (Sadock, 2009), **self-injurious behaviour is relatively common and can be dangerous**. Little is known about suicidal ideation in the very young.

**Is it OK to ask youth questions about suicidality?**

Clearly, there will be times where it does not feel appropriate to ask a youth about suicide; a common fear is that by asking a naïve youth a question about suicide, it may create distress or introduce suicidal thinking. To this point, there is no evidence to support this. A recent study of almost 2500 high school students (age 13-18) found that children who were asked questions about suicide in a questionnaire experienced **no additional distress or depressive symptoms** immediately after taking it or even two days later. In fact, **depressed or suicidal youth** who participated in the survey **reported significantly *less* distress** after taking it. (Gould MS, 2005)

**Can a tool really predict suicide?**

Suicide risk assessment is still in its infancy with respect to evidence-based practice, and one must always remember to rely on clinical judgment and to use the tool as an assisting instrument only. Any concerns about suicidal behaviour or safety should be taken seriously, even if the tool itself is non-contributory. Consultation with Mental Health or another appropriate service is recommended for any case where clinical judgment has you concerned about a patient's safety.

## Bibliography


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