Appendix B: SBQ-R: Clinical guideline for Suicide Risk

Patient name _____ Date of visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (circle one only)
1. Never
2. It was just a brief passing thought

3a. I have had a plan at least once to kill myself but did not try to do it
3b. I have had a plan at least once to kill myself and really wanted to die
4a. I have attempted to kill myself, but did not want to die
4b. I have attempted to kill myself and really hoped to die

2. How often have you thought about killing yourself in the past year? (circle one only)
1. Never
2. Rarely (1 time)
3. Sometimes (2 times)
4. Often (3-4 times)
5. Very often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (circle one only)
1. No

2a. Yes, at one time, but did not really want to die
2b. Yes, at one time, and really wanted to die
3a. Yes, more than once, but did not want to do it
3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (circle one only)
0. Never
1. No chance at all
2. Rather unlikely
3. Unlikely
4. Likely
5. Rather likely
6. Very likely

Patient Management Recommendations Based on guideline Score for Suicide Risk Patient

<u>SBQ-R- Score below 7</u>

Low risk:
- No further management is required.
- If yes to the question: Have tried to kill themselves before, regardless of the score.
    - Ask: Has anybody close to you committed suicide?
    - Provide education: Where to seek help if the feelings return.

SBQ-R- Score 7 or More

High risk:

- A referral to the mental health clinic (e.g., referral to the Stress Management ward or St. Giles Hospital).

High score on both CES-D and SBQ-R: Emergency (immediate) referral to divisional hospital SMW through A&E or St. Giles).

For **psychiatric inpatients** a score of 8 or more indicates suicide risk.