asQ
Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

- Use after a patient **(18+ years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

What to do when an adult patient screens positive for suicide risk:

WORKSHEET

Patient name:_____ **DOB:** _____

Interviewer name: _____ **Assessment date:**_____

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These can be hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient

Review patient's responses from the asQ
Interview the patient alone; ask any visitors to leave the room

❑ Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"_____(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?"

❑ "Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

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❑ Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself? Please describe." **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

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2 Assess the patient

Review patient's responses from the asQ

❑ Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

❑ Symptoms **Ask the patient about:**

- ❑ **Depression:** "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"
- ❑ **Anxiety:** "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"
- ❑ **Impulsivity/Recklessness:** "Do you often act without thinking?"
- ❑ **Hopelessness:** "In the past few weeks, have you felt hopeless, like things would never get better?"
- ❑ **Isolation:** "Have you been keeping yourself more than usual?"
- ❑ **Irritability:** "In the past few weeks, have you been feeling more irritable or grouchier than usual?"
- ❑ **Substance and alcohol use:** "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"
- ❑ **Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling?"

❑ Social Support & Stressors

- ❑ **Support network:** "Is there a trusted person you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When and for what purpose?"
- ❑ **Safety question:** "Do you think you need help to keep yourself safe?" (A "no" repsonse does not indicate that the patient is safe, but a "yes" is a reason to act immediately to ensure safety.)"
- ❑ **Reasons for living:** "What are some of the reasons you would NOT kill yourself?"

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3 Determine disposition

After completing the assessment, choose the appropriate disposition plan.

❑ **Emergency psychiatric evaluation:** **Patient is at imminent risk for suicide (current suicidal thoughts).**
Urgent/STAT page psychiatry; keep patient safe in ED.

❑ **Further evaluation of risk is necessary:**
Request full mental health health/safety evaluation in the ED.

❑ **No further evaluation in the ED:** Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)

- ❑ Send home with mental health referrals
  or
- ❑ No further intervention is necessary at this time

Comments _____

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4 Provide resources to all patients

- **24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
- **24/7 Crisis Text Line: Text "HOME" to 741-741**