NIMH TOOLKIT: YOUTH EMERGENCY DEPARTMENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

- Use after a patient **(8 - 24 years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, PAs, or other trained clinical professionals
- Prompts help determine disposition
- The ASQ BSSA is intended to be used as a guide. When enough information has been gathered to determine a disposition, the assessment can be considered completed

What to do when a pediatric patient screens positive for suicide risk:

1 Praise patient *for discussing their thoughts*

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

2 Assess the patient

If possible, assess patient alone *(depending on developmental considerations and parent willingness)*

Review patient's responses from the asQ

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.)

"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.)

Suicide plan / Intent to die

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). Assess intent to die.

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?"
Ask: "On a scale from 0 to 10, how serious are you about killing yourself (0 means no chance at all; 10 means absolutely certain)?"

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.).

Past behavior *(Strongest predictor of future attempts)*

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?"

Symptoms

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?"

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?"

Support & Safety

Support network: "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When?"

Safety question: "Do you think you need help to keep yourself safe?" (A "no" response 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?"

3 Interview

patient and parent/guardian together

***If patient is ≥ 18, ask patient's permission for parent to join.**

Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

- "Your child said (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behaviors that you're aware of?" **If yes, say:** "Please explain."
- "Does your child seem sad or depressed? Withdrawn? Anxious? Impulsive? Hopeless? Irritable? Reckless?"
- "Are you comfortable keeping your child safe at home?"
- "How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)?"
- "Is there anything you would like to tell me in private?"

4 Determine disposition

After completing the assessment, choose the appropriate disposition.

❑ **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/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

5 Provide resources to all patients

- 24/7 Suicide & Crisis Lifeline: Call, text, or chat 988
- 24/7 Crisis Text Line: Text "HOME" to 741-741