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 is at imminent risk and requires an urgent/ STAT mental health evaluation and cannot be left alone. Notify patient's medical team.)**

❑ 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?" **If yes, ask:** "What is your plan?" **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.).

❑ 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?" (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.

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

WORKSHEET

2 Assess the patient

Review patient's responses from the asQ

❑ 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?"
- ❑ **Anhedonia:** "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"
- ❑ **Isolation:** "Have you been keeping to 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 excessively or more than usual?" If yes, ask: "What? How much? Has this caused any legal problems or problems with more people in your life?"
- ❑ **Sleep pattern:** "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"
- ❑ **Appetite:** "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"
- ❑ **Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling? Or changes in your mood that we haven't discussed?"

❑ Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

- ❑ **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?"
- ❑ **Family situation:** "Are there any conflicts at home that are so difficult to manage that they are causing you a lot of distress?"
- ❑ **Employment:** "Do you currently have a job?" If yes, ask: "Do you ever feel so much pressure at work that you can't take it anymore?"
- ❑ **Domestic violence:** "Are you worried that anyone in your life is trying to hurt you?"
- ❑ **Suicide contagion:** "Do you know anyone who has killed themselves or tried to kill themselves?"
- ❑ **Reasons for living:** "What are some of the reasons you would NOT kill yourself?" (e.g. belief system/faith/family/other)

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

WORKSHEET

3 Make a safety plan with the patient

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security. **Say to patient:** "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide." Examples: "I will tell my partner/friend/sibling." "I will call the hotline." "I will call_____."

- ❑ **Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).
- ❑ **Discuss means restriction** (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"
- ❑ **Ask 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.)

Comments _____

_____

4 Determine disposition

After completing the assessment, choose the appropriate disposition plan.

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Keep patient safe on the unit. Follow the standard of care for a suicidal patient (e.g., remove dangerous objects, 1:1 observer). Request a STAT, emergency psychiatric evaluation.
- ❑ **Further evaluation of risk is necessary:** Request a comprehensive mental health/safety evaluation prior to discharge.
- ❑ **Patient might benefit from non-urgent mental health follow-up:** No further mental health evaluation in the hospital is needed at this time. Review safety plan for potential future suicidal thoughts and refer patient for a follow-up mental health evaluation in the community, post-discharge.
- ❑ **No further intervention is necessary at this time.**

Comments _____

_____

_____

_____

5 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**