Screening and Managing Suicide Risk in Medical Settings: Adapting Research into Practice

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Project ECHO
Billings Clinic

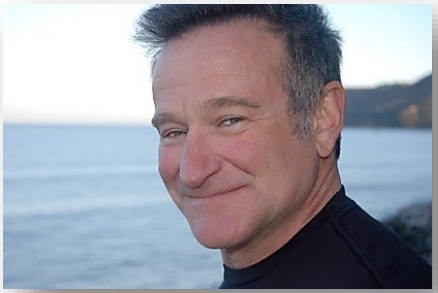
The views expressed in this presentation do not necessarily represent the views of the NIH, DHHS, or any other government agency or official. I have no financial conflicts to disclose.

Learning Objectives

- Review a brief epidemiology of suicide
  - Medical setting
- Discuss the development and study of a validated suicide risk screening instrument – ASQ
- Describe how to screen patients with the ASQ and manage patients that screen positive

Take Home Messages

- Universal suicide risk screening for all patients in medical settings: Ask directly
- Clinicians require population-specific and site-specific validated screening instruments
- Clinical Pathway- 3-tiered system
  - Brief Screen (20 seconds)
  - Brief Suicide Safety Assessment (~10 minutes)
  - Full Psychiatric/Safety Evaluation (30 minutes)
- Discharge all patients with safety plan, resources (National Suicide Lifeline and Crisis Text Line), and lethal means safety counseling



Robin Williams
1951 – 2014

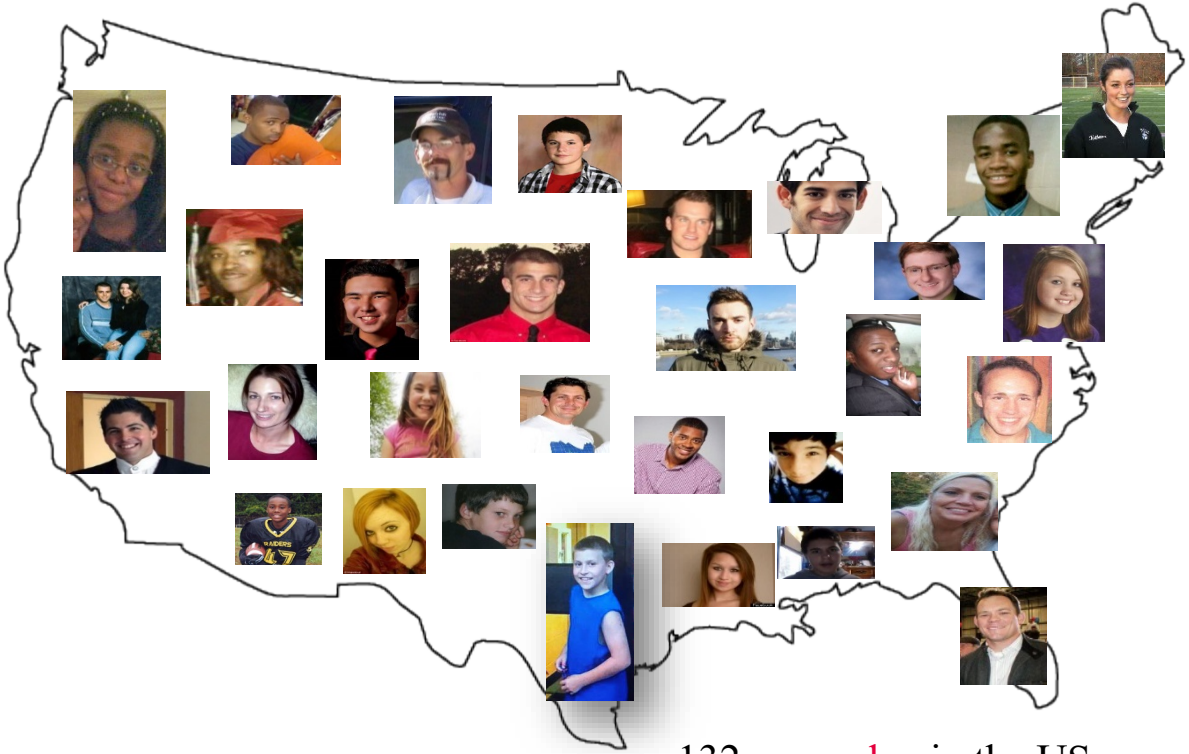
Anthony Bourdain
1956 – 2018

Kelly Catlin
1995 – 2019

Kate Spade
1962 – 2018

Thomas Raskin
1995 – 2020

Calvin Desir
2002 – 2019

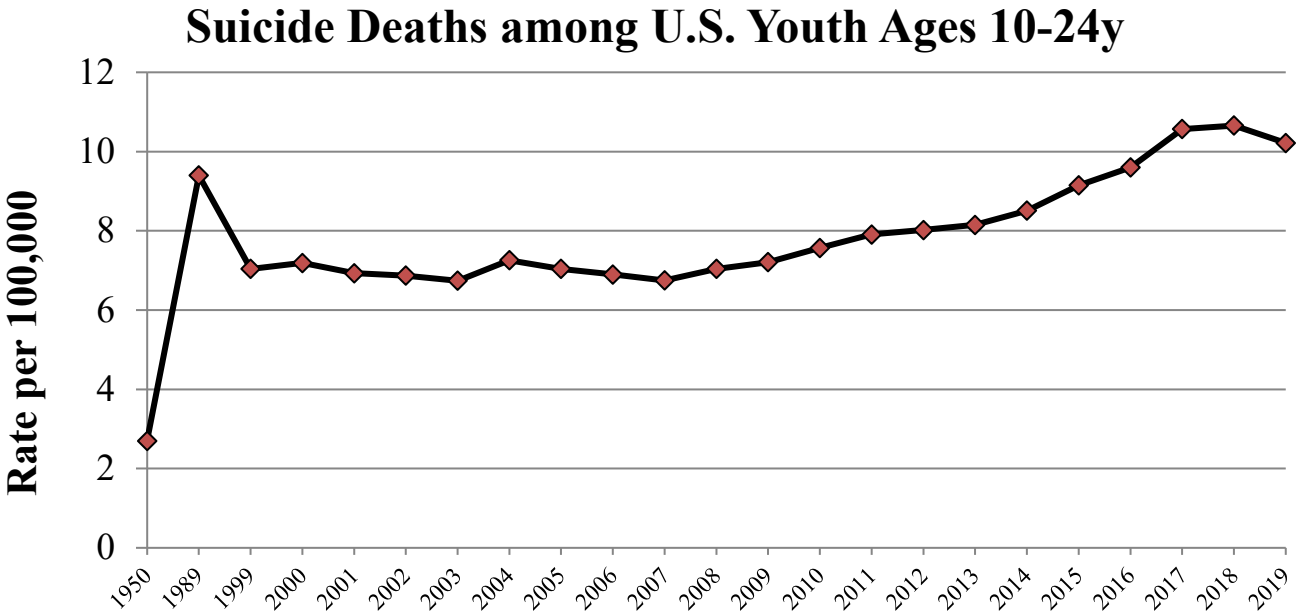


132 every day in the US,
including 18 youth (10-24y)

CDC, 2018

Youth Suicide in the U.S.

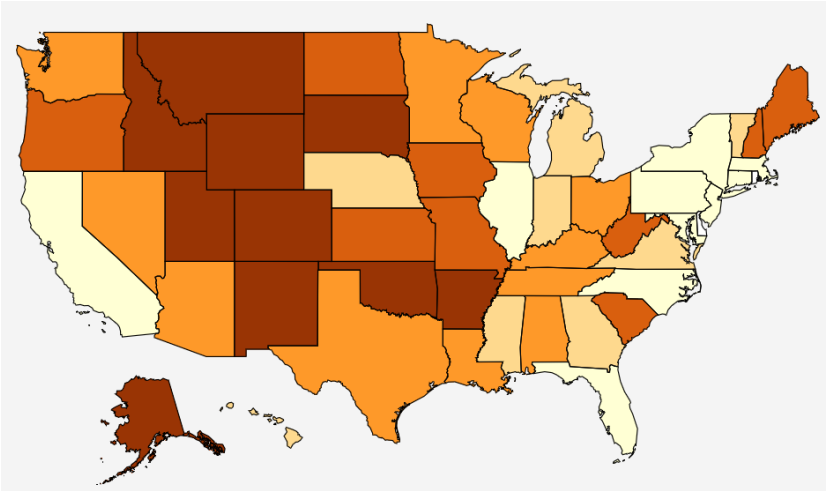
- **2nd leading cause of death** for youth aged 10-24y
- 24,587 total deaths in 2019 - 6,488 (**26%**) deaths by suicide



CDC WISQARS, 2019; Slide courtesy of Jeff Bridge, PhD

Youth Suicide by State

- 2019 crude rates (per 100,000), 10-24y
- Highest rates
  - Alaska: 40.6 deaths
  - Montana: 25.8 deaths
- Lowest rates
  - Massachusetts: 5.2 deaths
  - New Jersey: 5.2 deaths



CDC WISQARS, 2019

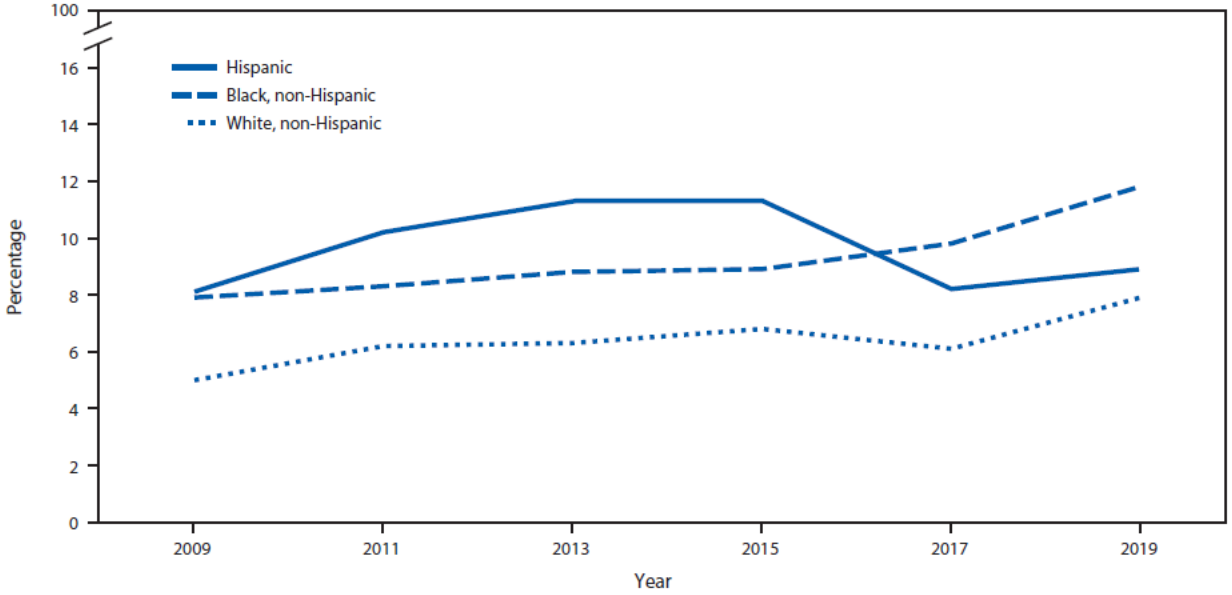
Suicide Among AI/AN – All Ages

- **In 2019, 8th leading cause of death** for AI/AN
- 3,532 deaths in the AI/AN population
  - 19% (658) deaths by suicide
- **33%** (188/571) of all U.S. based AI/AN youth deaths are by suicide
- AI/AN die by suicide at higher rates than other racial/ethnic groups, especially true for youth

CDC WISQARS, 2019

Racial Disparities Among High School Students

FIGURE 2. Percentage of high school students who attempted suicide during the 12 months before the survey, by race/ethnicity — Youth Risk Behavior Survey, United States, 2009–2019



Ivey-Stephenson et al., 2020

High Risk Factors

- **Previous attempt**
- **Mental illness**
- Symptoms of depression, anxiety, agitation, impulsivity
- Exposure to suicide of a relative, friend or peer
- Physical/sexual abuse history
- Drug or alcohol abuse
- Lack of mental health treatment
- Suicide ideation
- Over age 60 and male
- Between the ages of 15 and 24
- LGBTQ
- Neurodevelopmental disorders
- Isolation
- Hopelessness
- **Medical illness**

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

Suicide Is Preventable.

Call the Lifeline at 1-800-273-TALK (8255).

With Help Comes Hope

NIH National Institute of Mental Health

http://suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard.pdf

Wally

Can we save lives by screening for suicide risk in the medical setting?

Suicide in the Hospital Setting

- Hospital-based suicides are rare and devastating
  - Ranked as a top-five Sentinel Event reported to TJC
  - 14% of hospital suicides occur in non-behavioral health settings

Sentinel Event Alert

Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[5-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[8] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[8,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

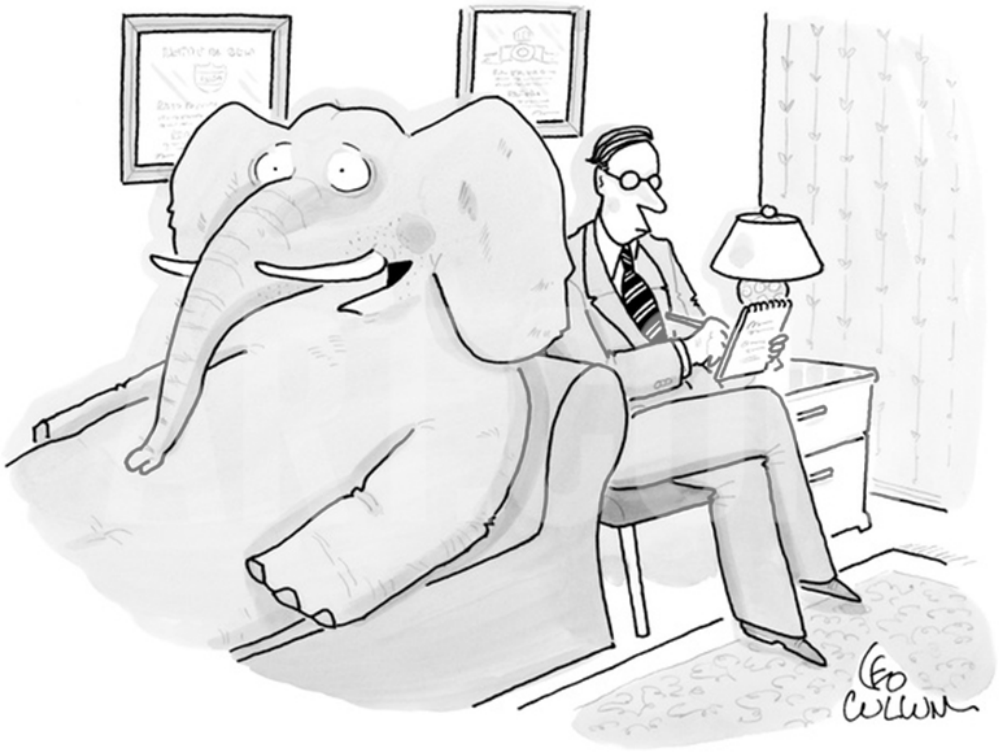
www.jointcommission.org

The Joint Commission, 2016

Underdetection

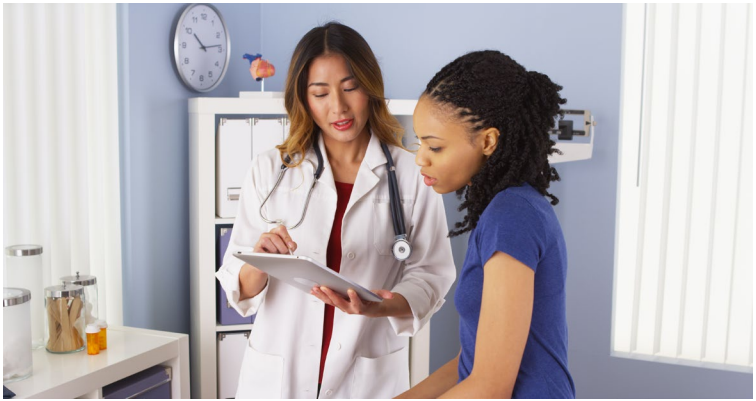
- Majority of those who die by suicide have contact with a medical professional within 3 months of killing themselves
  - 80% of youth visited healthcare provider
  - 38% of adolescents had contact with a health care system within 4 weeks
  - 50% of youth had been to ED within 1 year
  - Frequently present with somatic complaints

Ahmedani, 2017; Pan, 2009; Rhodes, 2013; Blum, 1996



"I'm right there in the room and no one even acknowledges me."

What are valid questions that nurses/physicians can use to screen medical patients for suicide risk in the medical setting?



Screening vs. Assessment: What's the difference?

- **Suicide Risk Screening**
  - Identify individuals at risk for suicide
  - Oral, paper/pencil, computer

- **Suicide Risk Assessment**
  - Comprehensive evaluation
  - Confirms risk
  - Estimates imminent risk of danger to patient
  - Guides next steps

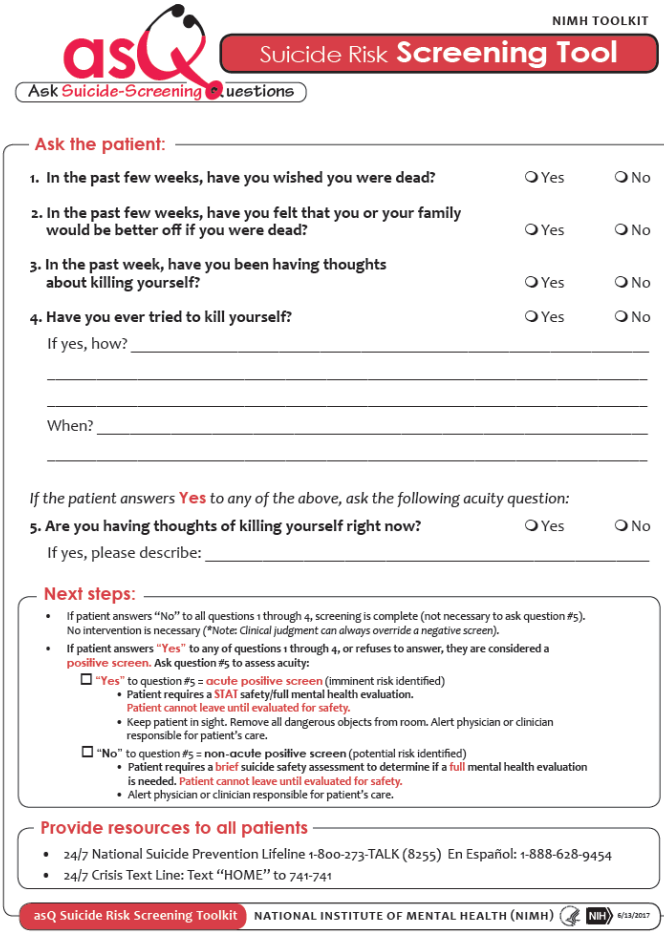
Ask Suicide-Screening Questions (ASQ)

- 3 pediatric EDs
  - Boston Children's Hospital, Boston, MA
  - Children's National Medical Center, Washington, D.C.
  - Nationwide Children's Hospital, Columbus, OH

- September 2008 to January 2011

- 524 pediatric ED patients
  - 344 medical/surgical, 180 psychiatric
  - 57% female, 50% white, 53% privately insured
  - 10 to 21 years (mean=15.2 years; SD = 2.6y)

Horowitz, Bridge… Ballard…Pao, et al. (2012) *Arch Pediatr Adolsc Med*



Sensitivity: 96.9% (95% CI, 91.3-99.4)

Specificity: 87.6% (95% CI, 84.0-90.5)

Negative predictive values:

-Medical/surgical patients: 99.7% (95% CI, 98.2-99.9)

-Psychiatric patients: 96.9% (95% CI, 89.3-99.6)

National Institute of Mental Health

Horowitz, Bridge, Wharff, Ballard…Pao, et al. (2012) *Arch Pediatr Adolsc Med*

Results

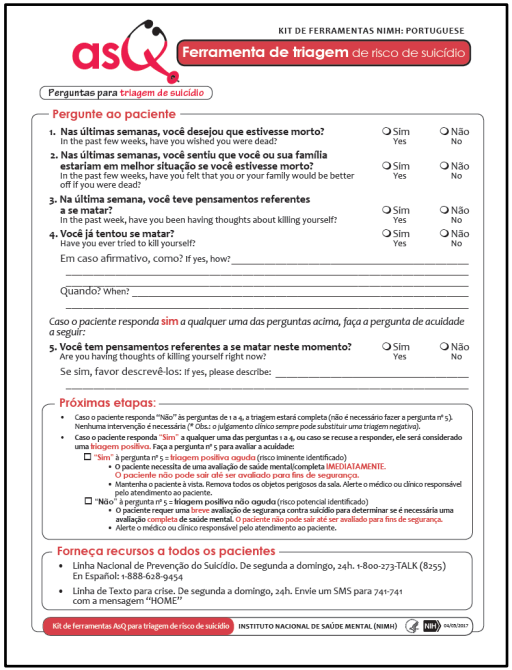
- 98/524 (18.7%) screened positive for suicide risk
  - 14/344 (4%) medical/surgical chief complaints
  - 84/180 (47%) psychiatric chief complaints
- Feasible
  - Less than 1 minute to administer
  - Non-disruptive to workflow
- Acceptable
  - Parents/guardians gave permission for screening
  - Over 95% of patients were in favor of screening
- ASQ is now available in the public domain

Validation and Implementations in Other Settings: Ongoing Research

- Inpatient medical/surgical unit
- Outpatient primary care/specialty clinics
- ASQ in adult medical patients
- Schools
- Child abuse clinics
- Detention Facilities
- Indian Health Service (IHS)
- ASD/NDD Population

Foreign languages

- Spanish
- Italian
- French
- Portuguese
- Dutch
- Arabic
- Somali
- Hindi
- Hebrew
- Vietnamese
- Mandarin
- Korean
- Japanese
- Russian
- Tagalog
- Urdu



KIT DE FERRAMENTAS NIMH: PORTUGUESE

asQ Ferramenta de triagem de risco de suicídio

Perguntas para triagem de suicídio

Pergunte ao paciente

1. **Nas últimas semanas, você desejou que estivesse morto?** In the past few weeks, have you wished you were dead? ○ Sim Yes ○ Não No
2. **Nas últimas semanas, você sentiu que você ou sua família estariam em melhor situação se você estivesse morto?** In the past few weeks, have you felt that you or your family would be better off if you were dead? ○ Sim Yes ○ Não No
3. **Na última semana, você teve pensamentos referentes a se matar?** In the past week, have you been having thoughts about killing yourself? ○ Sim Yes ○ Não No
4. **Você já tentou se matar?** Have you ever tried to kill yourself? ○ Sim Yes ○ Não No

Em caso afirmativo, como? If yes, how? _____

Quando? When? _____

Caso o paciente responda sim a qualquer uma das perguntas acima, faça a pergunta de acuidade a seguir:

5. **Você tem pensamentos referentes a se matar neste momento?** Are you having thoughts of killing yourself right now? ○ Sim Yes ○ Não No

Se sim, favor descrevê-los: If yes, please describe: _____

Próximas etapas:

- Caso o paciente responda "Não" às perguntas de 1 a 4, a triagem estará completa (não é necessário fazer a pergunta nº 5). Nenhuma intervenção é necessária (* Obs.: o julgamento clínico sempre pode substituir uma triagem negativa).
- Caso o paciente responda "Sim" a qualquer uma das perguntas 1 a 4, ou caso se recuse a responder, ele será considerado uma triagem positiva. Faça a pergunta nº 5 para avaliar a acuidade:
  - ☐ "Sim" à pergunta nº 5 = triagem positiva aguda (risco iminente identificado)
    - O paciente necessita de uma avaliação de saúde mental/completa IMEDIATAMENTE. O paciente não pode sair até ser avaliado para fins de segurança.
    - Mantenha o paciente à vista. Remova todos os objetos perigosos da sala. Alerte o médico ou clínico responsável pelo atendimento ao paciente.
  - ☐ "Não" à pergunta nº 5 = triagem positiva não aguda (risco potencial identificado)
    - O paciente requer uma breve avaliação de segurança contra suicídio para determinar se é necessária uma avaliação completa de saúde mental. O paciente não pode sair até ser avaliado para fins de segurança.
    - Alerte o médico ou clínico responsável pelo atendimento ao paciente.

Forneça recursos a todos os pacientes

- Linha Nacional de Prevenção do Suicídio. De segunda a domingo, 24h. 1-800-273-TALK (8255) En Español: 1-888-628-9454
- Linha de Texto para crise. De segunda a domingo, 24h. Envie um SMS para 741-741 com a mensagem "HOME"

Kit de ferramentas AsQ para triagem de risco de suicídio | INSTITUTO NACIONAL DE SAÚDE MENTAL (NIMH) | 04/05/2017

ASQ Toolkit: www.nimh.nih.gov/ASQ

Specialty Clinics

Shayla Sullivant, MD, Site PI

- 59 (17.9%) screened positive for suicide risk
  4/59 (9.3%) identified as having **current** thoughts of suicide (at time)

Clinic	N = patients enrolled	Positive screens	% Screening Positive
Diabetes Mellitus	n = 69	n = 20	29%
Endocrine	n =123	n = 27	22%
Orthopedics	n = 30	n = 5	16.7%
Sports Medicine	n = 108	n = 7	6.5%

Chi-square (3df) = 16.77, p=0.001

Children's Mercy HOSPITAL KANSAS

Aguinaldo et al. (2020) *General Hospital Psychiatry*

Primary Care Results

Elizabeth Wharff, PhD
Laika Aguinaldo, PhD, LICSW

- ~14% screened positive for suicide risk
- Only half had previously been asked about suicide by an adult
- More than 95% of patients supported universal suicide risk screening in primary care clinics

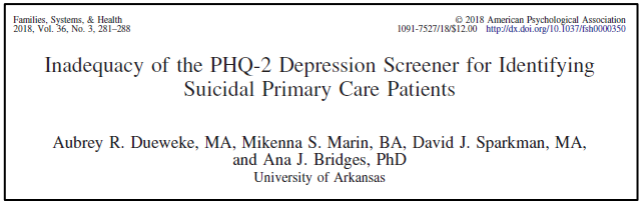
Aguinaldo et al. (2020) *General Hospital Psychiatry*

Can depression screening be used to effectively screen for suicide risk?

Patient Health Questionnaire -9 (PHQ-9)

- 9-item depression screen assessing symptoms during the past 2 weeks
- Available in the public domain and commonly used in medical settings

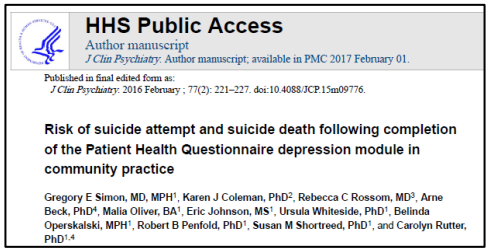
- One "suicide-risk" question: Item #9
  - How often have you been bothered by the following symptoms during the past two weeks? *"Thoughts that you would be better off dead* ***or*** *of* ***hurting*** *yourself in some way"*


Families, Systems, & Health
2018, Vol. 36, No. 3, 281–288

© 2018 American Psychological Association
1091-7527/18/$12.00 http://dx.doi.org/10.1037/fsh0000350

Inadequacy of the PHQ-2 Depression Screener for Identifying Suicidal Primary Care Patients

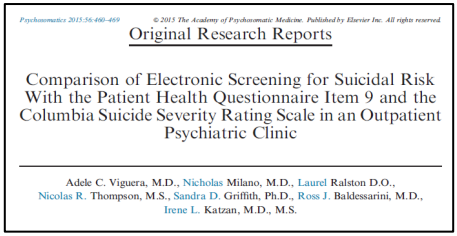
Aubrey R. Dueweke, MA, Mikenna S. Marin, BA, David J. Sparkman, MA, and Ana J. Bridges, PhD
University of Arkansas


HHS Public Access
Author manuscript
J Clin Psychiatry. Author manuscript; available in PMC 2017 February 01.

Published in final edited form as:
J Clin Psychiatry. 2016 February ; 77(2): 221–227. doi:10.4088/JCP.15m09776.

Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice

Gregory E Simon, MD, MPH[1], Karen J Coleman, PhD[2], Rebecca C Rossom, MD[3], Arne Beck, PhD[4], Malia Oliver, BA[1], Eric Johnson, MS[1], Ursula Whiteside, PhD[1], Belinda Operskalski, MPH[1], Robert B Penfold, PhD[1], Susan M Shortreed, PhD[1], and Carolyn Rutter, PhD[1,4]


Psychosomatics 2015;56:460–469 © 2015 The Academy of Psychosomatic Medicine. Published by Elsevier Inc. All rights reserved.

Original Research Reports

Comparison of Electronic Screening for Suicidal Risk With the Patient Health Questionnaire Item 9 and the Columbia Suicide Severity Rating Scale in an Outpatient Psychiatric Clinic

Adele C. Viguera, M.D., Nicholas Milano, M.D., Laurel Ralston D.O., Nicolas R. Thompson, M.S., Sandra D. Griffith, Ph.D., Ross J. Baldessarini, M.D., Irene L. Katzan, M.D., M.S.

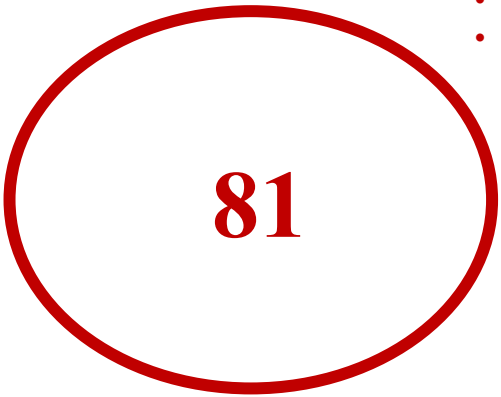
Dueweke, 2018; Simon, 2016; Viguera 2015

Depression Screening vs. Suicide Risk Screening

ASQ vs. PHQ-A

Suicide-risk positive (13.5%)

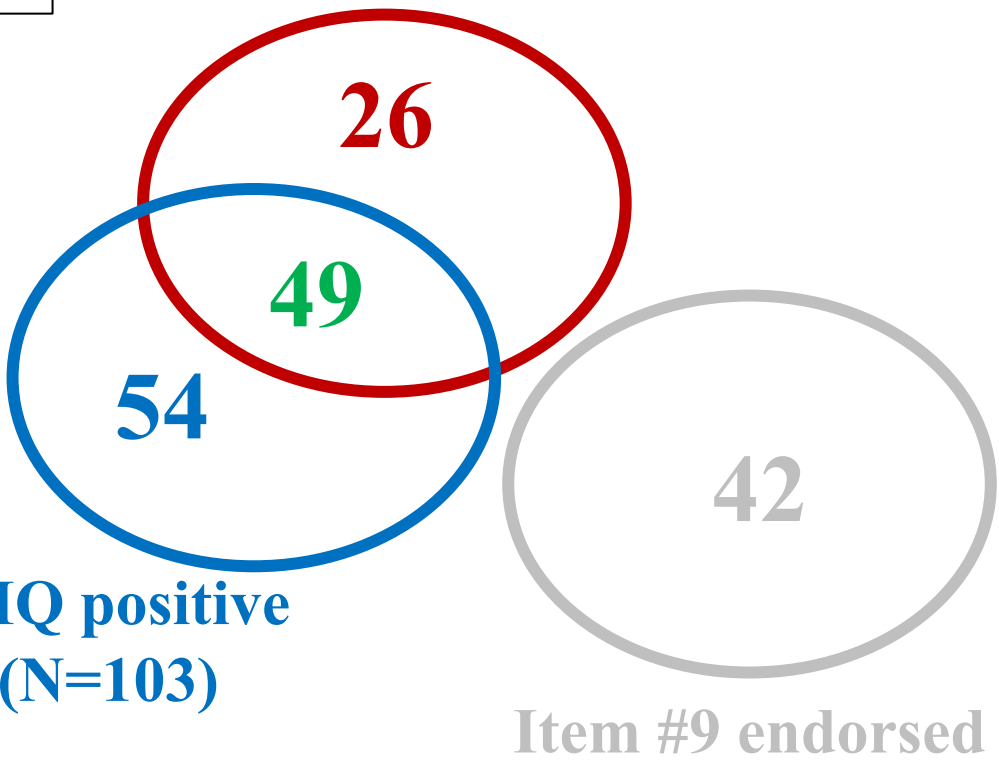
Total N=600
Medical/Surgical Inpatients



- SIQ ≥ 41
- SIQ-JR ≥ 31
- "Yes" to any ASQ item

Horowitz et al. (2021) *Journal of Adolescent Health*

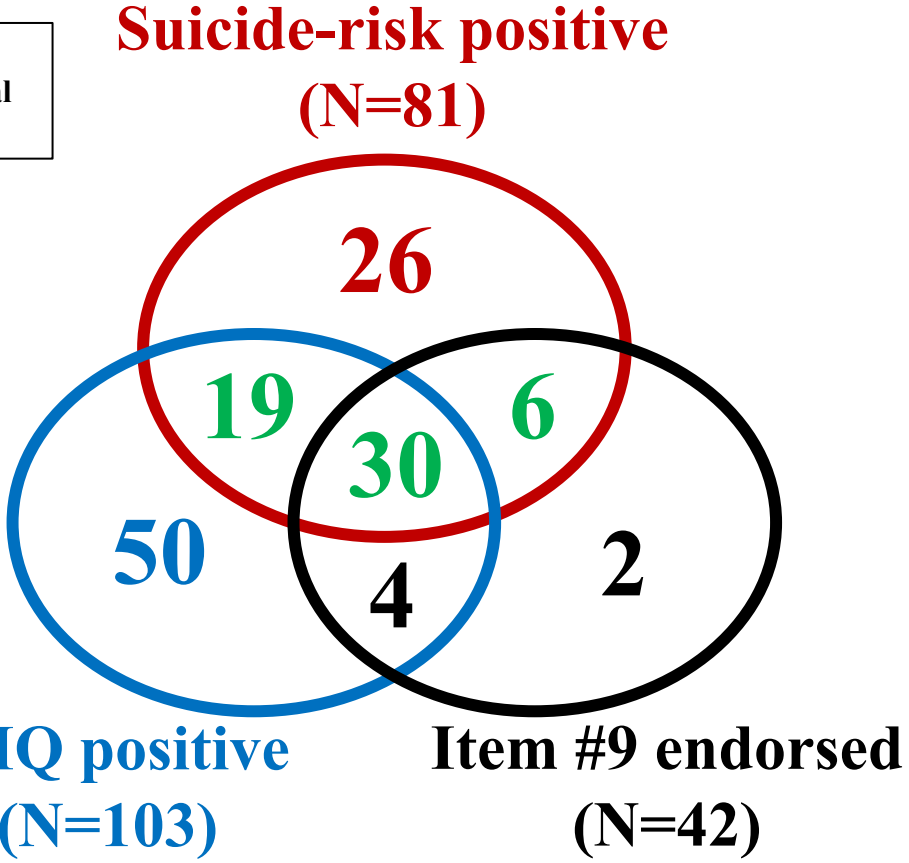
Total N=600
Medical/Surgical Inpatients



National Institute of Mental Health

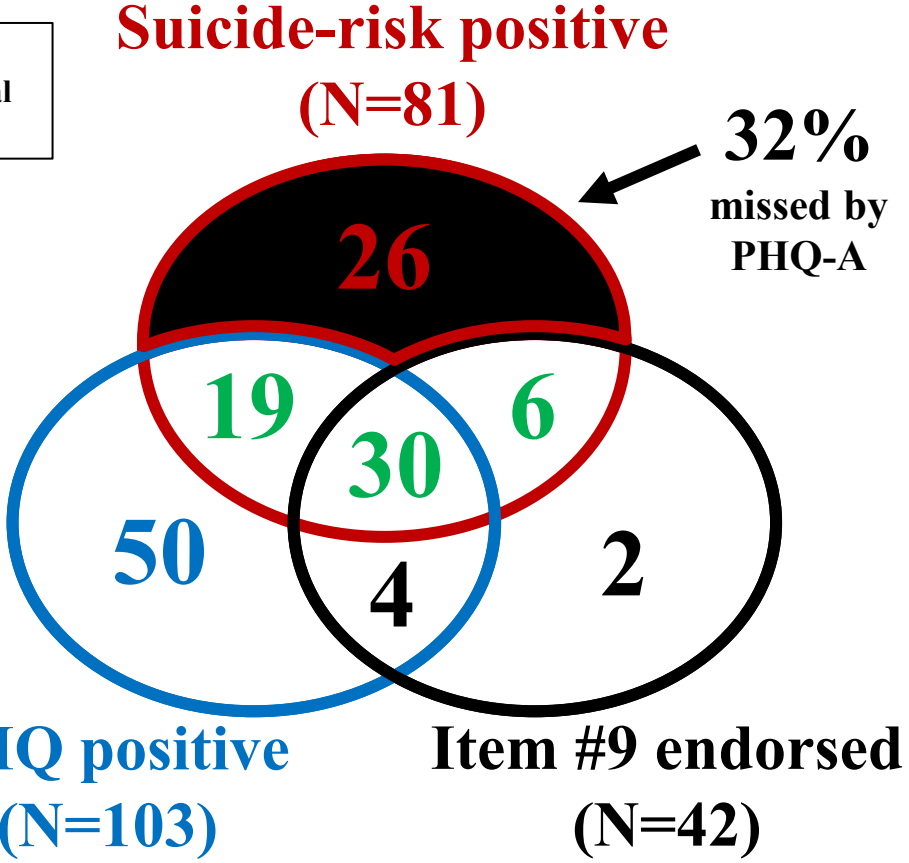
Horowitz et al. (2021) *Journal of Adolescent Health*

Total N=600
Medical/Surgical
Inpatients



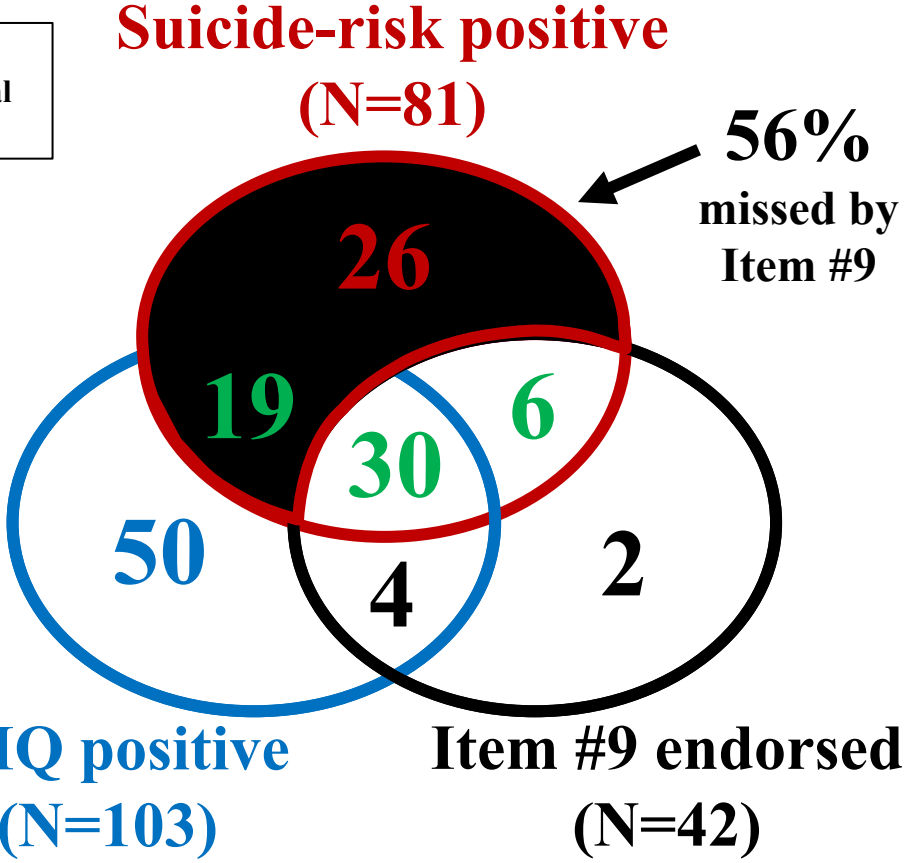
Horowitz et al. (2021) *Journal of Adolescent Health*

Total N=600
Medical/Surgical
Inpatients



Horowitz et al. (2021) *Journal of Adolescent Health*

Total N=600
Medical/Surgical
Inpatients



Horowitz et al. (2021) *Journal of Adolescent Health*

PHQ-2

PHQ-9

Suicide Risk Screen

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Office use only: **Severity score:** _____

asQ

Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO

If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now? YES NO

If yes, please describe: _____

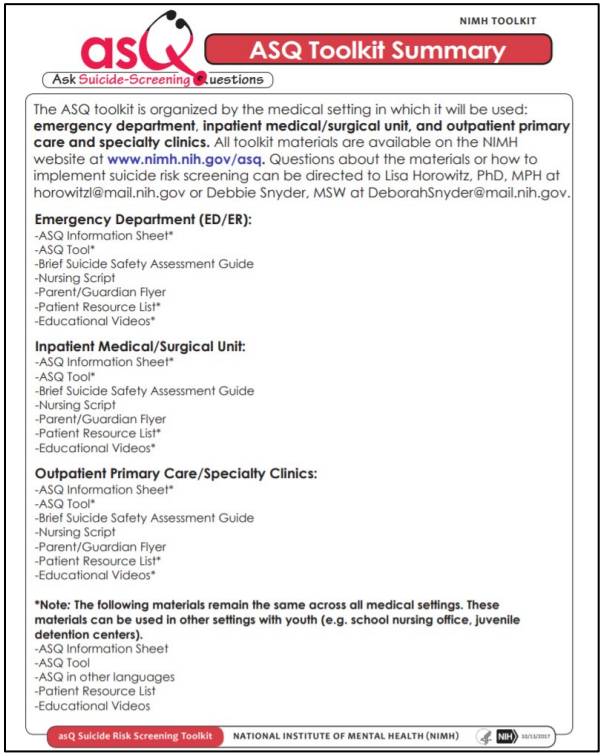
ASQ Toolkit

www.nimh.nih.gov/asq

The ASQ Toolkit

Organized by medical setting:

- ASQ Tool
- Brief Suicide Safety Assessments
- Information Sheets
- Scripts for staff
- Flyers for guardians
- Patient resources list
- Educational videos



NIMH TOOLKIT

asQ

Ask Suicide-Screening Questions

ASQ Toolkit Summary

The ASQ toolkit is organized by the medical setting in which it will be used: **emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics.** All toolkit materials are available on the NIMH website at **www.nimh.nih.gov/asq.** Questions about the materials or how to implement suicide risk screening can be directed to Lisa Horowitz, PhD, MPH at horowitzl@mail.nih.gov or Debbie Snyder, MSW at DeborahSnyder@mail.nih.gov.

Emergency Department (ED/ER):
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

Inpatient Medical/Surgical Unit:
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

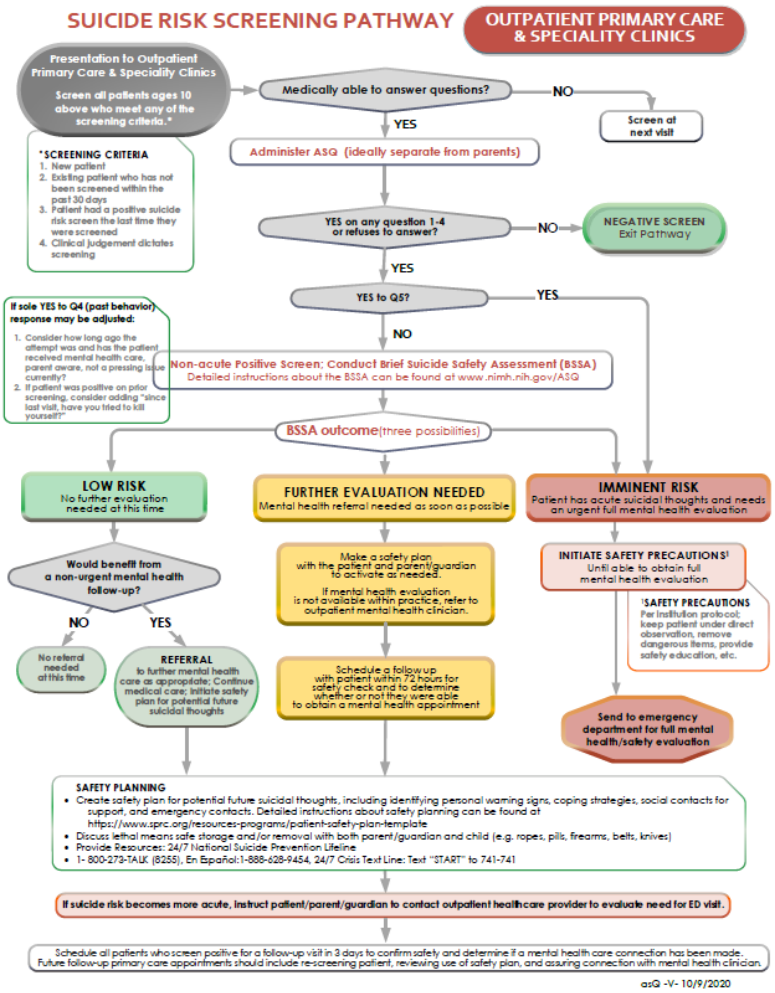
Outpatient Primary Care/Specialty Clinics:
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

***Note: The following materials remain the same across all medical settings. These materials can be used in other settings with youth (e.g. school nursing office, juvenile detention centers).**
-ASQ Information Sheet
-ASQ Tool
-ASQ in other languages
-Patient Resource List
-Educational Videos

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

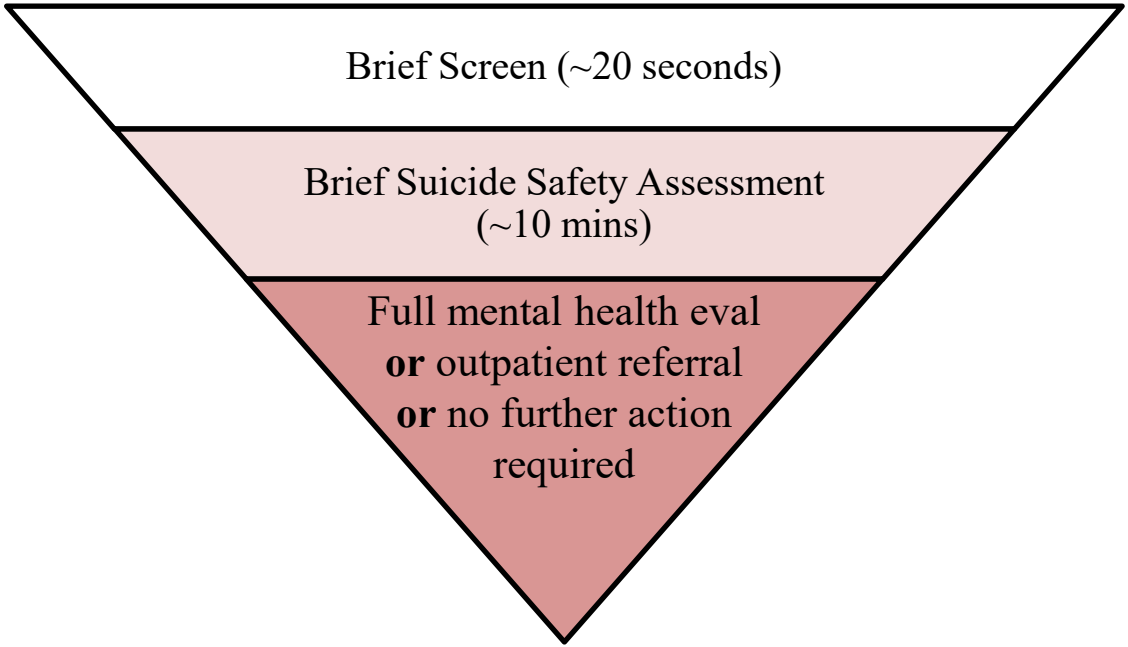
NIH National Institute of Mental Health

ASQ Toolkit: www.nimh.nih.gov/ASQ


SUICIDE RISK SCREENING PATHWAY
OUTPATIENT PRIMARY CARE & SPECIALITY CLINICS
Presentation to Outpatient Primary Care & Speciality Clinics
Screen all patients ages 10 above who meet any of the screening criteria.*
*SCREENING CRITERIA
1. New patient
2. Existing patient who has not been screened within the past 30 days
3. Patient had a positive suicide risk screen the last time they were screened
4. Clinical judgement dictates screening
Medically able to answer questions?
NO
Screen at next visit
YES
Administer ASQ (ideally separate from parents)
YES on any question 1-4 or refuses to answer?
NO
NEGATIVE SCREEN Exit Pathway
YES
YES to Q5?
YES
NO
If sole YES to Q4 (past behavior) response may be adjusted:
1. Consider how long ago the attempt was and has the patient received mental health care, parent aware, not a pressing issue currently?
2. If patient was positive on prior screening, consider adding "since last visit, have you tried to kill yourself?"
Non-acute Positive Screen; Conduct Brief Suicide Safety Assessment (BSSA)
Detailed instructions about the BSSA can be found at www.nimh.nih.gov/ASQ
BSSA outcome(three possibilities)
LOW RISK
No further evaluation needed at this time
FURTHER EVALUATION NEEDED
Mental health referral needed as soon as possible
IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation
Would benefit from a non-urgent mental health follow-up?
NO
YES
No referral needed at this time
REFERRAL
to further mental health care as appropriate; Continue medical care; Initiate safety plan for potential future suicidal thoughts
Make a safety plan with the patient and parent/guardian to activate as needed.
If mental health evaluation is not available within practice, refer to outpatient mental health clinician.
Schedule a follow up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a mental health appointment
INITIATE SAFETY PRECAUTIONS[1]
Until able to obtain full mental health evaluation
[1]SAFETY PRECAUTIONS
Per institution protocol; keep patient under direct observation, remove dangerous items, provide safety education, etc.
Send to emergency department for full mental health/safety evaluation
SAFETY PLANNING
• Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
• Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g. ropes, pills, firearms, belts, knives)
• Provide Resources: 24/7 National Suicide Prevention Lifeline
• 1- 800-273-TALK (8255), En Español:1-888-628-9454, 24/7 Crisis Text Line: Text "START" to 741-741
If suicide risk becomes more acute, instruct patient/parent/guardian to contact outpatient healthcare provider to evaluate need for ED visit.
Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made. Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.
asQ -V- 10/9/2020

Universal Suicide Risk Screening Clinical Pathway

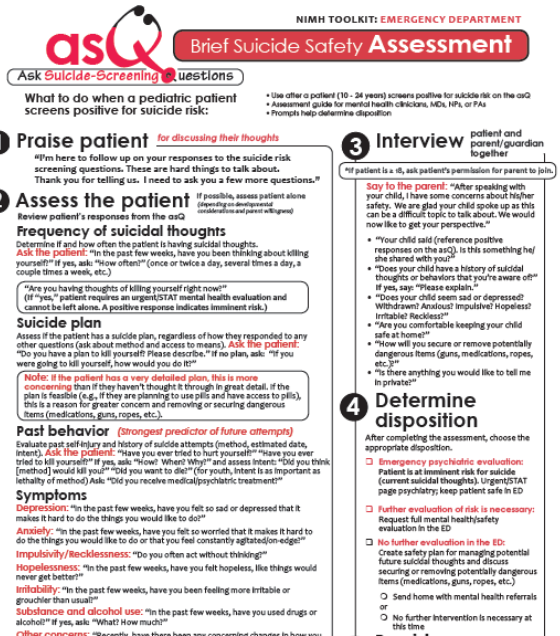
Clinical Pathway- 3-tiered system



Brahmbhatt, Kurtz, Afzal…Pao, Horowitz, et al. (2018*) Psychosomatics*

Brief Suicide Safety Assessment

ASQ BSSA



NIMH TOOLKIT: EMERGENCY DEPARTMENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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

- Use after a patient (10 - 24 years) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

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

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.).

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

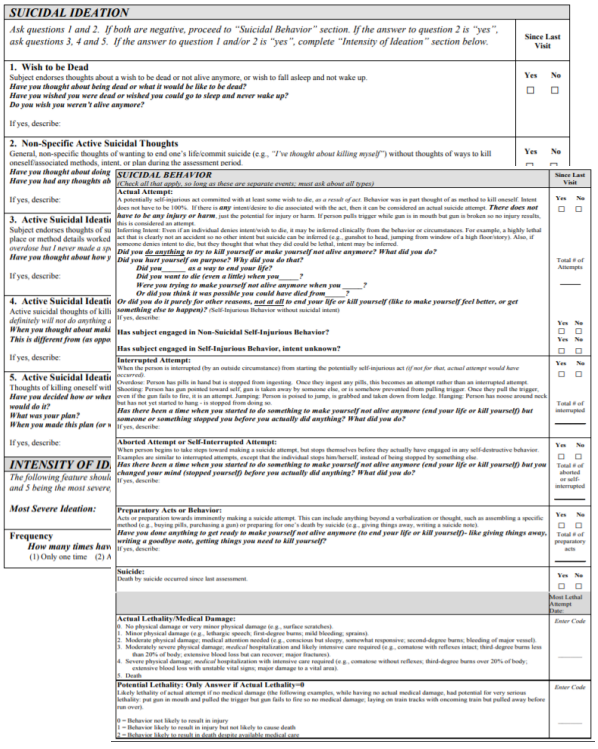
❍ No further intervention is necessary at this time

5 Provide resources to all patients

- 24/7 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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/14/2017

C-SSRS



SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Since Last Visit

1. Wish to be Dead — Yes ☐ No ☐

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Have you thought about being dead or what it would be like to be dead?

Have you wished you were dead or wished you could go to sleep and never wake up?

Do you wish you weren't alive anymore?

If yes, describe:

2. Non-Specific Active Suicidal Thoughts — Yes ☐ No ☐

General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

Have you thought about doing

Have you had any thoughts ab

If yes, describe:

3. Active Suicidal Ideati

Subject endorses thoughts of su place or method details worked *overdose but I never made a sp* ***Have you thought about how y***

If yes, describe:

4. Active Suicidal Ideati

Active suicidal thoughts of kill *definitely will not do anything a* ***When you thought about maki*** ***This is different from (as appr***

If yes, describe:

5. Active Suicidal Ideati

Thoughts of killing oneself wit ***Have you decided how or when*** ***would do it?*** ***What was your plan?*** ***When you made this plan (or s***

If yes, describe:

INTENSITY OF ID

The following feature shoul and 5 being the most severe.

Most Severe Ideation:

Frequency

How many times hav

(1) Only one time (2) A

SUICIDAL BEHAVIOR — Since Last Visit

(Check all that apply, so long as these are separate events; must ask about all types)

Actual Attempt: — Yes ☐ No ☐

A potentially self-injurious act committed with at least some wish to die, *as a result of act*. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?

Did you hurt yourself on purpose? Why did you do that?

Did you _____ as a way to end your life?

Did you want to die (even a little) when you_____?

Were you trying to make yourself not alive anymore when you _____?

Or did you think it was possible you could have died from_____?

Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

If yes, describe:

Total # of Attempts: _____

Has subject engaged in Non-Suicidal Self-Injurious Behavior? — Yes ☐ No ☐

Has subject engaged in Self-Injurious Behavior, intent unknown? — Yes ☐ No ☐

Interrupted Attempt: — Yes ☐ No ☐

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred)*.

Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.

Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?

If yes, describe:

Total # of interrupted: _____

Aborted Attempt or Self-Interrupted Attempt: — Yes ☐ No ☐

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself; instead of being stopped by something else.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?

If yes, describe:

Total # of aborted or self-interrupted: _____

Preparatory Acts or Behavior: — Yes ☐ No ☐

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?

If yes, describe:

Total # of preparatory acts: _____

Suicide: — Yes ☐ No ☐

Death by suicide occurred since last assessment.

Most Lethal Attempt Date: _____

Actual Lethality/Medical Damage: — Enter Code

0. No physical damage or very minor physical damage (e.g., surface scratches).
1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).
2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).
3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4. Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).
5. Death

Potential Lethality: Only Answer if Actual Lethality=0 — Enter Code

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).

0 = Behavior not likely to result in injury
1 = Behavior likely to result in injury but not likely to cause death
2 = Behavior likely to result in death despite available medical care

Brief Suicide Safety Assessment

Outpatient BSSA

NIMH TOOLKIT: OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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

- Use after a patient (**10 - 24 years**) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

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.) "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.)

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?" (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?"

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?" If yes, ask: "What? How much?"

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?"

Social Support & Stressors

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

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

Family situation: "Are there any conflicts at home that are hard to handle?"

School functioning: "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"

Bullying: "Are you being bullied or picked on?"

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?"

NIMH TOOLKIT: OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian 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 behavior that you're aware of?" If yes, say: "Please explain."
- "Does your child seem:
  - Sad or depressed?"
  - Anxious?"
  - Impulsive?"
  - Hopeless?"
  - Reckless?"
  - Unable to enjoy the things that usually bring him/her pleasure?"
  - Withdrawn from friends or to be keeping to him/herself?"
- "Have you noticed changes in your child's:
  - Sleeping pattern?"
  - Appetite?"
- "Does your child use drugs or alcohol?"
- "Has anyone in your family/close friend network ever tried to kill themselves?"
- "How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)
- "Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents)
- "Are you comfortable keeping your child safe at home?"

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

4 Make a safety plan with the patient

Include the parent/guardian, if possible.

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 mom/coach/teacher." "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.)

5 Determine disposition

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ❑ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ❑ **No further intervention is necessary at this time.**

For all positive screens, follow up with patient at next appointment.

6 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

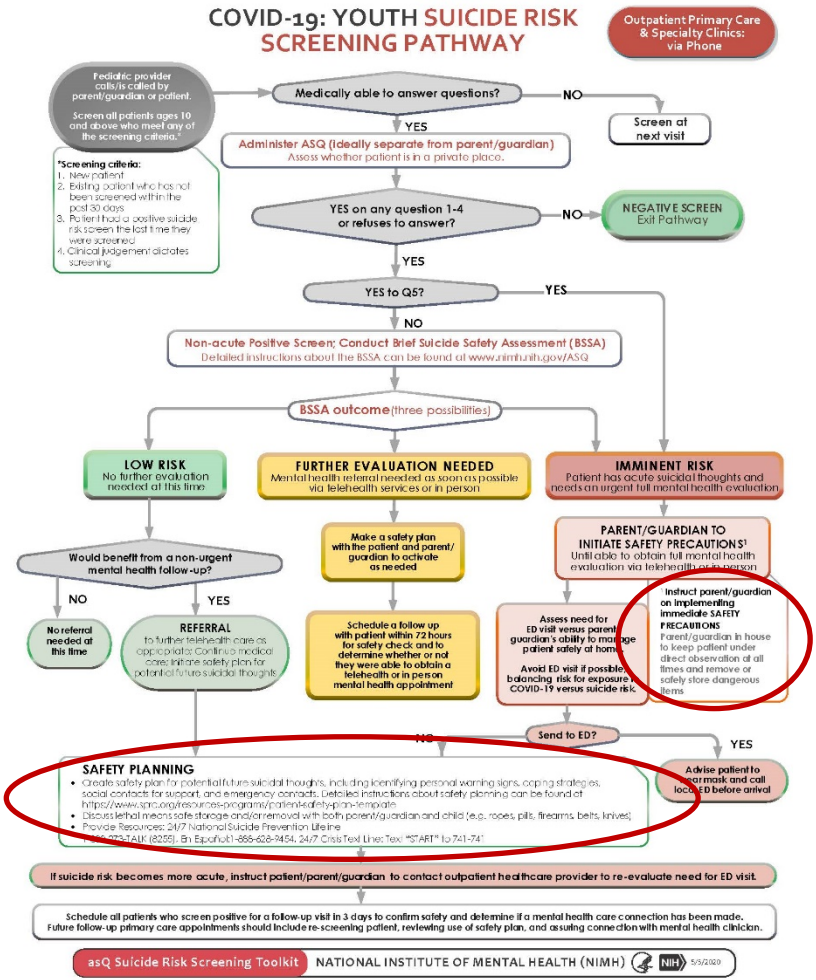
asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) 6/9/2017

National Institute of Mental Health

What is the purpose of the BSSA?

- To help clinician make “next step” decision
- 4 Choices

- **Imminent Risk**
  - **Emergency psychiatric evaluation**
- **High Risk**
  - **Further evaluation of risk is necessary**
- **Low Risk**
  - **Not the “business of the day”**
  - **No further intervention is necessary at this time.**


COVID-19: YOUTH SUICIDE RISK SCREENING PATHWAY
Outpatient Primary Care & Specialty Clinics: via Phone
Pediatric provider calls/is called by parent/guardian or patient.
Screen all patients ages 10 and above who meet any of the screening criteria.*
*Screening criteria:
1. New patient
2. Existing patient who has not been screened within the past 30 days
3. Patient had a positive suicide risk screen the last time they were screened
4. Clinical judgement dictates screening
Medically able to answer questions?
NO
Screen at next visit
YES
Administer ASQ (ideally separate from parent/guardian)
Assess whether patient is in a private place.
YES on any question 1-4 or refuses to answer?
NO
NEGATIVE SCREEN Exit Pathway
YES
YES to Q5?
YES
NO
Non-acute Positive Screen; Conduct Brief Suicide Safety Assessment (BSSA)
Detailed instructions about the BSSA can be found at www.nimh.nih.gov/ASQ
BSSA outcome (three possibilities)
LOW RISK
No further evaluation needed at this time
FURTHER EVALUATION NEEDED
Mental health referral needed as soon as possible via telehealth services or in person
IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation
Would benefit from a non-urgent mental health follow-up?
NO
YES
No referral needed at this time
REFERRAL
to further telehealth care as appropriate. Continue medical care; initiate safety plan for potential future suicidal thoughts
Make a safety plan with the patient and parent/guardian to activate as needed
Schedule a follow up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a telehealth or in person mental health appointment
PARENT/GUARDIAN TO INITIATE SAFETY PRECAUTIONS[1]
Until able to obtain full mental health evaluation via telehealth or in person
Assess need for ED visit versus parent/guardian's ability to manage patient safety at home
Avoid ED visit if possible, balancing risk for exposure to COVID-19 versus suicide risk
Instruct parent/guardian on implementing immediate SAFETY PRECAUTIONS
Parent/guardian in house to keep patient under direct observation at all times and remove or safely store dangerous items
Send to ED?
NO
YES
Advise patient to wear mask and call local ED before arrival
SAFETY PLANNING
Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g., ropes, pills, firearms, belts, knives)
Provide Resources: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255). En Español 1-888-628-9454. 24/7 Crisis Text Line: Text "START" to 741-741
If suicide risk becomes more acute, instruct patient/parent/guardian to contact outpatient healthcare provider to re-evaluate need for ED visit.
Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made. Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.
asQ Suicide Risk Screening Toolkit
NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)
NIH
5/5/2020

Safety Planning

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

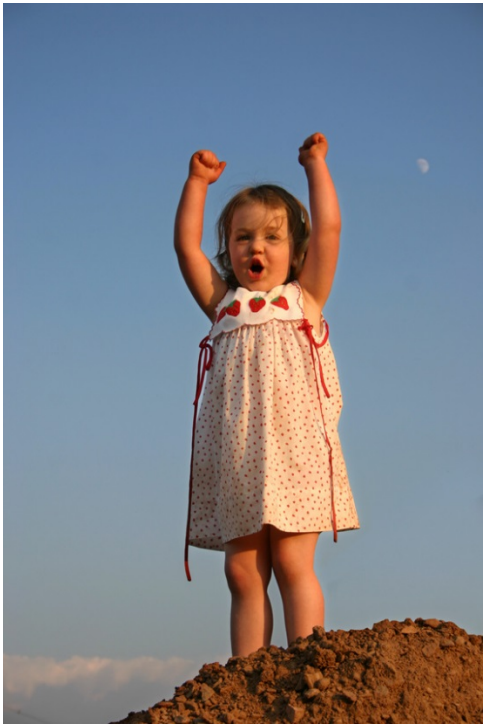
- Warning Signs
- Coping Strategies
- Social Contacts for Support
- Emergency Contacts
- Reduce Access to Lethal Means

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256-264.

Lethal Means Safety

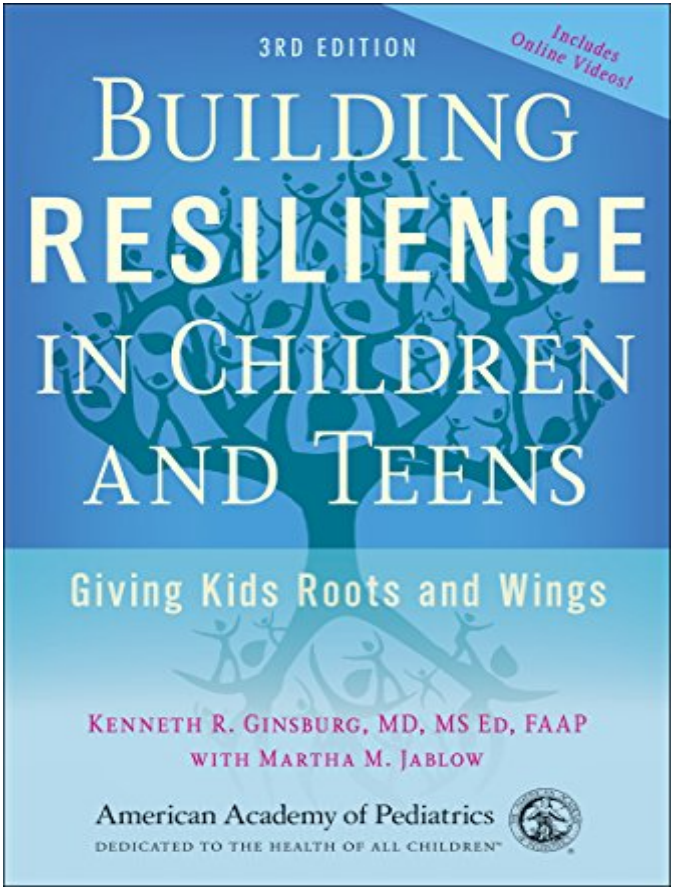
A Word about Fostering Resilience

Resilience is not the absence of struggle… It's messy.



Does not mean immediately being okay.

How do we teach young people to handle the ups and downs of life?



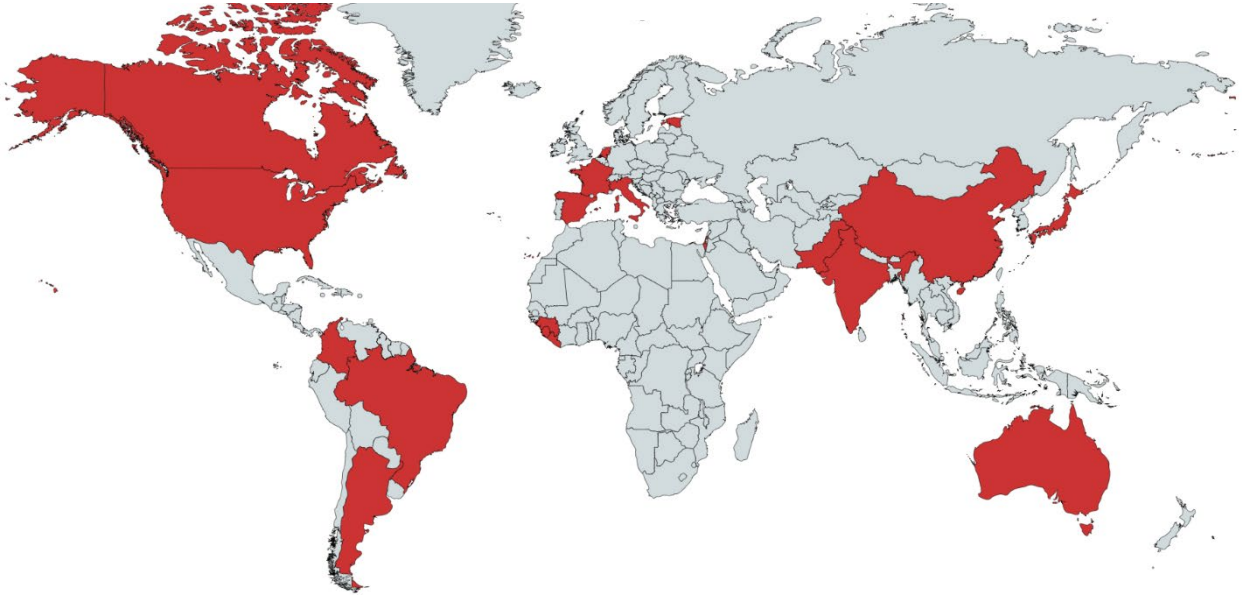
Seven C's of Resilience

- (1) Competence
- (2) Confidence
- (3) Connection
- (4) Character
- (5) Contribution
- (6) Coping
- (7) Control

Ginsburg & Jablow, 2015

Turning research into practice

ASQ Worldwide

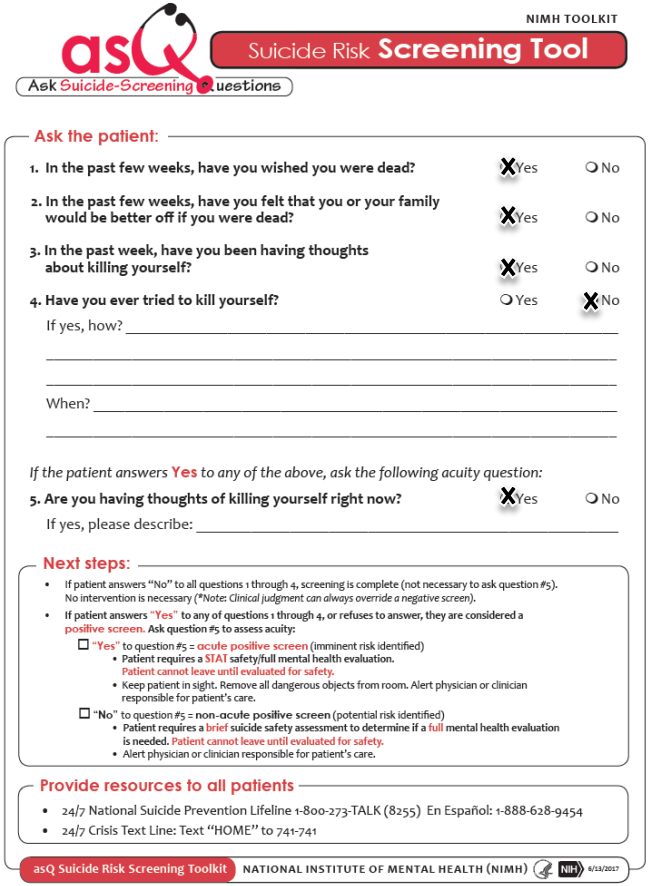


Summary

- Medical setting is important venue to identify individuals at risk for suicide – ask directly
- Screening can take 20 seconds
- Requires practice guidelines for managing positive screens
  - Clinical Pathway- 3-tiered system
    - Brief screen (20 seconds)
    - BSSA (~10 minutes)
    - Full mental health/safety evaluation (30 minutes)
- Fostering resilience is critical and may be protective against suicide risk
- Counsel families on how to safely store or remove lethal means (firearms, pills, knives, ropes)

A patient example

- 18 y.o. male presenting with fatigue
- Nurse intuition – something not right
- Administered ASQ



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead?	X Yes	○ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?	X Yes	○ No
3. In the past week, have you been having thoughts about killing yourself?	X Yes	○ No
4. Have you ever tried to kill yourself?	○ Yes	X No

If yes, how? _____

When? _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now?	X Yes	○ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: *Clinical judgment can always override a negative screen*).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - ☐ "Yes" to question #5 = acute positive screen (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = non-acute positive screen (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 6/13/2017

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Any Questions?

Just asQ !

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