



# ASQ Toolkit Summary

Ask **Suicide-Screening** Questions

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](http://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](mailto:horowitzl@mail.nih.gov) or Debbie Snyder, MSW at [DeborahSnyder@mail.nih.gov](mailto: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





## Screening Youth for Suicide Risk in Medical Settings

**A rapid, psychometrically sound 4-item screening tool for all pediatric patients presenting to the emergency department, inpatient units, & primary care facilities.**

### BACKGROUND

- In 2010, suicide became the 2nd leading cause of death for youth ages 10-24.
- In 2015, more than 5,900 American youth killed themselves.
- In the U.S., over 2 million young people attempt suicide each year. 90% of suicide attempts among youth are unknown to parents.
- Early identification and treatment of patients at elevated risk for suicide is a key suicide prevention strategy, yet high risk patients are often not recognized by healthcare providers.
- Recent studies show that the majority of individuals who die by suicide have had contact with a healthcare provider within three months prior to their death.
- Unfortunately, these patients often present solely with physical complaints and infrequently discuss suicidal thoughts and plans unless asked directly.

### Suicide in the Hospital

Suicide in the medical setting is one of the most frequent sentinel events reported to the Joint Commission (JC). In the past 20 years, over 1,300 patient deaths by suicide have been reported to the JC from hospitals nationwide.

- Notably, 25% of these suicides occurred in non-behavioral health settings such as general medical units and the emergency department.
- Root cause analyses reveal that the lack of proper “assessment” of suicide risk was the leading cause for these reported suicides.

*Ask directly about suicidal thoughts –*

**EVERY HEALTHCARE PROVIDER  
CAN MAKE A DIFFERENCE**

### Screening in Medical Settings

The emergency department, inpatient units, and primary care settings are promising venues for identifying young people at risk for suicide.

- Several studies have refuted myths about iatrogenic risk of asking youth questions about suicide, such as the worry about “putting ideas into their heads.”
- Screening positive for suicide risk on validated instruments may not only be predictive of future suicidal behavior, but may also be a proxy for other serious mental health concerns that require attention.
- Non-psychiatric clinicians in medical settings require brief validated instruments to help detect medical patients at risk for suicide.

### Emergency Department (ED)

- For over 1.5 million youth, the ED is their only point of contact with the healthcare system, creating an opportune time to screen for suicide risk.
- Screening in the ED has been found to be feasible (non-disruptive to workflow and acceptable to patients and their families).

### Inpatient Units

- Research reveals that the majority of medical inpatients have never been asked about suicide before; however, opinion data indicate that most adolescents support screening in inpatient settings.

### Primary Care/Inpatient Clinics

- Primary Care Physicians (PCPs) are often the de-facto principal mental healthcare providers for children and adolescents.
- Adolescents may be more comfortable discussing risk-taking activities with PCPs than with specialists.

### Suicide Risk Screening Recommendations

- 2007 – The JC issued National Patient Safety Goal 15A, requiring suicide risk screening for all patients being treated for mental health concerns in all healthcare settings.
- 2010 & 2016 – The JC issued a Sentinel Event Alert, recommending that all medical patients in hospitals also be screened for suicide risk.

## asQ Development

- The ASQ was developed in 3 pediatric Emergency Departments (EDs):
  - Children’s National Medical Center, Washington, DC
  - Boston Children’s Hospital, Boston, Massachusetts
  - Nationwide Children’s Hospital, Columbus, Ohio
- For use by non-psychiatric clinicians
- Takes less than 2 minutes to screen
- Positive screen: “yes” to any of the 4 items
- **Sound psychometric properties\***



## 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: \_\_\_\_\_



For description of study:

\*Horowitz LM, Bridge JA, Teach SJ, Ballard E, Klima J, Rosenstein DL, Wharff EA, Ginnis K, Cannon E, Joshi P, Pao M. Ask Suicide-Screening Questions (ASQ): A Brief Instrument for the Pediatric Emergency Department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176.

## After administering the asQ

- 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.

### For more information contact:

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Boston Children’s Hospital, Harvard Medical School



- Patients ages 10-24
- Positive screen: “Yes” to any question
- Public domain tool, free of charge
- Available in multiple languages





# Suicide Risk Screening Tool

## 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 acuity question:

5. Are you having thoughts of killing yourself right now?  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





# 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 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?” (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 grouchy 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?”





Ask **Suicide-Screening** Questions**3 Interview patient & parent/guardian together**

If patient is  $\geq 18$  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:
  - o Sad or depressed?"
  - o Anxious?"
  - o Impulsive? Reckless?"
  - o Hopeless?"
  - o Irritable?"
  - o Unable to enjoy the things that usually bring him/her pleasure?"
  - o Withdrawn from friends or to be keeping to him/herself?"

- "Have you noticed changes in your child's:
  - o Sleeping pattern?"
  - o 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.

- 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 post-discharge:** 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.**

**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





# 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 grouchy 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  $\geq 18$ , 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





# 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 grouchy 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?”





Ask **Suicide-Screening** Questions**3 Interview patient & parent/guardian together**

If patient is  $\geq 18$  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:
  - o Sad or depressed?"
  - o Anxious?"
  - o Impulsive? Reckless?"
  - o Hopeless?"
  - o Irritable?"
  - o Unable to enjoy the things that usually bring him/her pleasure?"
  - o Withdrawn from friends or to be keeping to him/herself?"
- "Have you noticed changes in your child's:
  - o Sleeping pattern?"
  - o 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



**Parent/guardian flyer**Ask **Suicide-Screening** Questions

**Your child's health and safety is our #1 priority.** New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today's visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.





## Parent/guardian flyer

Ask **Suicide-Screening** Questions

**Your child's health and safety is our #1 priority.** New national safety guidelines recommend that we screen children and adolescents for suicide risk.

We will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.



## Parent/guardian flyer

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Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.



## Script for nursing staff

Ask **Suicide-Screening** Questions

### **Say to parent/guardian:**

“National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know.”

### **Once parent steps out, say to patient:**

“Now I'm going to ask you a few more questions.”

*Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).*

### **If patient screens positive, say to patient:**

“These are hard things to talk about. Thank you for telling me. I'm going to share your answers with [insert name of MD, PA, NP, or mental health clinician] and he/she will come speak with you.”

### **If patient screens positive, and parent/guardian is awaiting results, say:**

“We have some concerns about your child's safety that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to [insert name of MD, PA, NP, or mental health clinician], and he/she will further evaluate your child for safety.”





## Script for nursing staff

Ask **Suicide-Screening** Questions

### **Say to parent/guardian:**

“National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child’s safety, we will let you know.”

### **Once parent steps out, say to patient:**

“Now I’m going to ask you a few more questions.”

*Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).*

### **If patient screens positive, say to patient:**

“I’m so glad you spoke up about this. I’m going to talk to your parent and your medical team. Someone who is trained to talk with kids about suicide is going to come speak with you.”

### **If patient screens positive, say to parent/guardian:**

“We have some concerns about your child’s safety that we would like to further evaluate. It’s really important that he/she spoke up about this. I’m going to talk to your medical team, and someone who is trained to talk with kids about suicide is going to come speak with you and your child.”

## **Nurses: The Importance of Screening**

-Video produced by Children's Mercy Kansas City Hospital

<http://bcove.video/2pWyvcN>

## **Physicians: The Importance of Screening**

-Video featuring doctors Ted Abernathy and Scott Keel

Long version: <https://youtu.be/OTjxEZkp4-Y>

Short version: [https://youtu.be/QaPeu6s\\_YM](https://youtu.be/QaPeu6s_YM)

## **Mayo Clinic: Youth Suicide Prevention - What to Say & Not to Say**

<https://www.youtube.com/watch?v=3BByqa7bhto&feature=youtu.be>



**National Suicide Prevention Lifeline**

1-800-273-TALK (8255)

Spanish/Español: 1-888-628-9454

**Crisis Text Line**

Text HOME to 741-741

**Suicide Prevention Resource Center**

[www.sprc.org](http://www.sprc.org)

**National Institutes of Health**

[www.nimh.nih.gov](http://www.nimh.nih.gov)

**Substance Abuse and Mental Health Services Administration**

[www.samhsa.gov](http://www.samhsa.gov)

