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

1. **Praise patient for discussing their thoughts**

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

2. **Assess the patient**

   **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?”

   **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?”

   **Past behavior**

   Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

   **Ask the patient:** “Have you ever tried to hurt yourself?” “Have you ever tried to kill yourself?”

   If yes, ask: “How? When? Why?” and assess intent: “Did you think [method] would kill you?” “Did you want to die?” (Intent is as important as lethality of method)

   **Note:** Past suicidal behavior is the strongest risk factor for future attempts.
Assess the patient  Review patient’s responses from the asQ

 Symptoms  Ask the patient about:

☐ Depression: “In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?”

☐ Anxiety: “In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?”

☐ Impulsivity/Recklessness: “Do you often act without thinking?”

☐ Hopelessness: “In the past few weeks, have you felt hopeless, like things would never get better?”

☐ Anhedonia: “In the past few weeks, have you felt like you couldn’t enjoy the things that usually make you happy?”

☐ Isolation: “Have you been keeping to yourself more than usual?”

☐ Irritability: “In the past few weeks, have you been feeling more irritable or grouchier than usual?”

☐ Substance and alcohol use: “In the past few weeks, have you used drugs or alcohol excessively or more than usual?” If yes, ask: “What? How much? Has this caused any legal problems or problems with more people in your life?”

☐ Sleep pattern: “In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?”

☐ Appetite: “In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?”

☐ Other concerns: “Recently, have there been any concerning changes in how you are thinking or feeling? Or changes in your mood that we haven’t discussed?”

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

☐ Support network: “Is there a trusted person you can talk to? Who? Have you ever seen a therapist/counselor?” If yes, ask: “When and for what purpose?”

☐ Family situation: “Are there any conflicts at home that are so difficult to manage that they are causing you a lot of distress?”

☐ Employment: “Do you currently have a job?” If yes, ask: “Do you ever feel so much pressure at work that you can’t take it anymore?”

☐ Domestic violence: “Are you worried that anyone in your life is trying to hurt you?”

☐ Suicide contagion: “Do you know anyone who has killed themselves or tried to kill themselves?”

☐ Reasons for living: “What are some of the reasons you would NOT kill yourself?” (e.g. belief system/faith/family/other)
3 Make a safety plan with the patient

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

- Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).
- Discuss means restriction (securing or removing lethal means): “Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?”
- Ask safety question: “Do you think you need help to keep yourself safe?” (A “no” response does not indicate that the patient is safe; but a “yes” is a reason to act immediately to ensure safety.)

4 Determine disposition **For all positive screens, follow up with patient at next appointment.**

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.**

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