Suicide Risk Screener

What is the asQ?

The Ask Suicide-Screening Questions (asQ) tool is a brief validated tool for use among both youth and adults. The asQ is a set of four screening questions that takes 20 seconds to administer. In an NIMH study, a "yes" response to one or more of the four questions identified 97% of youth (aged 10 to 21 years) at risk for suicide. Led by the NIMH, a multisite research study has now demonstrated that the ASQ is also a valid screening tool for adult medical patients. By enabling early identification and assessment of medical patients at high risk for suicide, the ASQ toolkit can play a key role in suicide prevention.

Link(s) to Screener(s)

screening_tool_asq_nimh_toolkit.pdf (nih.gov)

How to use it / Who should administer

Recommended age is 8 and up. The survey is typically administered verbally by a nurse or other professional. For screening youth, it is recommended that screening be conducted without the parent/guardian present. Refer to the nursing script for guidance on requesting that the parent/guardian leave the room during screening. If the parent/guardian refuses to leave or the child insists that they stay, conduct the screening with the parent/guardian present. For all patients, any other visitors in the room should be asked to leave the room during screening.

How to interpret / Next steps

Video example of using tool in practice
Training video (15 minutes) with more detail on how to use this screener: https://www.nimh.nih.gov/news/media/2019/suicide-risk-screening-training-how-to-use-the-asq-to-detect-patients-at-risk-for-suicide

<table>
<tr><td colspan="2">If a patient answers "no" to questions 1-4, the screening is complete and no interventions are necessary</td></tr>
<tr><td colspan="2">If a patient answers "yes" to ANY of the first four questions, or refuses to give an answer, they are considered positive screens. To determine next steps, ask question #5</td></tr>
<tr><td><u>If "yes" to question 5</u>
Acute positive screen (intermediate risk identified)
Patient requires a STAT safety/full mental health eval
Patient cannot leave until evaluated for safety
Keep patient in sight and remove all hazardous objects from room. Alert physician or clinician responsible for patient's care.</td><td>If "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 eval is required
Patient cannot leave until evaluated for safety
Alert physician or clinician responsible for patient's care.</td></tr>
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Sources:
Horowitz, L. M., Bridge, J. A., Teach, S. J., Ballard, E., Klima, J., Rosenstein, D. L., ... & Pao, M. (2012). Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Archives of Pediatrics & Adolescent Medicine, 166(12), 1170-1176.
Horowitz, L. M., Snyder, D. J., Boudreaux, E. D., He, J. P., Harrington, C. J., Cai, J., Claassen, C. A., Salhany, J. E., Dao, T., Chaves, J. F., Jobes, D. A., Merikangas, K. R., Bridge, J. A., Pao, M. (2020). Validation of the Ask Suicide-Screening Questions (ASQ) for adult medical inpatients: A brief tool for all ages. Psychosomatics, 61(6), 713-722.

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