South Piedmont AHEC
Behavioral Health Integrated Care Curriculum Project

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

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If a patient answers "no" to questions 1-4, the screening is complete and no interventions are necessary	
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	
If "yes" to question 5	**If "no" to question 5**
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.	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.

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.