Ask Suicide-Screening Questions (ASQ):

A Brief Introduction

Jesse McFerran, LISW
Emergency Department Social Worker II
Psychiatry Intake Response Center (PIRC)

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Objectives

- Understand 3-Tiered Clinical Pathway for assessing suicide risk
- Provide introduction to Ask Suicide-Screening Questions (ASQ)
- Provide an introduction to Cincinnati Children's Hospital Psychiatry Intake Response Center (PIRC)

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Three-Tiered Clinic Pathway to Assess for Suicide Risk

1. **ASQ:** five suicide screening questions that take less than 2 minutes to administer.
   - Administered at each outpatient visit.
   - If positive screen is obtained, move to second tier.

2. **Full C-SSRS**:
   - Used to guide next steps (safety plan or full psych eval)

3. **Full Psychiatric Evaluation**:
   - Emergency Department, Bridge Clinic, Best Point Urgent Care, or Outpatient Mental Health Provider

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Ask Suicide-Screening Questions (ASQ)

- A rapid, psychometrically sound 4-item screening tool for all pediatric (8 and up) and adult patients presenting to health care settings
- Developed by 3 pediatric Emergency Departments (EDs)
  - Children's National Medical Center, Washington, DC
  - Boston Children's Hospital, Boston, Massachusetts
  - Nationwide Children's Hospital, Columbus, Ohio
- Can be used by non-psychiatric clinicians
- Brief – takes less than 2 minutes to administer

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Initial Assessment Questions

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?
   - If yes, when?

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Acuity Question

- Ask only if individual has answered ‘Yes’ to any of the previous 4 questions

5. Are you having thought of killing yourself right now? Yes, No

   If yes, please describe:

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Screening Positive for Suicide Risk

- Non-Acute Positive
  - Most common positive screening
  - Individual answers ‘yes’ to any one of the first 4 questions
    - If anyone refuses to answer any question, it should be considered positive
  - Next step: Conduct a brief suicide safety assessment (Full C-SSRS) to determine next steps
- Acute Positive
  - Individual answers ‘yes’ to the 5th question
  - Complete C-SSRS and call PIRC to coordinate directions on next steps

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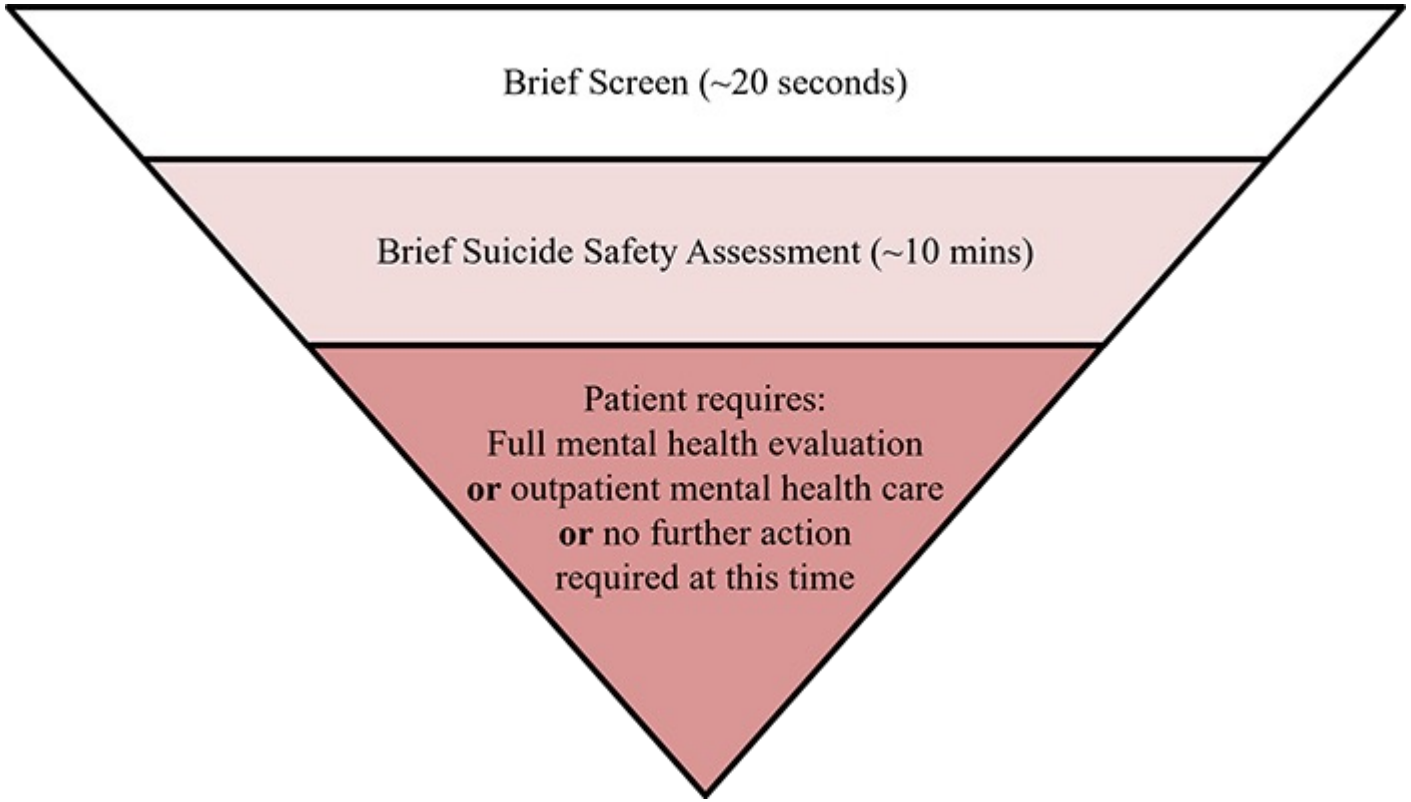

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Considerations

- ASQ questions are for children and adults ages 8 and older
- Try to ask questions with parents/guardians out the room
- ASQ should be administered at each outpatient visit (hospital setting)
- In a school setting, ASQ should be administered per school/agency policy

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Psychiatric Intake Response Center (PIRC)

Psychiatric
Intake
Response
Center
(PIRC)

513-636-4124

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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? ○ 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? Intentional Ingestion

   When? 2 years ago

*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

What is the next step?

A. No additional steps necessary
B. Complete Question 5 (Acuity Question) to determine next steps
C. Complete the Columbia (C-SSRS)

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What are next steps?

A. Complete the C-SSRS
B. Complete a full mental health evaluation
C. No additional steps necessary

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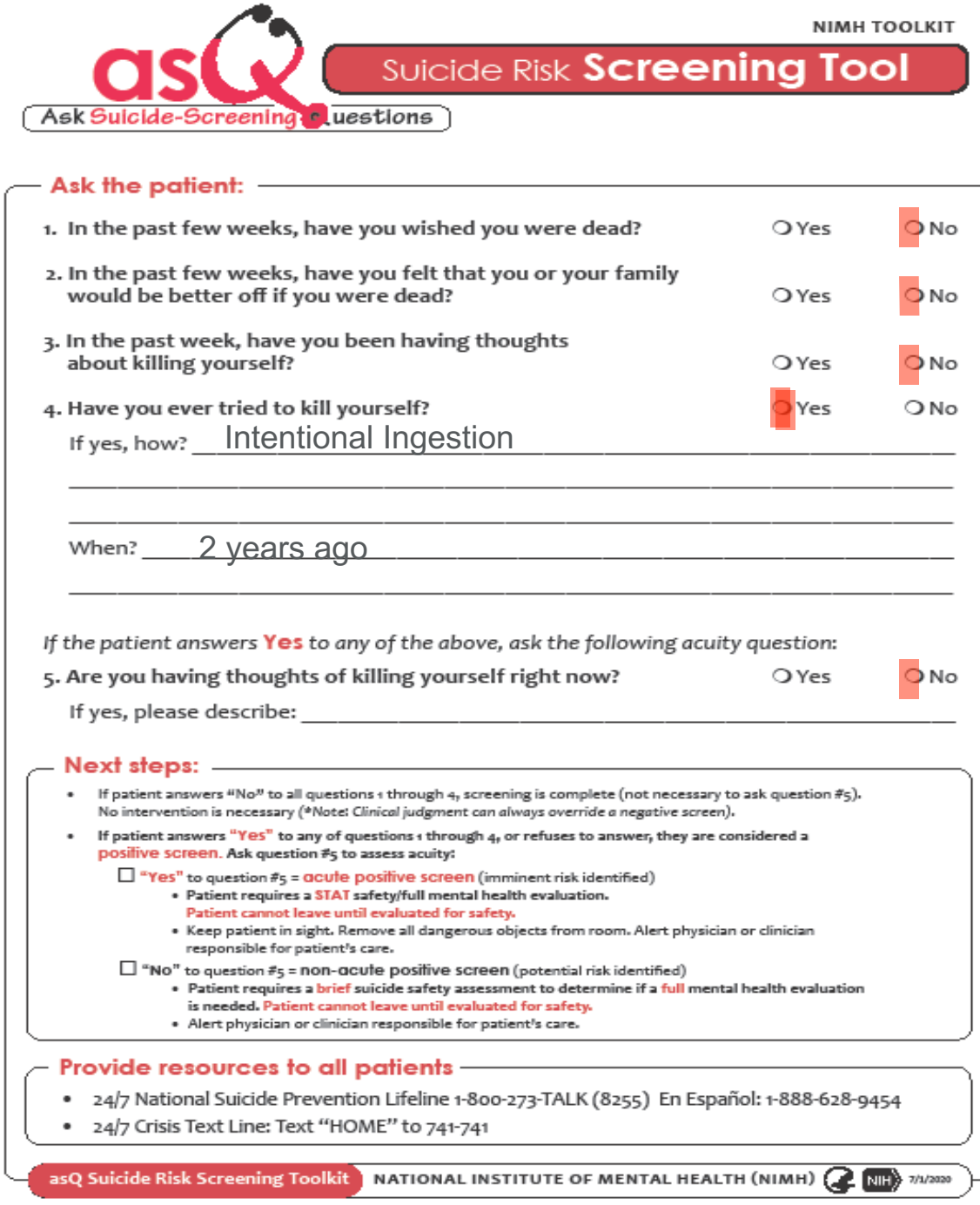

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asQ: Suicide Risk Screening Tool

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asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) NIH 7/1/2020

What are next steps?

A. Complete the C-SSRS
B. Complete a full mental health evaluation
C. No additional steps necessary

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   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: Drown self in bathtub

Next steps:

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What are the next steps?

A. Complete C-SSRS
B. Ensure pt is supervised until next steps are determined
C. Contact Parent to discuss safety
D. Contact PIRC to discuss next steps
E. All of the Above

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