

# Ask Suicide-Screening Questions (ASQ):

## A Brief Introduction

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



# Housekeeping and Helpful Hints

- Bathrooms
- Take breaks as needed
- Ask questions
- Suicide is an intense topic – take care of yourself

# CEU Information

- The State of Ohio Counselor, Social Worker and Marriage and Family Therapist Board has approved this seminar for 4 CEU credits. Cincinnati Children's Hospital Medical Center is an approved provider by the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board (provider number RCX111201 and RSX030902).
- No partial credit will be given.
- Be sure your sign in and your email is correct.
- Failure to complete sign in, full attendance and survey may result in CEU not given.

# 48 Hours to Complete Survey

You must complete the survey through **Survey Monkey** within **48 hours** of completion of the training. **CEU credit** will **NOT** be provided if you do not complete the survey within this timeframe.

# 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)

# Three Tiered Clinic Pathway to Assess for Suicide Risk

1. **ASQ:** four brief 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. **C-SSRS:** more comprehensive evaluation that confirms/estimates suicide risk.
  - Used to guide next steps for safety planning or additional assessment
3. **Full Psychiatric Evaluation:** at the Emergency Department, Bridge Clinic, or Best Point Urgent Care
  - Used to guide next steps for safety planning, short term crisis therapy or hospitalization

# 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

# 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?

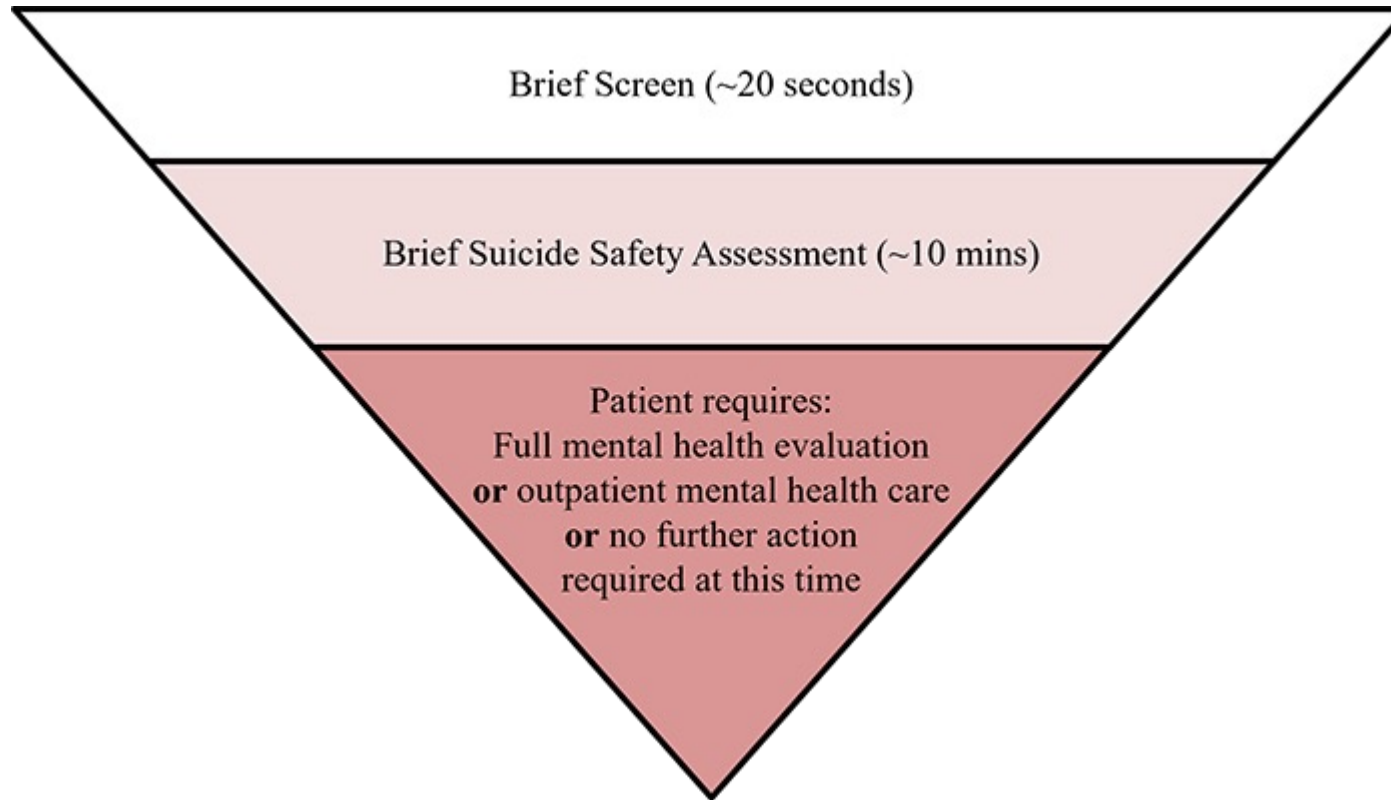


# Acuity Question

- Ask only if individual has answered 'Yes' to any of the previous 4 questions
1. Are you having thought of killing yourself right now? Yes, No
    - If yes, please describe:

# 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 (C-SSRS) to determine next steps
- Acute Positive
  - Individual answers 'yes' to the 5<sup>th</sup> question
  - Complete C-SSRS and call PIRC to coordinate directions on next steps



# 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

# Psychiatric Intake Response Center (PIRC)

Psychiatric  
Intake  
Response  
Center  
(PIRC)

513-636-4124



# What does PIRC do?

**Serves as a community resource to connect children to the right level of care and takes emergency department referrals**

- Can take information to be share with the individual assessing the child in the emergency department.
- If referral is made, provide you with information on decisions made while the child was in the emergency department.
- Connect a child to alternative crisis care via the Bridge Clinic.





Ask **Suicide-Screening** Questions

NIMH TOOLKIT

## Suicide Risk Screening Tool

### 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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- B. Complete a full mental health evaluation
- C. No additional steps necessary

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\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_

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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- 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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