NIMH TOOLKIT: SCREENING TOOL FOR YOUTH AND ADULTS

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, when was the most recent attempt? _____ ○ Within last 12 months ○ Over 1 year ago

*If patient answers **Yes** to any of Questions #1 through #4, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ○ Yes ○ No
   If yes, describe briefly: _____

Screening result and next steps:

No to all Questions #1–#4

Negative screen

No intervention is necessary at this time. **NOTE:** Clinical judgment can always override a negative screen.

Yes to any of Questions #1–#4 and…

Yes to Question #5

Acute positive screen (imminent/acute risk identified)

- **Patient requires a STAT/urgent safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
- Keep patient in sight. Remove dangerous objects from room (if possible).
- Alert clinician responsible for patient's care.

No to Question #5

Non-acute positive screen (potential risk identified)

- **Patient needs a brief suicide safety assessment to determine if a full mental health evaluation is needed (and when).**

  EXCEPTIONS: When positive screen is solely due to Yes on Question #4 (i.e., lifetime suicide attempt), then a brief suicide safety assessment may not be necessary if:

  For adults: most recent attempt is >1 year ago

  For youth/young adults (e.g. under age 25): most recent attempt is >1 year ago AND a documented brief suicide safety assessment has been conducted since that attempt
- Non-acute positive status does NOT require 1-to-1 observation while patient is awaiting further assessment (unless there are other safety concerns).
- **If adult patient, or parent/guardian of youth patient, refuses the brief suicide safety assessment, document the refusal. Patient can be permitted to leave, unless there are other safety concerns.** Follow-up call is recommended.
- Alert clinician responsible for patient's care.

If the patient refuses to answer the screening questions:

- **For youth**, refusal is considered a **non-acute positive screen**.
- **For adults**, refusal is NOT considered a positive screen. No intervention is necessary at this time unless there are other safety concerns. Document the refusal.

Provide resources to all patients:

- **988 Suicide and Crisis Lifeline:** call or text **988**, and 988lifeline.org
- **Crisis Text Line:** text HOME or HOLA to 741741, and www.crisistextline.org

National Institute of Mental Health

asQ Toolkit: www.nimh.nih.gov/asQ

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