[Insert organisation name/logo]

# SUICIDE RISK SCREENER TEMPLATE

|  |  |  |  |
| --- | --- | --- | --- |
| **Client name** |  | **Client ID**  |  |
| **Screen completed by**  |  |
| **Date** |  | **Time: .am/pm** |

**I need to ask you a few questions on how you have been feeling, is that ok?**

|  |
| --- |
| **1. In the past 4 weeks did you feel so sad that nothing could cheer you up?**□All of the time □Some of the time□Most of the time □A little of the time □None of the time |
| **2. In the past 4 weeks, how often did you feel no hope for the future?**□All of the time □Some of the time□Most of the time □A little of the time □None of the time |
| **3. In the past 4 weeks, how often did you feel intense shame or guilt?**□All of the time □Some of the time□Most of the time □A little of the time □None of the time |
| **4. In the past 4 weeks, how often did you feel worthless?**□All of the time □Some of the time□Most of the time □A little of the time □None of the time |
| **5. Have you ever tried to kill yourself?**

|  |  |
| --- | --- |
| **Yes\*** | **No** |

**If Yes,**1. How many times have you tried to kill yourself? □ Once □Twice □3 +
2. How long ago was the last attempt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please mark □ In the last 2 months □ 2-6 months ago □ 6-12 months ago  □ 1-2 years ago □More than 2 years ago1. Have things changed since? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **6. Have you gone through any upsetting events recently?** **(tick all that apply**)

|  |  |
| --- | --- |
| **Yes\*** | **No** |

□ Family breakdown □ Relationship problem □ Impending legal prosecution □Trauma □ Chronic pain/illness □Loss of loved one □Child custody issues □ Conflict relating to sexual identity□ Other (specify below)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Yes\*** | **No** |

**7. Have things been so bad lately that you have thought about killing yourself?** **If No, skip to question number 10.** **If Yes, please complete below**a. How often do you have thoughts of suicide? \_\_\_\_\_\_\_\_\_\_\_\_\_\_b. How long have you been having these thoughts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_c. How intense are these thoughts when they are most severe? □Very intense □Intense □Somewhat intense □Not at all intensed. How intense are these thoughts in the last week?□Very intense □Intense □Somewhat intense □Not at all intense |
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| --- | --- |
| **Yes\*** | **No** |
| **Yes\*** | **No** |
| **Yes\*** | **No** |

**8. Do you have a current plan for how you would attempt suicide?** **If Yes, please complete below**a. What method would you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Access to means?) b. Where would this occur?\_\_\_\_\_\_\_\_\_(Have all necessary preparations been made?)c. How likely are you to act on this plan in the near future? □ Very likely □ Likely □ Unlikely □ Very unlikely |
| **9. What has stopped you acting on these suicidal thoughts?** |
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|  |  |
| --- | --- |
| **Yes\*** | **No** |

**10. Do you have any friends/family members you can confide in if you have a serious problem?** 1. Who is/are this/these person/people? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How often are you in contact with this/these person/people? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Daily □ A few days a week □ Weekly □ Monthly □ Less than once a month |
| **11. What has helped you through difficult times in the past?** |

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| **Client presentation/statements (tick all that apply)** □ Agitated □Disorientated/confused □Delusional/ hallucinating □Intoxicated □ Self-harm □ Other: \_\_\_\_\_\_\_\_\_**NOTE**: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically HIGH |

**Yes\*** = Indicates high risk answer

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| **Workers rated risk level** | **□ Low** | **□ Moderate** | **□ High** |

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| --- | --- |
| **Level of risk**  | **Suggested response** |
| **Low** * No plans or intent
* No prior attempt/s
* Few risk factors
* Identifiable ‘protective’ factors
 | * Monitor and review risk frequently
* Identify potential supports/contacts and provide contact details
* Consult with a colleague or supervisor for guidance and support
* Refer client to safety plan and keep safe strategies should they start to feel suicidal.
 |
| **Moderate*** Suicidal thoughts of limited frequency, intensity and duration
* No plans or intent
* Some risk factors present
* Some ‘protective’ factors
 | * Request permission to organise a specialist mental health service assessment as soon as possible
* Refer client to safety plan and keep safe strategies as above
* Consult with a colleague or supervisor for guidance and support
* Remove means where possible
* Review daily
 |
| **High\*:** * Frequent, intense, enduring suicidal thoughts
* Clear intent, specific/well thought out plans
* Prior attempt/s
* Many risk factors
* Few/no ‘protective’ factors

\*or highly changeable | * If the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone
* Remove means where possible
* Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available
* Consult with a colleague or supervisor for guidance and support
 |

Reference:

Suicide Assessment Kit (SAK). Deady, M., Ross, J. & Darke, S. (2011) Sydney, National Drug and Alcohol Research Centre (NDARC).