

### Youth Suicide Risk Assessment Form

Student name \_\_\_\_\_ Date of assessment \_\_\_\_\_

Referral source (name / title): \_\_\_\_\_

Assessed by (name / title): \_\_\_\_\_

Reason for referral:

Student description of problem (use student’s words):

#### I. IDEATION

Does the student report thoughts of suicide?  Yes  No

Timeframe:

Right now  Yes  No

Past 24 hours  Yes  No

Past week  Yes  No

Past month  Yes  No

Past year / lifetime  Yes  No

When does the student first remember having thoughts of suicide? \_\_\_\_\_

Describe ideation in student’s words:

**Frequency** (every minute / hourly / daily / weekly): \_\_\_\_\_

**Duration** (a few seconds / minutes / hours / days): \_\_\_\_\_

**Intensity** (not disruptive → completely disruptive): \_\_\_\_\_

**Location** (where the ideation occurs): \_\_\_\_\_

What stops or interrupts the ideation? When and where is it **not** present?

**II. INTENT**

How much does the student want to **die**?  not at all  somewhat  a great deal  
Describe intent in student’s words:

How much does the student want to **live**?  not at all  somewhat  a great deal  
When is the student’s desire to live stronger? What is different when he or she wants to live?

**III. PLAN**

<b>Does the student report a plan?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Specific	<input type="checkbox"/> Vague
	<input type="checkbox"/> Imminent	<input type="checkbox"/> Future imminent

**Has the student written a suicide note?**  Yes  No

**How does the student envision dying?**

gun  hanging  cutting  pills  jumping  suffocation  other \_\_\_\_\_

Does the student have access to the means?  Yes  No

Does the student know how to use the means?  Yes  No

Where does the student envision dying? \_\_\_\_\_

When does the student envision dying? \_\_\_\_\_

**Has the student made an attempt in the past?**  Yes  No

How recently? \_\_\_\_\_

Did someone interrupt it?  Yes  No

Did the student stop him or herself?  Yes  No

Did it result in hospitalization?  Yes  No

Describe the current **suicide plan** in the student’s words:

What would make it more likely that the student will follow through with the plan (**triggers**)?

What could **reduce the likelihood** that the student will follow through with the plan?

**IV. STRENGTHS AND RESOURCES**

What are the student's **reasons for living**?

What **family member** or adult does the student identify as a support?

What **friends / peers** does the student identify as supports (online or offline)

What is the student good at / likes to do / enjoys doing? What does the student look forward to doing?

**V. RISK FACTORS** (check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Prior suicide attempt                   | <input type="checkbox"/> Gun in the home                               | <input type="checkbox"/> Chronic illness     |
| <input type="checkbox"/> Failing a grade / repeating a grade     | <input type="checkbox"/> Dissatisfied with grades                      | <input type="checkbox"/> Conflict with staff |
| <input type="checkbox"/> Suspended from school                   | <input type="checkbox"/> Disciplinary crisis                           | <input type="checkbox"/> Conduct disorder    |
| <input type="checkbox"/> Recent humiliation in front of peers    | <input type="checkbox"/> Socially isolated                             | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Recent suicide death of friend / family | <input type="checkbox"/> General dislike of school                     | <input type="checkbox"/> Stressful events    |
| <input type="checkbox"/> Victim of intimate partner violence     | <input type="checkbox"/> Sexual abuse                                  | <input type="checkbox"/> Physical abuse      |
| <input type="checkbox"/> Sleep disturbance / insomnia            | <input type="checkbox"/> Victim of (cyber) bullying                    | <input type="checkbox"/> Substance abuse     |
| <input type="checkbox"/> Depression / bipolar depression         | <input type="checkbox"/> Perpetrator of (cyber) bullying               | <input type="checkbox"/> PTSD                |
| <input type="checkbox"/> Perceived burden to others              | <input type="checkbox"/> Self-injurious behavior (NSSI; cutting, etc.) | <input type="checkbox"/> Legal involvement   |
| <input type="checkbox"/> Other _____                             |  |  |

**VI. PRESENTATION AT TIME OF ASSESSMENT** (Check all that apply)**Emotional state**

- |                                      |                                    |                                  |
|--------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Numb        | <input type="checkbox"/> Depressed | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Irritable   | <input type="checkbox"/> Angry     | <input type="checkbox"/> Scared  |
| <input type="checkbox"/> Other _____ |                                    |                                  |

**Cognitive state**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Hopeless about future                    | <input type="checkbox"/> Blaming self      | <input type="checkbox"/> Blaming others |
| <input type="checkbox"/> Rigid thinking                           | <input type="checkbox"/> Poverty of speech | <input type="checkbox"/> Confused       |
| <input type="checkbox"/> Auditory, visual, tactile hallucinations | <input type="checkbox"/> Poor insight      | <input type="checkbox"/> Unrealistic    |
| <input type="checkbox"/> Poor judgment                            | <input type="checkbox"/> Other _____       |   |

**Behavioral state**

- |   |                                      |                                      |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Lethargic          | <input type="checkbox"/> Agitated    | <input type="checkbox"/> Impulsive   |
| <input type="checkbox"/> Abnormal movements | <input type="checkbox"/> Threatening | <input type="checkbox"/> Risk-taking |
| <input type="checkbox"/> Other _____        |                                      |                                      |

**VII. ASSESSMENT OF SCHOOL ENVIRONMENT**

School staff interviewed \_\_\_\_\_

Documents reviewed \_\_\_\_\_

Recent changes in **schoolwork**? Yes  No

Describe:

Recent changes in **emotions/mood**? Yes  No

Describe:

Recent changes in **thoughts/cognitions**? Yes  No

Describe:

Recent changes in **behaviors** (discipline)? Yes  No

Describe:

Changes in **appearance**? Yes  No

Describe:

Changes in **peer interaction**? Yes  No

Describe:

Any **environmental stressors**? (e.g., this calendar-year, such as academic testing or activities such as significant sports loss or upsetting assemblies, classroom presentations, school disruptions or teacher changes, etc?) Yes  No

Describe:

Any **comments indicating suicidal ideation, self-destruction or death**? Yes  No

Describe:

**VIII. ASSESSMENT OF PARENT(S)/GUARDIAN(S)**

Parent/guardian interviewed \_\_\_\_\_

Has your child ever mentioned having thoughts of suicide or dying?

 Yes  No

If so, when and how often?

Describe:

How likely do you think it is that he/she would act on these thoughts? Please describe:

Can you think of anything that has been very **stressful** for your child lately, such as the loss of a family member or change in family structure (e.g., parent moves in or out)? Please describe:

Have you noticed a change in what you would consider normal for your child in terms of his/her **behavior** - either significantly more active (e.g., engaging in risky behaviors or harming him/herself) or withdrawn (e.g., not participating in activities that he/she would normally)? Please describe:

Have you noticed a change in what you would consider normal for your child in terms of his/her **emotions** – either significantly more emotional (e.g., sad, angry, scared) or less emotional (e.g., quiet, withdrawn, unresponsive) than usual? Please describe:

Have you noticed a change in what you would consider normal for your child in terms of his/her **thoughts** – either significantly more preoccupied or significantly less able to concentrate and focus on any one thing?

**Does your child know anyone who has died by suicide or attempted suicide? If so, who and when?**

#### **IX. RISK ASSESSMENT SUMMARY**

1. **Low risk:** None or passing ideation that does not interfere with activities of daily living; reports no desire to die (i.e., intent), has no specific plan, exhibits few risk factors, and has identifiable protective factors.
2. **Moderate risk:** Reports frequent suicidal ideation with limited intensity and duration; has some specific plans to die by suicide but no reported intent. Demonstrates some risk factors but is able to identify reasons for living and other protective factors.
3. **High risk:** Reports frequent, intense, and enduring suicidal ideation. Reports specific plans, including choice of lethal methods and availability / accessibility of the method. Student presents with multiple risk factors and identifies few if any protective factors. If the student has written a suicide note, the student is immediately considered at high risk.

**OVERALL RISK LEVEL (summary):** Student meets criteria for **low / moderate / high** suicide risk based on the following information *(If a student falls between levels, err on the side of caution and assume higher risk category):*

**X. ACTIONS TAKEN / RECOMMENDATIONS**

Actions taken should be a direct result of the risk level identified above in collaboration with your school district procedure. In all cases, parents should be notified to inform them you met with their child.

Parent/guardian contacted?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Released to parent/guardian?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Referrals provided to parent?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Safety plan developed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Recommending removal of method/means?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If currently in treatment, contact made with therapist/psychiatrist?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Outpatient therapy recommended?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Recommending 24-hour supervision?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hospitalization recommended?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Release of Information signed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Copy of this assessment provided to referral?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Consultation received?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Other? Please describe:

_____ Assessor's signature and credentials	_____ Date
Reviewed by:	
_____ Name and credentials	_____
_____ Signature	_____ Date

**Note:** This form is intended for use by qualified mental health professionals who have been trained in how to conduct a youth suicide assessment. For a more in-depth explanation of how to use this form, please refer to chapter 6 of Erbacher, Singer and Poland (2015): *Suicide in Schools: A Practitioner's Guide to Multi-Level Prevention, Assessment, Intervention and Postvention*. New York: Routledge Press.