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# SUICIDE RISK SCREENER INSTRUCTIONS

**🖌Note\***

All the information included in this document is part of the SAK\*, Suicide Assessment Kit National from the Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia

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

## How to complete the Suicide Risk Screener

As stress can reduce a client’s capacity to concentrate, it is important to speak clearly, slowly and calmly when completing the screener. Furthermore, client intoxication prevents an accurate assessment. Importantly, however, the resulting lack of inhibition and increased impulsivity caused by intoxication may greatly increase the risk of suicide 7. If the client is intoxicated and reporting suicidal ideation, the client’s suicidal risk level is automatically deemed to be high.

### Items 1 – 4:

Hopelessness and other depressive symptoms (e.g., guilt, shame) are important risk factors for suicide. The broad aim of the first four items on the screener is to assess the client’s current emotional state. These items use ‘the past four weeks’ as a timeframe. It may be helpful to read all response categories to the client in order for them to choose the most correct answer. These questions are modified versions of items on the Kessler 10 scale of psychological distress 8.

### Item 5:

Item 5 is a flagged question. This means that a response of “yes” shifts a client automatically into the moderate or high risk categories (depending on responses to ideation (7) and planning (8) questions). Generally, a client scoring two out of three positive responses to these items should be considered ‘high’ risk. This item is emphasised because previous suicide attempts are arguably the clearest predictor for future suicide attempts 9.

After this question has been asked, if the client’s response is “no,” the staff member moves on to Item 6. If the client’s response is “yes,” however, it is necessary to ask and code questions 5a and 5b, relating to the number of past attempts and the recency of these attempts, respectively. The client’s response to question 5b should be written in the space provided and coded in the boxes below it.

### Item 6:

Suicidal thoughts and behaviours often follow a significantly distressing event (e.g., a relationship breakdown or legal issues). The purpose of Item 6 is to establish whether the client has experienced any such personal stressor of late. More than one “event” may be relevant and where this is the case the staff member should tick all that apply. It may be necessary to prompt the client where s/he fails to comprehend what kind of event is being elicited. Where the “upsetting event,” does not fall into any of the listed categories, specify this event in the “other” section.

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### Item 7:

Like Item 5, Item 7 is also flagged. This means that a response of “yes” shifts a client automatically into the moderate or high risk categories (depending on responses to the previous attempts (5) and the planning (8) items). This Item aims to establish whether the client is having thoughts of suicide, a preceding factor to any attempt.

If the client’s response is “no,” the staff member ‘skips’ to Item 10. If the client’s response is “yes,” however, it is necessary to ask and code questions 7a, 7b, 7c and 7d, relating to the frequency and intensity of these thoughts. The client’s response to question’s 7a and 7b should be written in the space provided, while question’s 7c and 7d are to be coded in the boxes provided. It may be appropriate to read all response categories to the client in order for them to pick their most correct answer.

### Item 8:

Like Items 5 and 7, Item 8 is also flagged. Having a plan for suicide indicates premeditation and a serious suicidal intent. This is not to discount the impulsive nature of many suicides, but this level of preparation shows a substantial amount of time has gone into thinking about the act.

After this question has been asked, if the client’s response is “no,” Item 9 is asked. If the client’s response is “yes,” however, and the client does not reveal specific details without prompting, questions 8a, 8b, and 8c, relating to the means, location and likelihood of these plans are asked and coded. The client’s response to question’s 8a and 8b should be written in the space provided. After both questions there is a question in parentheses, staff are NOT to read this out, but rather to consider, based on what they have been told by the client, if the answers to these questions are “yes” or “no.” Finally, the client’s response to question 8c is to be coded in the boxes provided.

### Item 9:

The purpose of Item 9 is two-fold. Firstly, it is important to ascertain what ‘protective’ factors may be operating and how stable these factors are. Secondly, the nature of these factors may directly impact upon the stability of the entire assessment. For instance, if the only thing preventing a client acting on suicidal thoughts is their children, but there is a current custody battle taking place, the stability of the suicide risk is likely to be low. Conversely, this question might also highlight for the client their “reasons for living” and similarly, might indicate to staff the factors which are crucially important to the client and should be a focal point in any treatment plan.

### Item 10:

The purpose of Item 10 is to directly determine the client’s level of social support. Social isolation is a key risk factor for suicide, so it is important to establish whether the client has anyone in their life that they feel they can confide in (and thus draw support from).

If the client’s response to Item 10 is “no,” Item 11 is asked. If the client’s response is “yes,” however, questions 10a and 10b, naming who these people are, and how often s/he is in contact with said people, are asked and coded. The client’s response to question’s 10a should be written in the space provided. The client’s response to question 10b should be written in the space provided and coded in the boxes below.

### Item 11:

Like Item 9, Item 11 can help the client understand their means of coping and similarly, might indicate to staff the factors which are crucially important to the client and should be a focal point in any treatment plan.

## How to score the Suicide Risk Screener

### Risk level

Based on the completed screener the client’s level of suicide risk is coded. There are three distinct categories: low, moderate and high risk. Despite the variation in every client’s presentation, all clients will fall into one of these three broad categories.

A guide outlining the above categories is included as part of the screener (see “suggested response” below). It is important to note that suicidal ideation in combination with either a clear plan, client intoxication or a previous attempt automatically classifies a client as high risk. Classification into the high risk category does not require the client to fulfil the above table perfectly, merely two of these high risk indicators is sufficient. Irrespective of the staff member’s level of experience, it is crucial that they never attempt to manage suicide risk alone. It is anticipated that treatment agencies will have a policy in place outlining the expected consultation process.

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| **Risk level** | **Presentation** |
| Low  | * A client in the low risk category would present no plans or intent;
* No prior attempts;
* Negative thinking patterns only a little/some/none of the time;
* Few risk factors; and
* Identifiable ‘protective’ factors.
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| Moderate  | * Suicidal thoughts of limited frequency, intensity and duration;
* No plans or intent;
* Negative thinking patterns only some of the time;
* Some risk factors present; and
* Some ‘protective’ factors.
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| High | * Frequent, enduring and intense suicidal thoughts and clear intent;
* A definite plan and available means;
* No perceived social support or hope for the future, intense depressive symptoms;
* Previous attempts;
* Many risk factors; and
* Few/no ‘protective’ factors.
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### Client presentation

It is also useful to record the presentation of client at the time of the assessment. Certain presentations in the presence of even mild suicidal ideation can place the client in the HIGH risk category. These presentations include agitation, disorientation, recent self-harm, intoxication and hallucinating/delusional (e.g., hearing voices, fixed false beliefs). This section of the screener allows the AOD worker to assess how the client appears and provides some key high risk presentations which may be apparent. If the client presents in a high risk way which is not listed, it can be coded in the “other” section.

### Suggested response to identified risk

The response to suicide risk categories will depend on the policies and procedures established by your individual service. A guide to both risk level assessment and the appropriate response, however, is presented at the end of the screener. Client’s whose risk level appears changeable require careful re-assessment as soon as possible and should be treated as high risk until this can occur.

Where the guide refers to Safety Plan and Keep Safe Strategies, these resources are contained in the supporting documentation of this resource (pages 29 – 39). It is important to stress that where any suicidal thoughts exist there is a risk to the individual.

On entry to treatment your service may choose to ask clients to sign a Commitment to Treatment contract an example of which is on page 41 of this document.

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| **Risk level** | **Presentation** |
| Low  | * 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.
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| Moderate  | * 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
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| High | * 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
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