Suicide Screener

Printable version (further information referred to is available on the website)

Rationale: NADA recognises the unique opportunity AOD services have to reduce the very serious risk of suicide, and where appropriate assist in linking clients with medical treatment providers. The integration of suicide screening questions into the NADAbase will help ensure all people accessing AOD treatment will be screened as part of standard practice. The Suicide Assessment Kit (SAK) has been developed to support you in this work.

Process: All clients are to be screened for risk of suicide using the below questions and pre-amble. Clients are to be made aware that these questions are standard practice and they will not be excluded from the service based on their responses. **Clients will not be asked to complete these questions themselves.** Messages for consideration are included in text boxes like this one.

Read the statement:

To better assist us in providing support and information to you, we ask all our clients a set of questions that tells us about their situation. We ask these questions a few times throughout the program to help people tell us about their experiences when they are ready. These questions may or may not apply to you and you don't have to answer if you don't want to. We may share results with your medical treatment team in consultation with you and as part of a holistic care plan. We also want you to know that support is always available to you via Lifeline on 13 11 14.

SECTION A

1. I need to ask you a few questions on how you have been feeling, is that ok?
- ☐ Yes
- ☐ No
- ☐ Did not ask

2. In the past 4 weeks did you feel so sad that nothing could cheer you up?
- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Don't wish to say
- ☐ Did not ask

3. In the past 4 weeks, how often did you feel no hope for the future?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Don't wish to say
- ☐ Did not ask

4. In the past 4 weeks, how often did you feel intense shame or guilt?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Don't wish to say
- ☐ Did not ask

5. In the past 4 weeks, how often did you feel worthless?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time
- ☐ Don't wish to say
- ☐ Did not ask

Note: Response boxes marked in red indicates a high or moderate risk answer. If yes is selected, ensure your agency's policy for assessing the safety of the client is followed. If your agency does not have a policy relating to managing suicide risk, please refer to the Suicide & Self Harm Prevention Section taken from the Client Clinical Management Policy, NADA Policy Toolkit. The Suicide Assessment Kit (SAK) has also been developed to support you in this assessment.

6. Have you ever tried to kill yourself?

- ☐ Yes*
- ☐ No
- ☐ Don't wish to say
- ☐ Did not ask

If YES is selected at Question 6 the below shadowed questions are to be responded to.

a. How many times have you tried to kill yourself?

- ☐ Once
- ☐ Twice
- ☐ Three times or more
- ☐ Don't wish to say
- ☐ Did not ask

b. How long ago was the last attempt?
☐ In the last 2 months
☐ 2–6 months ago
☐ 6-12 months ago
☐ 1-2 years ago
☐ More than 2 years ago
☐ Don't wish to say
☐ Did not ask

c. Have things changed since?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

7. Have you gone through any upsetting events recently? (*tick all that apply*)
☐ Family breakdown
☐ Relationship problem
☐ Loss of loved one
☐ Conflict relating to sexual identity
☐ Impending legal prosecution
☐ Child custody issues
☐ Chronic pain/illness
☐ Trauma
☐ Homelessness
☐ Loss of job
☐ Not applicable
☐ Don't wish to say
☐ Did not ask

8. Have things been so bad lately that you have thought about killing yourself?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

If YES is selected at Question 8 the below shadowed questions are to be responded to.

a. How often do you have thoughts of suicide?
☐ Daily
☐ Weekly
☐ Monthly
☐ Don't wish to say
☐ Did not ask

b. How long have you been having these thoughts?
☐ In the last 2 months

☐ 2–6 months ago
☐ 6-12 months ago
☐ 1-2 years ago
☐ More than 2 years ago
☐ Don't wish to say
☐ Did not ask

c. How intense are these thoughts when they are most severe?
☐ Very intense
☐ Intense
☐ Somewhat intense
☐ Not at all intense
☐ Don't wish to say
☐ Did not ask

d. How intense have these thoughts been in the last week?
☐ Very intense
☐ Intense
☐ Somewhat intense
☐ Not at all intense
☐ Don't wish to say
☐ Did not ask

e. Do you have a current plan for how you would attempt suicide?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

If YES is selected at Question 8e the below shadowed questions are to be responded to.

f. Do you have access to means?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

g. Have all necessary preparations been made?
☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

h. How likely are you to act on this plan in the near future?
☐ Very likely
☐ Likely
☐ Unlikely
☐ Very Unlikely

☐ Don't wish to say
☐ Did not ask

9. Do you have any friends/family members you can confide in if you have a serious problem?

☐ Yes
☐ No
☐ Don't wish to say
☐ Did not ask

If YES is selected at Question 9 the below shadowed questions are to be responded to.

a. Who is/are this/these person/people? (*tick all that apply*)
   ☐ Friend
   ☐ Partner
   ☐ Carer/counsellor
   ☐ Parent
   ☐ Peer
   ☐ Sibling
   ☐ Child
   ☐ Other family member
   ☐ Don't wish to say/no response

b. How often are you in contact with this/these person/people?
   ☐ Daily
   ☐ A few days a week
   ☐ Weekly
   ☐ Monthly
   ☐ Less than once a month
   ☐ Don't wish to say
   ☐ Did not ask

10. Client presentation/statements (*tick all that apply*)

☐ Agitated
☐ Disorientated/confused
☐ Delusional/hallucinating
☐ Intoxicated
☐ Self-Harm

Alert: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically **HIGH**. Ensure your agency's policy for assessing the safety of the client is followed. The Suicide Assessment Kit (SAK) has also been developed to support you in this assessment with guidance on how to respond to each level of risk. The clinician is to complete the below risk level of the client based on responses to questions and using the SAK as guidance in the final assessment.

Clinician rated risk level of client

☐ Low

☐ Moderate
☐ High

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 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	• 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

11. Action/s taken as a result of the screener. (*at least one box must be selected)*

☐ Action added to client care plan
☐ Referral made to external service
☐ Referral made to internal service
☐ Consultation recorded in client progress notes
☐ No action taken