DEPARTMENT OF JUVENILE JUSTICE
SUICIDE RISK SCREENING INSTRUMENT
(Must be completed on JJIS)

Identifying Data: DJJID:_____ Referral#: _____

_____ _____ _____
Youth's Name Date of Birth Age

_____
Aliases

_____
Parent/Guardian

_____
Address/Telephone

_____
Date/Time Detained

Statute Number/Offense(s)

Interview of Arresting/Transporting Officer (To be completed by Juvenile Probation Officer before the officer leaves)

Officer's Name: _____ Badge/ID#:_____

If Yes, Place youth on Suicide Precautions and constant supervision
Refer youth for immediate Suicide Risk Assessment Agency/Provider:

	YES	NO
Do you have any reason to think this youth will try to kill himself?	☐	☐

Explain: _____

Other Comments:_____

Juvenile Probation Officer Interview Of Child (Juvenile Probation Officer shall ask the youth the following questions)

If Yes, for questions 1 or 2, place youth on Suicide Precautions and constant supervision
Refer youth for immediate Suicide Risk Assessment

	YES	NO
1. Have you tried to kill yourself in the past 6 months?	☐	☐
When? _____		
How? _____		
2. Are you thinking about killing yourself now?	☐	☐
Explain: _____		
3. Have you ever tried to kill yourself?	☐	☐
When? _____		
How? _____		

Other Comments: _____

If Yes, for question 3, place youth on Suicide Precautions and constant supervision
Refer youth for Suicide Risk Assessment to be conducted within 24 hours, or immediately if the youth is in need of emergency services or crisis intervention.

Youth's Current DJJ or DCF Involvement: (Check all that apply)

☐ Delinquency Intake	☐ Conditional Release	☐ Foster Care
☐ Probation	☐ Child Protective Investigation	☐ Adoptions
☐ Delinquency Commitment	☐ Protective Services	☐ None

DCF Case Manager/Counselor(s): _____ DJJ Probation Officer: _____

Juvenile Probation Officer Interview of Parent/Guardian or Relative and/or Assigned DCF Case Manager/Counselor:

(To be completed by Juvenile Probation Officer (JPO) during the intake process. Interview the parent, legal guardian or relative and/or assigned DCF case manager/counselor. If the parent/legal guardian or relative is unavailable, the JPO must document that he/she initiated contact, but was unable to interview parent/legal guardian or relative and proceed with screening and contact the next day.Detention must be immediately notified if one or more "Yes" responses are provided for questions 1 through 6.)

Parent/Legal Guardian or Relative Name: _____

Relationship: _____ Contacted Date/Time _____

Initiated Contact Date/Time: _____ Initiated Contact Date/Time: _____

Comments: _____

Assigned DCF Case Manager/Counselor: _____ Contacted Date/Time _____

Comments: _____

If Yes for question 1, place youth on Suicide Precautions and constant supervision . Refer youth for immediate Suicide Risk Assessment

	Parent/Guardian Or Relative		Assigned DCF Case Manager/Counselor	
	Yes	No	Yes	No
1. Has the child tried to kill himself in the past six months?	☐	☐	☐	☐
When? _____				
How? _____				

If one or more Yes for questions 2-6, place youth on Suicide Precautions and constant supervision . Refer youth for Suicide Risk Assessment to be conducted within 24 hours, or immediately if the youth is in need of emergency services or crisis intervention.

2. Has the child threatened to kill himself in the past six months?	☐	☐	☐	☐
Explain: _____				
3. Has the child ever tried to kill himself?	☐	☐	☐	☐
When? _____				
How? _____				
4. Have you noticed the child having any of the following behaviors: Giving away his favorite things, dropping close friends, drastic changes in eating or sleeping habits, saying that things are hopeless?	☐	☐	☐	☐
5. Other than being arrested and detained, has the child had a major change or loss in the past six months, such as a death, divorce of parents, breaking up with (girlfriend, boiyfriend, etc?)	☐	☐	☐	☐
Explain: _____				
6. Does the child have any serious mental health problems (e.g. depression, withdrawn, hears voices, etc.)?	☐	☐	☐	☐
Explain: _____				
7. Has someone this child knows well committed suicide?	☐	☐	☐	☐
Who? _____				
When? _____				
How? _____				

8. Is there any other information that will help us in caring for this child?

Explain: _____

Other Comments: _____

Juvenile Probation Officer & Detention Officer Observations

(These are not interview questions. **DO NOT ASK THE YOUTH THESE QUESTIONS** but observe the youth during the intake process and record the observations.)

Have you observed any of the following:

If one or more Yes for questions 1 through 3, place youth on Suicide Precautions and constant supervision Refer youth for immediateSuicide Risk Assessment	Intake Screener YES	Intake Screener NO	Detention Officer YES	Detention Officer NO
1. Threatening to kill self/preoccupied with suicide.	☐	☐	☐	☐
2. Fresh wounds/injuries that appear to be self-inflicted.	☐	☐	☐	☐
Describe: _____				
3. Do you have any other reason to think that the youth will try to kill himself?	☐	☐	☐	☐
Explain: _____				

If one or more Yes for questions 4 through 6, place youth on Suicide Precautions and constant supervision Refer youth for Suicide Risk Assessment to be conducted within 24 hours, or immediately if the youth is in need of emergency services or crisis intervention				
4. Symptoms of alcohol/drug withdrawal (depression, anxiety, jittery).	☐	☐	☐	☐
5. Dramatic mood changes (e.g., from crying to laughing in a short period of time).	☐	☐	☐	☐
Describe: _____				
6. Indications of self-mutilating behavior (e.g., marks/scars or cigarette burns observed).	☐	☐	☐	☐
Describe: _____				
Other Comments: _____				

JUVENILE PROBATION OFFICER NAME: _____

Observation Complete: Date/Time: _____

DETENTION OFFICER NAME: _____

Observation Complete: Date/Time: _____
Shift: _____

Juvenile Probation Officer Screening Results

☐ No referral necessary based on available information.

_____
Juvenile Probation Officer Signature

☐ Telephone consultation with assessor:
- ☐ Assessor will see child immediately
- ☐ Assessor will see child within 24 hours

Referred to: _____

Referred by: _____

Date/Time: _____ _____
Intake Screener's Signature

Juvenile Probation Officer Screening Results

Suicide Risk Assessment Results

(This section must be completed by a licensed mental health professional or mental health clinical staff person working under the direct supervision of a licensed mental health professional)

Assessed by: _____ _____
Date/Time

Results:
POTENTIAL SUICIDE RISK ☐ YES ☐ NO

_____
Assessor's Signature

Recommended:
Supervision:

- ☐ One-to-One Supervision
- ☐ Constant Supervision
- ☐ Step Down to Close Supervision
- ☐ Standard Supervision _____

Intervention:
Describe: _____

_____
Licensed Mental Health Professional's Signature and License Number

Detention Officer Screening Results

☐ No referral necessary based on available information.

_____
Detention Officer Supervisor's Signature

☐ Telephone consultation with assessor:

- ☐ Assessor will see child immediately
- ☐ Assessor will see child within 24 hours

Referred to: _____

Referred by: _____

Date/Time: _____ _____
Detention Officer Supervisor's Signature

Suicide Risk Assessment Results

(This section must be completed by a licensed mental health professional or mental health clinical staff person working under the direct supervision of a licensed mental health professional)

Assessed by: _____ _____
Date/Time:

Results:
POTENTIAL SUICIDE RISK ☐ YES ☐ NO

_____
Assessor's Signature

Recommended:
Supervision:

Intervention:
Describe: _____

Suicide Precautions: ☐ Precautionary Observation ☐ Secure Observation

- ☐ One-to-One Supervision
- ☐ Constant Supervision
- ☐ Step Down to Close Supervision
- ☐ Standard Supervision _____

_____
Licensed Mental Health Professional's Signature and License Number

Nursing Screening or Mental Health Clinical Staff Screening

(Is to be filled out by Nurse or Mental Health Clinical Staff Person. The questions should be alternated with usual health questions.)

If one or more Yes for questions 1 or 2, place youth on Suicide Precautions and constant supervision & refer youth for immediate Suicide Risk Assessment. Consult with assessor immediately.

	YES	NO
1. Have you tried to kill yourself in the past six months?	☐	☐
When? _____		
How? _____		
2. Are you thinking of hurting or killing yourself now?	☐	☐
Explain: _____		

If Yes for questions 3 through 7, place youth on Suicide Precautions and constant supervision & refer youth for Suicide Risk Assessment to be conducted within 24 hours or immediately if the youth is in need of emergency services or crisis intervention. Consult with assessor within 24 hours.

3. Do you feel that there is no future, that life is not worth living?	☐	☐
4. Have you recently put yourself in a situation where you could have been seriously hurt or killed? (e.g., reckless driving while drunk or high, etc.)	☐	☐
Explain: _____		
5. Have your sleeping or eating habits changed recently?	☐	☐
6. Other than being arrested and detained, have you had a major change or loss in the past six month, such as a death divorce of parents, breaking up with a boy or girl friend, etc.?	☐	☐
Explain: _____		
7. Have you ever tried to kill yourself?	☐	☐
When? _____		
How? _____		
8. Has anyone in your family or any close friend ever killed himself or tried to kill himself?	☐	☐
Who? _____		
When? _____		
How? _____		
Other Comments: _____		

Nurse's Name: _____
Interview Complete: Date/Time: _____
Shift: _____

Mental Health Clinical Staff Person's Name: _____
Interview Complete: Date/Time: _____
Shift: _____

Nursing Screening or Mental Health Clinical Staff Screening Results

☐ No referral necessary based on available information.

_____ _____
Nurse's Signature Mental Health Clinical Staff Person's Signature

☐ Telephone consultation with assessor: ☐ Assessor will see child immediately
☐ Assessor will see child within 24 hours

Referred to: _____

Referred by: _____

Date/Time: _____

_____ _____
Nurse's Signature Mental Health Clinical Staff Person's Signature

Suicide Risk Assessment Results

(This section must be completed by a licensed mental health professional or mental health clinical staff person working under the direct supervision of a licensed mental health professional)

Assessed by: _____ _____
Date/Time

Results:
POTENTIAL SUICIDE RISK ☐ YES ☐ NO _____
Assessor's Signature

Recommended Supervision: Intervention: Describe: _____

Suicide Precautions: ☐ Precautionary Observation ☐ Secure Observation

☐ One-to-One Supervision
☐ Constant Supervision
☐ Step Down to Close Supervision
☐ Standard Supervision _____

_____
Licensed Mental Health Professional's Signature and License Number

Comments:

Copies to: Case File, Nurse or Mental Health Clinical Staff Person, Detention File, Mental Health Assessor