PROGRAM NAME:

CLIENT NAME:       CASE NUMBER:

**ASSESSMENT OF RISK FACTORS:** Any “yes” response should be addressed in the overall risk and treatment planning section. For all unlicensed staff and trainees, documentation of a consultation with a Program Manager or Licensed/Reg/Waivered designee is required. **Any “yes” response for questions with an (\*) should elicit enhanced precaution, which would require review and creation of a safety plan with a licensed supervisor prior to the end of session with client.**

Has client had suicidal ideation in the past 12 months: Yes No Unable to Assess

If Yes:

Thoughts but not intention or plan? Yes No Unable to Assess

Thoughts with intention, but no plan? Yes No Unable to Assess

\*Thoughts, intention and plan? (method/means?) Yes No Unable to Assess

Does client have past suicidal behaviors? Yes No Unable to Assess

(Things to consider: first attempt, most serious attempt, substance involvement,

complications, how was it prevented?)

Has client had violent/homicidal ideation or impulses in the past 12 months? Yes No Unable to Assess

If Yes:

Thoughts/impulses, but no intention or plan? Yes No Unable to Assess

Thoughts/impulses with intention, but no plan? Yes No Unable to Assess

\*Thoughts/impulses with intention and plan? (method/means?) Yes No Unable to Assess

Does the client have past violent behaviors? Yes No Unable to Assess

(Things to consider: toward property or animals, toward people, domestic

violence, antisocial, intimidation, predatory)

Does client have non-suicidal self-injurious behaviors? Yes No Unable to Assess

(Things to consider: method, severity, frequency, remote vs. ongoing)

Does the client have any recent (within the past 12 months) activating stressors? (select all that apply)

Family/primary support group

Social environment

Economic/occupational/educational problems

Housing problems

Health problems

Legal problems

Other

\*If yes, are these stressors experienced as “catastrophic” or insurmountable? Yes No Unable to Assess

Does the client have any historic stressors? (select all that apply)

Family/primary support group

Social environment

Economic/occupational/educational problems

Housing problems

Health problems

Legal problems

Other

\*If yes, are these stressors experienced as “catastrophic” or insurmountable? Yes No Unable to Assess

**CONCURRENT CLINICAL FACTORS:**

Active severe mental illness or serious emotional disturbance not yet Yes No Unable to Assess

stabilized or in remission?

Active self-destructive and/or impulsive personality traits such as that Yes No Unable to Assess

found in borderline, histrionic and/or antisocial personality disorder?

Active moderate or severe substance use disorder and/or recent relapse? Yes No Unable to Assess

Active physical illness which causes severe pain, immobility, life Yes No Unable to Assess

dysfunction or risk of death?

\*Currently experiencing hopelessness, excessive guilt/responsibility/family Yes No Unable to Assess

burden, isolation, extreme psychological pain and suffering, extreme

bullying/victimization or making pre-death arrangements?

\*Currently experiencing extreme confusion, paranoia, command auditory Yes No Unable to Assess

hallucinations, restlessness/agitation, anxiety/panic or severe sleep

disturbance?

**PROTECTIVE FACTORS:** (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

**OVERALL RISK AND TREATMENT PLANNING:**

Based on the above analysis, along with the completed comprehensive assessment, summarize concerns with respect to client’s risk for suicide, self-injury and violence, and describe what will be done to manage or mitigate these risks in the treatment plan. In addition, be sure to address any yes or yes\* response in the overall treatment plan. If creation of a safety plan is required, include specific details of the plan:

If applicable, enter name and credential of licensed staff with which any yes response to an asterisk question was identified and the safety plan was created/reviewed prior to end of the session with the client:

Signature of Staff or Clinician Completing/Accepting Assessment: Date: