



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

Identifying Data: DJJID: \_\_\_\_\_ Referral#: \_\_\_\_\_ Direct Admit to Detention:  Yes  NO

Youth's Name _____	Date of Birth _____	Age _____
Aliases _____		
Parent/Guardian _____		
Address/Telephone _____		
Date/Time Detained _____	Created Date: _____	

**Statute Number/Offense(s)** \_\_\_\_\_

**Interview of Arresting/Transporting Officer** (To be completed before the officer leaves)

**If Yes, Place youth on Suicide Precautions and constant supervision.  
If "yes" for item 1, transport youth for immediate evaluation under the Baker Act. If yes for item 2, transport youth for emergency medical evaluation or evaluation under the Marchman Act**

Arresting/Transporting Officer's Name: \_\_\_\_\_ Badge/ID#: \_\_\_\_\_

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Do you have any reason to think this youth will try to kill himself?<br>Explain: _____               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have reason to think this youth is intoxicated or high on drugs or alcohol?<br>Explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Other Comments: \_\_\_\_\_  
Name of Staff Person Completing this Section: \_\_\_\_\_

**JAC Screener or Juvenile Probation Officer (JPO) Interview Of Youth**  
(JAC Screener or JPO shall ask the youth the following questions)

**If one or more "Yes", for questions 1 through 3 place youth on Suicide Precautions and constant supervision. Refer youth for Assessment of Suicide Risk to be conducted within 24 hours, or immediately if the youth is in need of emergency services or crisis intervention.**

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Have you ever tried to kill yourself?<br>When was the most recent time? _____<br>How? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Was there another time in the past that you tried to kill yourself?  
When? \_\_\_\_\_  YES  NO  
How? \_\_\_\_\_

Other Comments: \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 2. Are you thinking about killing yourself now?<br>Explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

**Yes, requires immediate referral for Assessment of Suicide Risk to be conducted within 24 hours, or immediately if the youth is in crisis, or Baker Act.**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 3. Have you been high on drugs or alcohol in the past 24 hours, and are currently coming down from alcohol or drugs?<br>Explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

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

<input type="checkbox"/> Delinquency Intake	<input type="checkbox"/> Delinquency Commitment	<input type="checkbox"/> Child Protective Investigation	<input type="checkbox"/> Foster Care	<input type="checkbox"/> None
<input type="checkbox"/> Probation	<input type="checkbox"/> Conditional Release	<input type="checkbox"/> Protective Services	<input type="checkbox"/> Adoptions	

**JAC Screener or JPO Interview of Parent/Guardian or Relative or DCF Case Manager and Assigned JPO:**

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

▶ **Parent/Legal Guardian or Relative Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**OUTCOME:**  Contacted Date/Time \_\_\_\_\_  Unable to Contact Date/Time \_\_\_\_\_  
 Refused to Answer Interview Questions

**Comments:** \_\_\_\_\_

▶ **DCF Case Manager Name:** \_\_\_\_\_

**OUTCOME:**  Contacted Date/Time \_\_\_\_\_  Unable to Contact Date/Time \_\_\_\_\_  
 Refused to Answer Interview Questions

**Comments:** \_\_\_\_\_

▶ **Assigned JPO:** \_\_\_\_\_

**OUTCOME:**  Contacted Date/Time \_\_\_\_\_  Unable to Contact Date/Time \_\_\_\_\_  
 Refused to Answer Interview Questions

**Comments:** \_\_\_\_\_

**Name of JAC Screener or JPO Completing this Section:** \_\_\_\_\_

**Interview of Parent/Guardian or Relative or DCF Case Manager and Assigned JPO:**

**If one or more "Yes" for questions 1 through 6, place youth on Suicide Precautions and constant supervision. Refer youth for Assessment of Suicide Risk to be conducted within 24 hours, or immediately if the youth is in need of emergency services or crisis intervention.**

Begin interview with the statement: *"Please answer the following questions to the best of your knowledge"*

	Parent/Guardian or Relative		DCF Case Manager		Assigned JPO	
	Yes	No	Yes	No	Yes	No
1. Has the youth ever tried to kill himself/herself? When was the most recent time? _____ How? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there another time in the past that the youth tried to kill himself/herself? When? _____ How? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the youth threatened to kill himself/herself in the past six months? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you noticed the youth having any of the following behaviors: Giving away his/her favorite things, dropping close friends, drastic changes in eating or sleeping habits, saying that things are hopeless? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Other than being arrested and detained, has the youth had a major change or loss in the past six months, such as a death, divorce of parents, breaking up with girlfriend, boyfriend, etc? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the major loss related to someone this youth knows well committing suicide? Who? _____ When? _____ How? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the youth have any serious mental health problems (e.g. depression, withdrawn, hears voices, etc.)? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there any other information or reason for you to believe that this youth is a risk for suicide? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Detention Officer Interview of Parent/Guardian or Relative or DCF Case Manager and Assigned JPO:**

If the youth is detained and the JAC/JPO screener was unable to contact the parent/legal guardian or DCF Case Manager and the assigned JPO prior to the youth's admission to the detention center, then the detention center's admitting detention officer must complete the interview of the parent/legal guardian or DCF Case Manager and the assigned JPO section above. If the detention center's admitting detention officer is unable to contact the parent/legal guardian, the detention center must notify the youth's assigned JPO. If the youth is scheduled for court, the youth's assigned JPO must attempt to interview the parent/legal guardian in court.

► Parent/Legal Guardian or Relative Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

OUTCOME:  Contacted Date/Time \_\_\_\_\_  Unable to Contact Date/Time \_\_\_\_\_  
 Refused to Answer Interview Questions

Comments: \_\_\_\_\_

► DCF Case Manager Name: \_\_\_\_\_

OUTCOME:  Contacted Date/Time \_\_\_\_\_  Unable to Contact Date/Time \_\_\_\_\_  
 Refused to Answer Interview Questions

Comments: \_\_\_\_\_

► Assigned JPO: \_\_\_\_\_

OUTCOME:  Contacted Date/Time \_\_\_\_\_  Unable to Contact Date/Time \_\_\_\_\_  
 Refused to Answer Interview Questions

Comments: \_\_\_\_\_

Name of JDO Screener Completing this Section: \_\_\_\_\_

**JAC Screener/Juvenile Probation Officer & Detention Officer Observations**

**If one or more Yes for items 1 through 4, place youth on Suicide Precautions and constant supervision. Immediately refer youth for Assessment of Suicide Risk or Baker Act**

JPO or JAC Screener  
 Detention Officer

**HAVE YOU OBSERVED ANY OF THE FOLLOWING:**

- |   | YES                      | NO                       | YES                      | NO                       |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Threatening to kill self/preoccupied with suicide.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Fresh wounds/injuries that appear to be self-inflicted.<br>Describe: _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any other reason to think that the youth will try to kill himself?<br>Explain: _____                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Symptoms of alcohol/drug withdrawal (slurred speech, dilated pupils, depression, anxiety, jittery).<br>Describe: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**If one or more Yes for items 5 through 7, place youth on Suicide Precautions and constant supervision. Refer youth for Assessment of Suicide Risk to be conducted within 24 hours, or immediately if the youth is in need of emergency services or crisis intervention.**

- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 5. Dramatic mood changes (e.g., from crying to laughing in a short period of time).<br>Describe: _____                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Indications of self-mutilating behavior (e.g., marks/scars or cigarette burns observed).<br>Describe: _____                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does the youth have suicide risk noted on the PACT Mental Health/Substance Abuse Report and Referral Form or MAYSI-2 Suicide Scale? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**JAC Screener or Juvenile Probation Officer Screening Results**

- No referral for Assessment of Suicide Risk necessary based on available information
- Referred for Assessment of Suicide Risk (Referred to: \_\_\_\_\_ Referred by:  Telephone  E-mail Date/Time \_\_\_\_\_ )  
 Assessor will be immediately consulted to determine if youth is in need of immediate Assessment or crisis intervention  
 Assessor will see youth within 24 hours
- Emergency Transport (Baker Act) **NOTE: Youth presenting an imminent threat of suicide must be transported for emergency care.**
- Emergency Transport (Marchman Act Evaluation or Medical Evaluation)  
**NOTE: Youth presenting as intoxicated or high on drugs/alcohol must be transported for emergency care.**
- Youth released to parent/guardian.  The required form, Suicide Risk Screening Parent/Guardian Notification Form (MHSA 003) provided.
- Youth being detained in secure detention.  Detention Superintendent or Designee verbally notified and "Suicide Risk Alert" entered in JJIS.  
 (Verbally Notified: \_\_\_\_\_ Date/Time: \_\_\_\_\_)

JAC Screener's Name and Date/Time

Juvenile Probation Officer's Name and Date/Time

### Detention Officer Screening Results

- No referral for Assessment of Suicide Risk necessary based on available information
- Referred for Assessment of Suicide Risk (Referred to: \_\_\_\_\_ Referred by:  Telephone  E-mail Date/Time \_\_\_\_\_ )
- Assessor will be immediately consulted to determine if youth is in need of immediate Assessment or crisis intervention
- Assessor will see youth within 24 hours
- Emergency Transport (Baker Act)
- Emergency Transport (Marchman Act Evaluation or Medical Evaluation)

NOTE: Youth presenting an imminent threat of suicide must be transported for emergency care.

NOTE: Youth presenting as intoxicated or high on drugs/alcohol must be transported for emergency care

\_\_\_\_\_  
Juvenile Detention Officer's Name and Date/Time

### Nursing Screening or Mental Health Clinical Staff Screening

(Is to be filled out by Nurse or Mental Health Clinical Staff Person.)

If one or more Yes for questions 1 through 6, place youth on Suicide Precautions and constant supervision and refer youth for Assessment of Suicide Risk to be conducted within 24 hours, or immediately if the youth is in need of emergency services or crisis intervention.

	Nurse Screening		Mental Health Clinical Staff	
	YES	NO	YES	NO
1. Have you ever tried to kill yourself?  When was the most recent time? _____ How? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there another time in the past that you tried to kill yourself?  When? _____ How? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you thinking of hurting or killing yourself now?  <div style="border: 1px solid black; padding: 2px; color: red; font-weight: bold; margin: 5px 0;">Yes, requires immediate referral for Assessment of Suicide Risk to be conducted within 24 hours or immediately if the youth is in crisis. or Baker Act.</div> Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel that there is no future, that life is not worth living?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you recently put yourself in a situation where you could have been seriously hurt or killed because you did not care whether you lived or died? (e.g., reckless driving while drunk or high, etc.) Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have your sleeping or eating habits changed to the extent that you are losing weight because you don't have an appetite or you can't sleep most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Other than being arrested and detained, have you had a major change or loss in the past six months, such as a death, divorce of parents, breaking up with a boyfriend or girl friend, etc.? Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the major change or loss related to someone in your family or a close friend killing himself/herself or trying to kill himself/herself? Who? _____ When? _____ How? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Comments: _____				

**Nursing Screening or Mental Health Clinical Staff Screening Results**

- No referral for Assessment of Suicide Risk necessary based on available information
- Referred for Assessment of Suicide Risk (Referred to: \_\_\_\_\_ Referred by:  Telephone  E-mail Date/Time \_\_\_\_\_ )
  - Assessor will be immediately consulted to determine if youth is in need of immediate Assessment or crisis intervention
  - Assessor will see youth within 24 hours
- Emergency Transport (Baker Act) **NOTE: Youth presenting an imminent threat of suicide must be transported for emergency care.**
- Emergency Transport (Marchman Act Evaluation or Medical Evaluation) **NOTE: Youth presenting as intoxicated or high on drugs/alcohol must be transported for emergency care.**

\_\_\_\_\_  
Nurse's Name and Date/Time

\_\_\_\_\_  
Mental Health Clinical Staff Person's Name and Date/Time

**Assessment of Suicide Risk Results**

(The Assessment of Suicide Risk (MHSA 004) 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)

Date of Assessment of Suicide Risk (ASR) \_\_\_\_\_

Assessment of Suicide Risk (MHSA 004) Results:

POTENTIAL SUICIDE RISK  YES  NO

ASR Recommendations Regarding Suicide Precautions

Emergency Transport (Baker Act)

Suicide Precautions:

Precautionary Observation

- Continue youth on Precautionary Observation
- Move youth from Precautionary Observation to Secure Observation
- Discontinue Precautionary Observation and transition youth to Close Supervision
- Discontinue Precautionary Observation and place youth on standard supervision

Secure Observation

- Continue Secure Observation
- Move youth from Secure Observation to Precautionary Observation
- Discontinue Secure Observation and transition youth to Close Supervision

Assessed By: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
(Mental Health Clinical Staff Assessor's Name )

Reviewed By: \_\_\_\_\_ Date/Time: \_\_\_\_\_  
(Licensed Mental Health Professional's Name, Title)

No Assessment of Suicide Risk Completed

Comment: \_\_\_\_\_

Detention Suicide Risk Parent/Guardian Notification Form (MHSA 009) provided to parent/guardian.

Completed By: \_\_\_\_\_ Date/Time \_\_\_\_\_  
Mental Health Clinical Staff Assessor's Name

*Copies to: When all sections of the SRSI have been completed, a printed copy of the SRSI must be placed in the youth's DJJ Case File and DJJ Individual Healthcare Record-Mental Health Section.*