



NEURODIVERSITY-AFFIRMING SUICIDE RISK ASSESSMENT & SAFETY PLAN

Client: _____ Date: _____

Risk Assessment			
Verbal Statements <input type="checkbox"/> Direct <input type="checkbox"/> Indirect Describe Statements: Meaning/Intent of Statements:			
Psychological <input type="checkbox"/> Pre-occupation with death <input type="checkbox"/> Feeling isolated <input type="checkbox"/> Other:	<input type="checkbox"/> Long term depression <input type="checkbox"/> Anhedonia <input type="checkbox"/> Lack of appetite/overeating	<input type="checkbox"/> Poor concentration <input type="checkbox"/> Burnout	<input type="checkbox"/> Masking/Camouflaging <input type="checkbox"/> Sleep disturbances
Emotional <input type="checkbox"/> Feeling overwhelmed <input type="checkbox"/> Other:	<input type="checkbox"/> Feeling helpless <input type="checkbox"/> Feeling sad	<input type="checkbox"/> Crying/tearfulness <input type="checkbox"/> Anxiety/OCD	<input type="checkbox"/> Feeling hopeless <input type="checkbox"/> Alexithymia
Behavioral <input type="checkbox"/> Inability to perform daily tasks <input type="checkbox"/> Loss of interest in preferred activities <input type="checkbox"/> Other:	<input type="checkbox"/> Low self esteem <input type="checkbox"/> Sudden unexplained recovery/positive outlook <input type="checkbox"/> Sudden withdrawal from family/friends	<input type="checkbox"/> Engaging in risky behavior <input type="checkbox"/> Sudden poor school/job performance <input type="checkbox"/> Impulsivity	<input type="checkbox"/> Previous suicide attempts <input type="checkbox"/> Giving away important things <input type="checkbox"/> Self-injurious behaviors
Situational <input type="checkbox"/> Suicide of loved one/peer <input type="checkbox"/> Lack of accommodations <input type="checkbox"/> Other:	<input type="checkbox"/> School or career problems <input type="checkbox"/> Divorce/break-up <input type="checkbox"/> Social Exclusion	<input type="checkbox"/> Loss of job/career <input type="checkbox"/> Multiple losses <input type="checkbox"/> Unmet sensory needs	<input type="checkbox"/> Death of a loved one/peer <input type="checkbox"/> Bullying <input type="checkbox"/> Marginalized community
Initial Risk Assessment			
Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	Means? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	Timeline? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	

<i>Strengths & Supports</i>
What are the client's future goals?
What type of connection does the client have with their culture/community/religion?
Who are the supportive people in the client's life?
What strategies does the client have that are effective in mitigating distress?
What are the client's areas of passion/interests?
What is the client's preferred communication method for self-disclosure or vulnerable situations?
When does the client self-advocate effectively?
What strategies have worked when the client has been able to cope in the past?
What sensory tools are comforting and safe for the client?

Strengths-Based Safety Plan

1. How will you know when the safety plan should be used?

2. What coping strategies do you prefer to use? How do they build on your strengths?

3. Who are the social contacts or what are the activities you can do to distract from your distress?

4. Who are the trusted friends and family you can go to for help?

5. Who are the mental health professionals or agencies to go to for help in a crisis?

6. What needs to be done to make sure your environment is safe?

Clinician Signature: _____ Date: _____