Social Services Outpatient Suicide Assessment Protocol
for Patients 18 Years Old and Over

Purpose:
The primary purpose of the suicide protocol is to provide a guideline in the assessment and disposition of suicidal patients in an outpatient setting.

Procedure:
To evaluate the patient by following this suicide protocol, which consists of an assessment and disposition plan.

Suicide Assessment:
Social workers come in contact with suicidal patients in a variety of ways and settings. The following guidelines are intended to help the social worker determine when a patient is at risk.

Ask a patient about suicide if:

- Patient brings up that he/she is thinking about ending his/her life.
- Patient looks depressed and is not engaged during the interaction.
- Patient makes statements such as, "life is not worth living," "I would be better off dead," or "my family would be better off without me."
- Providers or family members are worried about the patient.
- Past suicidal ideation is documented in the patient's chart.
- You are doing an outpatient initial diagnostic evaluation.

If the social worker determines that the patient may be suicidal, the social worker asks the patient *directly and clearly* if the patient is suicidal. Example of questions to ask:

- "Are you thinking now of hurting yourself?"
- "Have you ever felt like ending your life?"
- "Have you ever tried to end your life?"

If the patient says, "Yes," determine if there are any protective factors that would prevent the patient from following through with the suicidal feeling. *Be direct, goal directed* and ask the patient:

- "Is there any reason why you would not act on the way you are feeling?"
- "Do you have a family? What impact do you think this would have on your family?"
- "Are you a religious person?"
- "What do you think happens after a person is dead?"

If the patient indicates that he/she is suicidal and no protective factors are present the patient is at ***HIGH RISK*** for self harm. The social worker must then determine the patient's:

Plan:

- "Are you thinking now about hurting yourself?"
- "How would you take your life?"
- "Would you shoot yourself? Would you take pills, hang yourself, jump off a cliff, throw yourself in front of a car and so on?"

Access:

- "Do you have a weapon?"
- "What pills would you use?"
- "Where would you jump from?"

Lethality:

- Is the method chosen by the patient lethal?

Severity of Intent:

- "Do you intend to act on your thoughts?"
- "Have you ever hurt yourself before?" If yes, ask:
    - "What did you do?"
    - "How long ago did this happen?"
    - "Did you require hospitalization?"
    - "How do you feel about what you did?"

Suicide is not a predictable event, but there are known risk factors which contribute to the increased risk for suicide. Below is a list of known risk factors to be aware of while doing the assessment:

- Patient is male
- Patient is an adolescent or young adult 15-24 years
- Patient is an older adult > 60 years
- Patient is depressed and hopeless
- Patient is using alcohol or drugs
- Patient is psychotic or not using rational thinking
- Patient is separated, divorced or widowed
- Patient has no or limited social supports, and
- Patient has a previous history of suicide attempt or psychiatric care

Based on ALL the information gathered, the social worker determines the suicide risk level that the patient presents. The more risk factors present, the higher the risk.

If the patient is ***HIGH RISK*** or the social worker feels the need for a consultation, it is *encouraged* that the social worker consults with his/her Clinical Director or any of her colleagues. If applicable, the social worker consults any other mental health providers involved in the care of the patient.

Disposition:
If the social worker determines that the patient is suicidal, immediate intervention is needed. The next step is to call MGH Police and Security at 617-726-2121 to request an escort to MGH Acute Psychiatric Services (APS) and to call APS at 617-726-2994 to give a brief summary of the situation.

Based on his/her clinical judgment, the social worker decides before/after MGH Police and Security arrives when to share with the patient that further evaluation by APS is required.

If the patient *agrees* to be seen by APS:

- The social worker waits for MGH Police and Security to arrive and to escort the social worker and the patient to APS.
- The social worker carries a blank Section 12 form in the event that the patient changes his/her mind.

If the patient *refuses* to be seen by APS:

- A Section 12 or "Pink Paper" is required. [NOTE: The Section 12 permits MGH Police and Security to involuntarily escort the patient to APS. A copy of the form can be found on the Social Service website.]
- An LICSW completes the Section 12 (LCSW consults with supervisor).

If the patient *refuses* to be seen by APS *and leaves* MGH before MGH Police and Security arrives, the social worker has to let the patient leave since social workers are not licensed to restrain patients. If the patient leaves:

- The social worker calls APS and informs them that the patient has left.
- LICSW completes the Section 12 (LCSW consults with supervisor).
- LICSW will fax the Section 12 to the police department of the city where the patient lives or where the social worker thinks the patient is and call police to follow up.
- The social worker files a Safety Report which can be found under "Partners Applications, Safety Reporting MGH." [NOTE: The Safety Report is *not* part of the patient's medical chart, and it should *not* be documented in the medical chart that a Safety Report was filed.]

Documentation:
The social worker documents in the patient's medical record the interaction with the patient and the reason for further evaluation. A "Clinical Social Work Suicide Assessment Note "template is available on LMR and on the Social Service website.

The documentation has to include:

- Reason for referral
- Patient's presentation
- Patient's plan
- Patient's access to means/lethality of means
- The severity of patient's intent

- Patient's history of previous suicide attempts
- Self-destructive behavior observed by the social worker
- Any evidence that the patient is currently under the influence of a substance
- Any demonstrated disorder of thought, mood, perception, orientation or memory to the extent that judgment, behavior, capacity to recognize reality, and/or ability to meet the ordinary demands of life are impaired, and
- Protective factors: what if anything prevents the patient from carrying out the suicidal plan

Reporting:

If the patient has other providers at MGH, the social worker informs:

- The referring provider, when applicable
- The patient's PCP
- Any mental health providers involved in the care of the patient, and
- The social worker forwards the note to his/her Clinical Director

Important Numbers and Services:

MGH Acute Psychiatric Services (APS): 617-726-2994

MGH Police and Security: 617-726-2121

MGH Office of General Counsel at 617-726-8625 is available for consultations

MGH Social Service Website: www.mghsocialwork.org