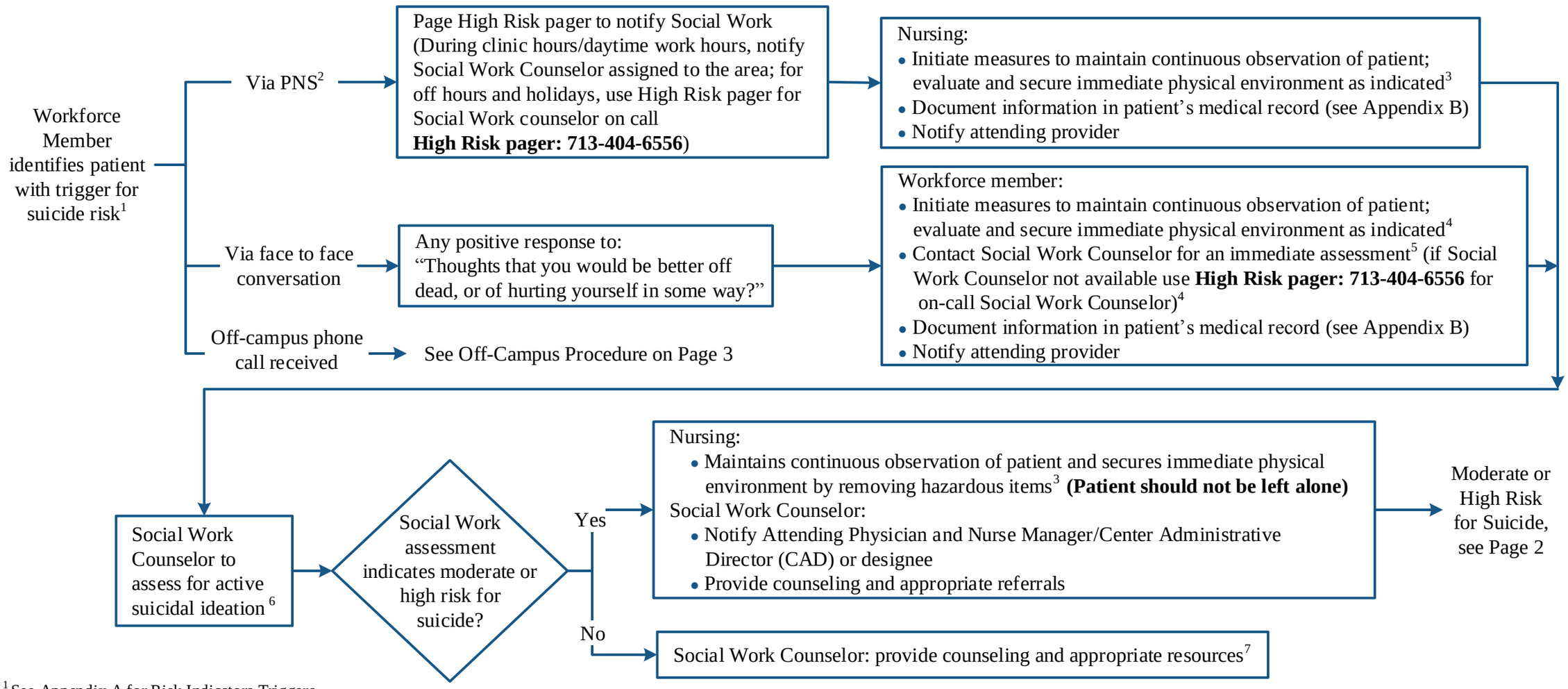
Suicide Risk Assessment

This practice algorithm has been specifically developed for MD Anderson using a multidisciplinary approach and taking into consideration circumstances particular to MD Anderson, including the following: MD Anderson's specific patient population; MD Anderson's services and structure; and MD Anderson's clinical information. Moreover, this algorithm is not intended to replace the independent medical or professional judgment of physicians or other health care providers. This algorithm should not be used to treat pregnant women.



[1] See Appendix A for Risk Indicators Triggers

[2] Questions from PNS (Patient Needs Screening) regarding feelings over the last two weeks: • Little interest or pleasure in doing things • Feeling down, depressed or hopeless

[3] Hazardous items to be removed from immediate area: sharp objects, potential weapons, other implements that could be used to cause harm (scissors, other sharps, medication, silverware, belts, glass, liquids, and dining trays). Include patient personal items.

[4] If face to face conversation is with a qualified mental health professional, that mental health professional may assess for active suicidal ideation.

[5] Expect a response from Social Work within 30 minutes

[6] See Appendix C for Suicidal Assessment checklist

[7] See Appendix D for Available Resources

Department of Clinical Effectiveness V3
Approved by the Executive Committee of the Medical Staff on 08/29/2017

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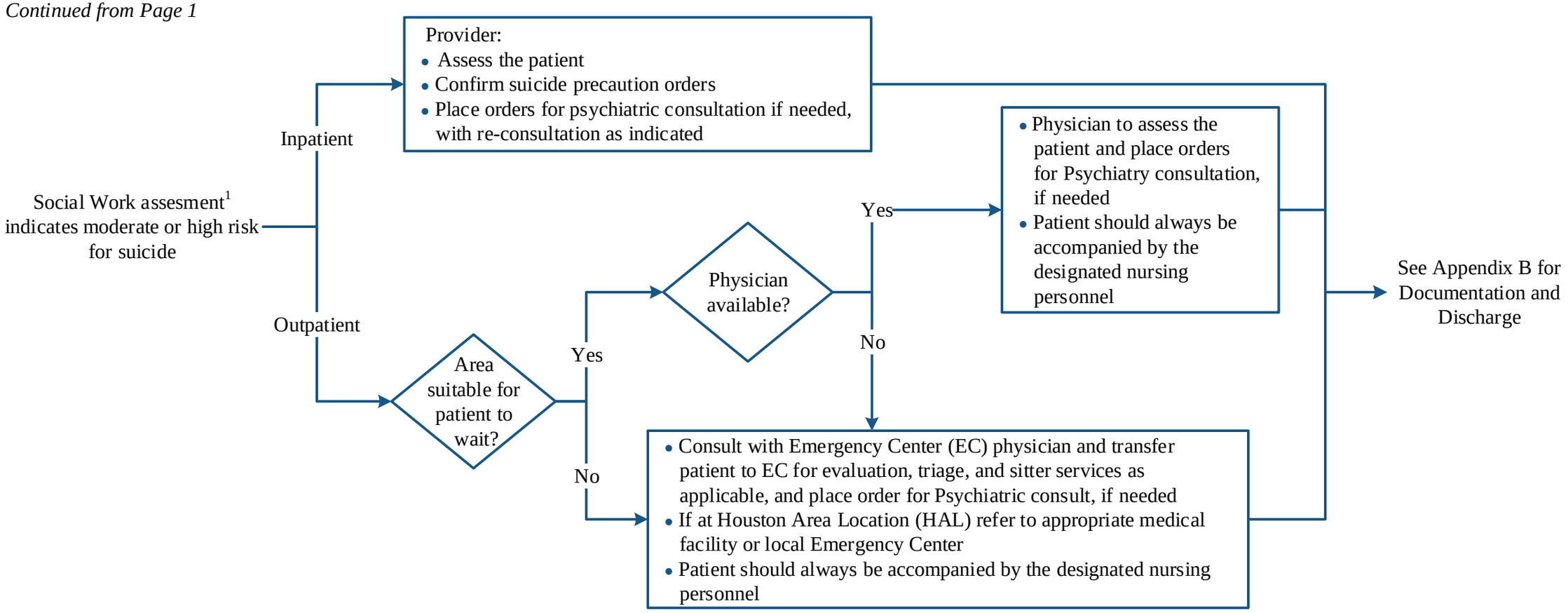

[1] Social Work assessment questions: see Appendix D

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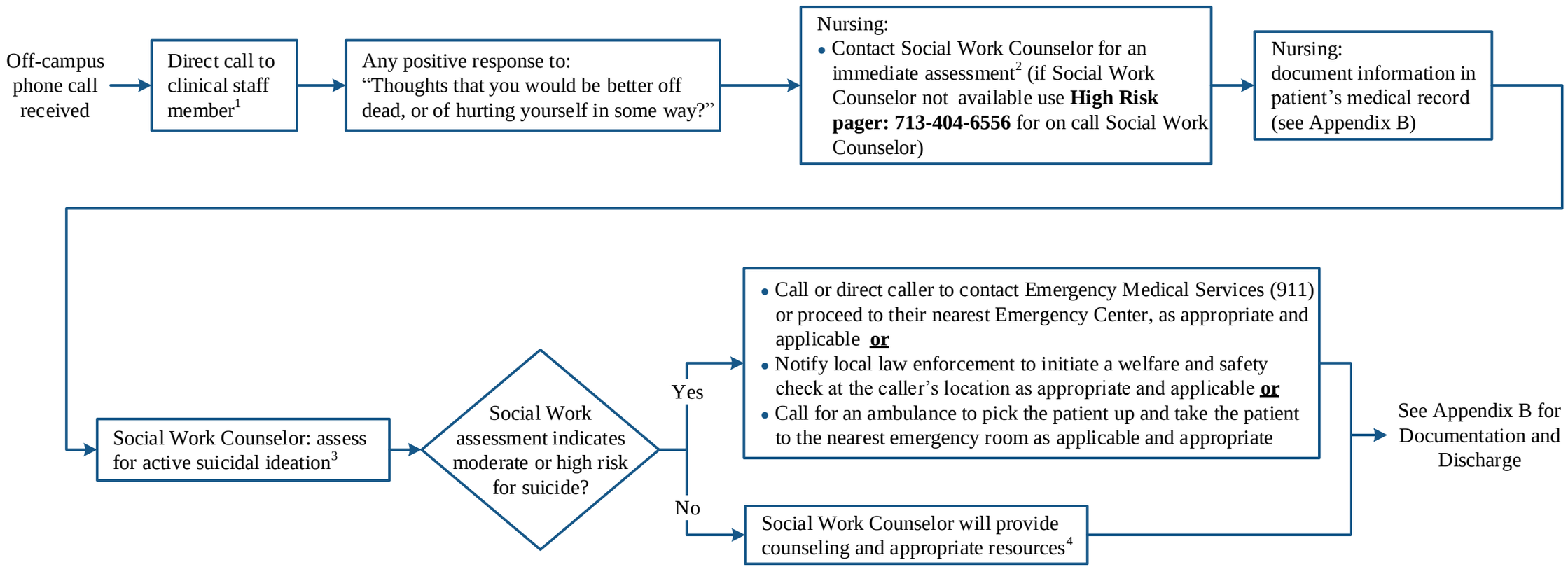
OFF-CAMPUS PROCEDURE



[1] Stay on line with patient until clinical staff member picks up the line, no cold transfer. **Do not place the caller on hold.** Obtain as much information as possible in order to inform 911 operator if needed.
[2] Expect a response from Social Work within 30 minutes
[3] Social Work assessment questions: see Appendix D
[4] See Appendix C for some available resources

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APPENDIX A: Risk Indicator Triggers (Alone or in combination)

- Verbalizing of suicidal gestures or ideations with plan
- History of past suicidal attempts
- Recent treatment for the presence of psychiatric illness
- A family history of suicide
- Major depression
- Verbalizing no hope for the future
- Major depression followed by a sudden elevation in mood
- Giving away personal possessions if not imminently terminal
- Reports of command auditory hallucinations to harm self or others
- Evidence of persecutory delusions
- Recent significant actual or perceived loss of job, relationship, physical abilities, limbs, etc.
- Decreased social support
- Evidence of alcohol or substance abuse
- Perception of increased burdensomeness
- Intractable symptoms causing distress
- Unmanaged pain

APPENDIX B: Documentation and Discharge

Staff involved with patient to complete documentation of the following in the patient's medical record:

- Suicidal remarks, gestures, or self-destructive comments/behaviors
- Assessment, reassessment
- Date and time suicide precautions initiated and discontinued (nursing)
- Maintenance of suicide precautions every shift (nursing)

At discharge:

- Provide suicide patient education document
- Provide crisis hotline number
- Provide counseling or psychiatric referral as appropriate

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APPENDIX C: Suicidal Assessment Checklist

Below is the information asked on the Social Work Suicide Assessment Checklist by the Social Work Counselor.

Suicide Risk Assessment – questions to ask:
Are you feeling hopeless about the present/future? _____ yes ____ no
Have you had thoughts about taking your life? ____ yes ____ no
When did you have these thoughts and do you have a plan to take your life? If so, what is your plan? Have you rehearsed this plan?
Have you ever had a suicide attempt in the past? When? What happened?
How long have you been thinking about this?
If you were to kill yourself, when would it be?
Do you have the means? (guns, pills, etc.)
What has been stopping you/Where are you finding your hope, etc.?

Risk Factors
____ Past Attempts
____ Current ideation/intent/plan/access to means
____ Substance Abuse
____ Psychiatric diagnosis
____ Impulsiveness and poor self-control
____ Hopelessness-presence, duration, severity
____ Recent losses-physical, financial, personal
____ Recent discharge from an inpatient unit
____ Burdensomeness
____ Isolation
____ Trapped
____ Command Hallucinations
____ Change in Treatment
____ Physical Pain
____ Other

Protective Factors
____ Positive social support
____ Spirituality
____ Sense of responsibility
____ Children in home/pregnancy
____ Life satisfaction
____ Positive problem solving skills
____ Positive coping skills
____ Positive relationship with medical team
____ Access/willingness for mental health care
____ Other

Level of Risk
____ Low
____ Moderate
____ High

Collateral Information
Name:
Telephone Number:
How often are they able to see patient?

Follow-up Plan
Did patient agree to limit access to means? ____ yes____ no
Did patient agree to follow-up treatment? ____ yes ____ no
Does patient have a crisis hotline number and emergency numbers to call? ____ yes ____ no
Comments:

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APPENDIX D: Resources

- National Suicide Prevention Hotline: **1-800-273-TALK (8255)**
- Emergency number: **911**
- Internal numbers for questions about safety for MD Anderson patients at risk for suicide:
  - The Department of Social Work: 713-792-6195
  - The Department of Psychiatry: 713-792-7546
- **Reference documents:**
  - The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) (n.d.) Suicide Warning Signs. *National Suicide Prevention Hotline.* Retrieved June 12, 2013, from http://www.suicidepreventionlifeline.org/Learn/WarningSigns
  - United States Department of Veterans Affairs. (n.d.) *ACE: Suicide Prevention for Veterans and Their Families and Friends*. [Brochure]. Retrieved from http://www.mentalhealth.va.gov/docs/VA_Brochure_08_25_2009.pdf
- **Education Center computer based training:**
  - "Suicide Awareness" course number NPDE 4418

SUGGESTED READINGS

Fang, F., Fall, K., Mittleman, M. A., Sparén, P., Ye, W., Adami, H. O., & Valdimarsdóttir, U. (2012). Suicide and cardiovascular death after a cancer diagnosis. *New England Journal of Medicine*, 366(14), 1310-1318.

Fang, F., Keating, N. L., Mucci, L. A., Adami, H. O., Stampfer, M. J., Valdimarsdóttir, U., & Fall, K. (2010). Immediate risk of suicide and cardiovascular death after a prostate cancer diagnosis: cohort study in the United States. *Journal of the National Cancer Institute*, 102(5), 307-314.

Johnson, T. V., Garlow, S. J., Brawley, O. W., & Master, V. A. (2012). Peak window of suicides occurs within the first month of diagnosis: implications for clinical oncology. *Psycho-Oncology*, 21(4), 351-356.

Joiner, T. (2007). *Why people die by suicide*. Harvard University Press.

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DEVELOPMENT CREDITS

This practice consensus algorithm is based on majority expert opinion of the Suicide Risk Assessment Workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following faculty and caregivers:

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