Regional Personal Care Home

Suicide Risk Assessment Resource Guide

Adapted from Winnipeg Regional Health Authority Long Term Care Program: Suicide Risk Assessment Long Term Care Resource Guide

Contents

Purpose

This document is intended to be a resource to help guide Personal Care Home staff to identify, through assessment, residents at risk for suicide and to assist with the implementation of strategies to treat and monitor residents at risk for suicide. Evidence shows that suicide risk assessments are safe and do not cause or create suicide ideation (Journal of Clinical Psychiatry 12 (6); 2010). The Suicide Risk Screening Tool Personal Care Home, Risk Assessment for Suicide Tool (RAST) Personal Care Home and Suicide Prevention Care Planning Strategies are also included as resources to guide assessment, interventions and monitoring of residents.

Note: When suicide risk exists, an expert opinion should be sought to determine the need for hospitalization and clarification of diagnosis.

Background

Older adults (65 years or older) have high rates of suicide and employ lethal means of self-harm. Statistics Canada reported that in 2013, older adults accounted for 623 (15.4%) of the nation's 4054 official deaths by suicide. Deteriorating health, functioning, and independence along with a reduction in social contacts may place older adults at higher risk for depression and thoughts of suicide. Older adults may end their lives by refusing food and/or needed medications; these deaths are typically not classified as suicide (NASH). Nearly 6,000 older North Americans die by suicide every year; that number could increase with shifting population demographics. Older adults will represent 20-25% of the Canadian population by 2030 (Statistics Canada). Older adults have high rates of morbidity and mortality and have high healthcare service utilization, especially in the context of mental disorders. Detection of suicide risk in older adults is crucial; interventions can then follow.
Major depression is the most common diagnosis in older adults who attempt or die by suicide. Recurrent major depression is associated with the greatest risk. Seventy-one to ninety-five percent (71-95%) of those who died by suicide 65 years and older had a major psychiatric disorder at the time of death. Using established tools and guidelines, residents should be assessed and treated for symptoms of depression.

The following framework can guide discussions for residents assessed as a risk for suicide:

Medical Indications *Guiding Principles: Beneficence & Non-maleficence* • What is the resident's medical problem? History? Diagnosis? Prognosis? • Is the problem acute? Chronic? Critical? Emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • How can this resident benefit by the intervention and how can harm be avoided?	**Resident/Client Preferences** *Guiding Principle: Autonomy* • Is the resident mentally capable and legally competent? • If competent, what is the resident stating about preferences for treatment? • Has the resident been informed of benefits and risks, understood the information and given consent? • If incompetent, who is the designated substitute decision maker? • Has the resident expressed prior preferences e.g. Health Care Directive? • Is the resident unwilling/unable to cooperate with medical treatment? If so, why? • Is the resident's right to choose being respected to the extent possible?
Quality of Life *Guiding Principles: Beneficence, Non-maleficence, Autonomy*	**Contextual Features** *Guiding Principles: Loyalty & Fairness*

• What are the prospects, with or without treatment, for a return to normal functioning? • What physical, mental and social deficits is the resident likely to experience if the treatment succeeds? • Are there biases that might prejudice the provider's evaluation of the resident's quality of life? • Is the resident's present or future condition such that his or her continued life might be judged undesirable? • Is there a plan or rationale to forego treatment? • Are there plans for comfort and palliative care?	• Are there family issues that might influence treatment decisions? • Are there health care provider issues that might influence treatment decisions? • Are there financial and economic factors? • Are there religious or cultural factors? • Are there limits on confidentiality? • Are there problems of allocation of resources? • How does the law affect treatment decisions? • Is clinical research or teaching involved? • Is there any conflict of interest on the part of the providers or the site?

Definitions

Designate: Any health care professional other than nursing deemed appropriate by the Personal Care Home/Long Term Care facility to complete suicide risk assessments (e.g. social work).

Family: Defined by the resident and includes all those persons that the resident considers family. This may include, but is not limited to: life-partners, parents, children, grandparents, other relatives, friends, neighbours, and community members. An individual's understanding of family may be influenced by factors such as: culture, personal history, immigration experience, and living environment.
Interdisciplinary Team: A group of health care providers from diverse fields who work in a coordinated fashion toward a common goal for the resident.

Mental Illness: Any mental disorder, major depressive disorder, any mood disorder, psychotic disorders, substance misuse disorders.

Protective Factors: Aspects of a resident's life which provides meaning, purpose and connection with others and promotes resiliency and recovery. They are dynamics that lessen, compensate or protect the resident from exposure and impact to risk factors.

Risk Factors: These are characteristics which are shown to be associated with an increased likelihood of suicide. These characteristics do not cause the disorder or problem and are not symptoms of the illness, but rather are factors that have been shown to influence the likelihood of developing the problem.

Substitute Decision Maker (SDM): A third party identified to participate in decision-making on behalf of a patient/resident/client, who has been determined to lack Decision-Making Capacity, concerning a proposed Procedures(s), Treatment(s), or Investigation(s). The task of a Substitute Decision-Maker is to faithfully represent the known preferences or, if the preferences are not known, the best interests of the incapable patient/resident/client. The following, in order of priority, may act as a Substitute Decision-Maker(s):

1. Proxy named in a Health Care Directive;
2. A committee of both property and personal care appointed by:
    a. The court under section 75(2) of The Mental Health Act (Manitoba);
    b. An order under section 61(1) of The Mental Health Act (Manitoba); or

c. A Substitute Decision-Maker for Personal Care appointed under The Vulnerable Persons Living with a Mental Disability Act (Manitoba). A committee or a Substitute Decision-Maker for Personal Care may be an individual(s) or the Public Trustee.

3. Family, friends, and other. This category does not have binding legal authority, the following principles may provide guidance. Within this context, such a Substitute Decision-Maker must have the support of all interested and available parties. Such a person will usually, but not necessarily, be a close relative, who speaks for all. The listing contained in The Mental Health Act (Manitoba) is guidance and is as follows in order of preference:
    a. The adult relatives being of whole blood is preferred to relatives of the same description of the half-blood. The elder or eldest of two or more relatives described in any clause is preferred to the other of those relatives, regardless of gender:
        - Spouse or common-law partner;
        - Son or daughter;
        - Father or mother;
        - Brother or sister;
        - Grandfather or grandmother;
        - Grandson or granddaughter;
        - Uncle or aunt;
        - Nephew or niece

    b. A supportive friend when family is unavailable or non-existent, or if the patient requested while competent.
    c. On occasion, an existing power of attorney may be most appropriate to fulfill this role, since such an individual, although limited to property decision, has obviously been placed in a position of trust.

    For the Responsible Party or Authorized Designate to feel confident in identifying a Substitute Decision-Maker from family, friends, and others it will be necessary, within reason, to:
    - Understand relationships, dynamics, hierarchy , and values;
    - Ascertain that there exists acceptance from involved family/friends in the designation of the Substitute Decision-Maker;
    - Clarify as necessary the role of the Substitute Decision-Maker for all interested parties.

    If this is not possible, the Responsible Party or Authorized Designate shall act in the best interests of the patient/resident/client. The Responsible Party or Authorized Designate may refer to conflict resolution resources such as ethics services, mediation with family/friends or referral to the Public Trustee or courts if apparent dissension among family/friends cannot be resolved.

Suicidal Behaviour: Self-inflicted actions, with a nonfatal outcome accompanied by explicit or implicit evidence that the person intended to die.

Suicidal Ideation: On a continuum from general non-specific thought of wanting to end one's life to active suicidal ideation with specific plan and intent.

Suicide: Self-inflicted death with the evidence (either explicit or implicit) that the person intended to die. This could involve active suicide attempts e.g. taking overdose, jumping, or using a weapon or actions such as refusing to eat or drink.

Suicide Attempt: A potentially self -injurious act carried out with the wish to die.
Therapeutic Relationship: An interpersonal process between the health care professional and the resident. Therapeutic relationship is a purposeful, goal-directed relationship focused on advancing the best interest and outcome of the resident.

Warning Signs: These are key indicators or behaviours alerting staff that a resident may be at imminent risk for suicide, and may be setting into motion the process of suicide.

Assessment of Suicide Risk

Suicidal behaviour is complex and despite the best available expertise and exemplary care, some residents will go on to die by suicide. There is no current rating scale or clinical algorithm that has proven predictive value in the clinical assessment of suicide. A thorough assessment of the individual remains the only valid method of determining risk. Assessments are based on a combination of the background conditions and the current factors in a person's life and the way in which they are interacting. Suicide risk assessment tools provide information that can be used, in conjunction with clinical judgment, to identify risk and to make decisions. Suicide risk assessments are safe and do not cause or create suicide ideation (Journal of Clinical Psychiatry 12(6); 2010).

Suicide Risk Screening Tool Personal Care Home

The Nurse (Registered Nurse, Licensed Practical Nurse, Registered Psychiatric Nurse) or Designate will assess the risk of suicide for residents within 24-48 hours of admission to the Personal Care Home. The Suicide Risk Screening Tool Personal Care Home (CLI.6410.PL.021.FORM.01) is completed within a collaborative partnership between health care team members, and the resident or Substitute Decision Maker or other supports whenever possible.

Ongoing monitoring and reassessment of risk for suicide for all residents will occur at the quarterly interdisciplinary care plan review (see section "Reassessment of Suicide Risk" on page 11), or as the resident's needs change (e.g., individual disclosure of suicidal ideation, recent discharge from acute mental health service, following a suicide attempt or self-harm, significant change in circumstances).

Risk Assessment for Suicide Tool (RAST) Personal Care Home

The RAST (CLI.6410.PL.021.FORM.02) should be completed with all residents identified at risk for suicide on the Suicide Risk Screening Tool or if suicide risk is identified at the quarterly care plan review.

Identify Risk Factors for Suicide Risk Factors for Suicide The presence of any one of the below noted risk factors should serve as a warning and prompt a thorough clinical assessment to guide appropriate intervention to keep the resident safe. **Note: this is not an exhaustive list of suicide risk factors**	
Suicidal Ideation	Does the resident report suicidal ideation or has s/he written about his/her suicide or death? Deteriorating health, functioning, and independence along with a reduction in social contacts may place older adults at higher risk for depression and thoughts of suicide. Mental Health Commission of Canada (2015).

Suicidal Behaviour	Does the resident display suicidal or self-harm behavior? Has there been previous suicide attempts? Four out of 5 people who have died by suicide have made at least one previous attempt. Stats Canada (2011).
Family History	Is there a family history of death by suicide, suicide ideation, suicidal actions or mental illness?
Mental Illness	Does the resident have a mental illness which can include: any mental disorder, major depressive disorder, any mood disorder, psychotic disorder, substance abuse? More than 90 percent of suicide victims have a diagnosable psychiatric illness. In patients with mood disorders, major depression and bipolar disorder account for 15 to 25 percent of all deaths by suicide. Stats Canada (2011).
Violence/Trauma	Has the resident experienced violence or trauma (e.g. domestic violence; sexual or physical abuse or neglect, torture and trauma as refugees). Studies show that there is a significant correlation between a history of sexual abuse and the lifetime number of suicide attempts, and this correlation is twice as strong for women as for men (Canadian Mental Health Association). A new study from Statistics Canada finds that more than one in five First Nations living off reserve, Metis and Inuit adults report having suicidal thoughts at some point in their lives. Residential school experience has been linked to high rates of mental illness, child abuse and family breakdown, all of which are associated with suicidal thoughts. Stats Canada (2016).
Substance abuse/misuse, gambling	Individuals with a substance use disorder (i.e., either a diagnosis of abuse or dependence on alcohol or drugs) are almost 6 times more likely to report a lifetime suicide attempt than those without a substance use disorder (Ilgen and Kleinberg, 2011).
Medication Side Effects	Close monitoring is needed, and adequate follow-up care should be provided for patients after initiation of a new antidepressant. The use of divalproex in the treatment of Bi-polar disorder showed greater risk of suicide than use of lithium (JAMA, 2003). Epilepsy and other illnesses for which antiepileptic drugs are prescribed are associated with an increased risk of suicidal thoughts and behavior (U.S. FDA, 2009).
Negative life events	Has the resident experienced recent social, physical and financial losses or negative events, and other transitional events (e.g., death of a family member)?
Interpersonal factors	Does the resident express feelings of loneliness, have few social supports, has little social interaction.
Medical Concerns	Does the resident have a chronic illness, pain, a sensory impairment, perceived or anticipated/feared illness?
Access to Means	Older adults who attempt suicide are more likely to use lethal means and die from suicide than younger people who attempt suicide. Centre for Disease Control (2013).
Age	The rate of suicide in seniors (10.4 per 100,000) has been very stable over the past decade. Rates are higher among males than females with men over 85 having the highest suicide rate (29 per 100,000). Mental Health Commission of Canada (2015), Stats Canada.
Gender	Men are more likely to die by suicide than women. Manitoba Stats -Stats Canada. The rate of suicide per 100,000 males is 66% higher than females in MB. This is the highest percentage across all of Canada.

Source: National Guidelines for Seniors' Mental Health. The Assessment of Suicide Risk and Prevention of Suicide. Canadian Coalition for Seniors Mental Health (2006); Framework for Suicide Risk Assessment and Management for NSW Health Staff (2004).

Warning Signs for Risk of Suicide

- Threatening to harm oneself or end one's life
- Seeking or access to means
- Evidence or expression of a suicide plan
- Expressing (writing or talking) ideation about suicide, wish to die or death
- Hopelessness
- Withdrawing from significant others or society
- Feelings of being trapped with no escape
- Severe emotional pain or distress
- Severe anxiety, panic attacks
- Agitation
- Intoxication
- Acting reckless, engaging impulsively in risky behaviour
- Psychosis (command hallucinations to end life)
- Rage, anger, aggression, seeking revenge
- Sleep disturbance
- Depressive Symptoms
- Dramatic changes in mood
- Express no reason for living, no sense of purpose in life

Source: Ontario Hospital Association (2013). Suicide Risk Assessment Guide: A Resource for Health Organizations. CAMH (2014) Assessment and Care for Adults at Risk for Suicidal Ideation and Behaviour

Identify Protective Factors

Protective factors are aspects of a resident's life which provide meaning, purpose and connection with others. They may lessen, compensate or protect the resident from exposure and impact of risk factors. Protective factors, even if present, may not counteract significant acute risk.
The following are examples of Protective Factors. **(Note: This is not an exhaustive list of Protective Factors)**

- Strong connections to family and community support
- Monitoring for medication side effects
- Support through ongoing medical and mental health care relationships
- Restricted access to highly lethal means of suicide
- Skills in problem solving, coping and conflict resolution
- Management of chronic conditions and pain
- Effective clinical care for mental, physical and substance use disorders
- Sense of belonging, sense of identity, and good self-esteem
- Engagement in purposeful activities that nurture hope, self- esteem, resilience and spirituality
- Easy access to a variety of clinical interventions and support for seeking help

Sources: Ontario Hospital Association. (2013). Suicide Risk Assessment Guide: A Resource for Health Organizations; Extendicare . (2017). Suicide Assessment, Prevention and Support.

Management of Immediate Safety Needs

Assess the resident's environment for potential safety risks:

- Search of resident's clothing, belongings and room for objects that may cause harm. If found, these objects should be sent home with family or labeled and safely stored away from the resident.
- Ensure that all sharp or dangerous objects are removed from the room including but not limited to: belts, pens and pencils, needles, medications, cosmetics, nail file, necklaces, glass objects, metal, razors, razor blades, knives, aerosol sprays, plastic bags, drawstring pants, shoelaces. Monitor call bell strings and bedding.
- Assign resident a room in close proximity to the nursing desk and initiate observation checks
- Monitor the need to move the resident to a more controlled environment (own room) to decrease stimuli which may be influencing mood, behavior, and emotions.
- Maintain line of sight with resident.
- Remove excess linens from the resident's room
- Visually inspect the resident's mouth after giving medications to ensure they have been swallowed

The most common means of suicide in long term care and senior living communities include: hanging, jumping from buildings or high places (e.g., stairwells), cutting, and taking an overdose of medication.

Residents may also attempt to harm themselves by acting in an unusually high-risk manner or by refusing to eat, drink, take medication or follow recommended treatment.

Allow the person to verbalize their feelings, be there with them and do not leave them alone. Call 911 immediately if the resident is in crisis and an immediate risk of harm to him/herself.

Care Planning

Identify Suicide Risk Treatment, Interventions and Monitoring Strategies

Health care providers working with residents at risk for suicide should ensure that they are appropriately assessed and treated for depression.

The care plan is developed with the healthcare team, including the prescriber, resident and/or substitute decision-maker when risk for suicide has been identified. Initiate focus of care for the resident re: depression/altered well- being/suicidal risk on the interdisciplinary care plan. Communicate the care plan to the healthcare team. The care plan should include the date that the reassessment is to occur, minimally once every three months.

Resources to support care plan development include:

- Canadian Coalition for Seniors Mental Health (2006). National Guidelines for Seniors Mental Health: The Assessment and Treatment of Suicide Risk and Prevention of Suicide. Available on-line (retrieved October 2, 2018): https://ccsmh.ca/wp-content/uploads/2016/03/NatlGuideline_Suicide.pdf.
- Canadian Coalition for Seniors Mental Health (2006). National Guidelines for Seniors Mental Health: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (Focus on Mood and Behaviour Symptoms). Available on-line (retrieved October 2, 2018): https://ccsmh.ca/wp-content/uploads/2016/03/NatlGuideline_LTC.pdf.

For residents assessed as being at risk of suicide, treatment, intervention and monitoring strategies should be identified, which may include, but are not limited to, the following:

- Maximize the safety of the resident's environment and restrict access to lethal means (see "Management of Immediate Safety Needs")
- Ensure that the resident is appropriately assessed (e.g. Geriatric Depression Scale or SIG E CAPS) and treated for symptoms of depression
- Address underlying issues: medical illness, mental health issues, social problems, concerns, transitions, environmental factors
- Refer to a Mental Health Provider e.g. Seniors Consultation Team
- Treat substance abuse/misuse (e.g. refer to Addictions Foundation of Manitoba)
- Identify and address psychological and emotional issues.
- Assist the resident in identifying strengths and coping mechanisms
- Connect the resident with other supports e.g., spiritual health services, family members, friends and/or other community members
- Develop a therapeutic relationship with the resident so they feel comfortable discussing their thoughts with staff. In developing a therapeutic relationship staff should be professional and non- judgmental; show genuine interest and concern for the resident's situation, be empathic and provide reassurance and hope. Actively and attentively listen to the resident and take your time. When present, these elements help contribute to a person feeling heard and respected and can help to contribute to the resident feeling connected.
- Foster hope in residents who are suicidal, promote hope by initiating hope-focused conversations.
- Explore strategies to help the resident find and maintain meaning and purpose in their lives.
- Reduce distress, stressors and stress

Communicate the care plan to the resident, physician, pharmacist, SDM, family, other health care team members.

Documentation

The assessment of suicide risk, actions taken to address safety needs, and implementation of the treatment, intervention and monitoring strategies will be documented in the integrated progress note of the resident's health record including the following elements as applicable:

- Suicide risk screening results- determination of suicide risk level

- Reason for the assessment or reassessment (e.g. completion of the RAST)
- Specific assessment of suicide risk
- Collateral history
- Risk factors and protective factors
- Identification of and actions taken to address the immediate safety needs
- Implementation of the risk treatment and monitoring strategies
- Resident reactions and outcomes
- Communication of the care plan to resident, Physician, Pharmacist, SDM, family, other health care team members
- Consults to Social Work, Spiritual Health, Seniors Consultation Team, Psychiatrist, other
- Recommended date for reassessment for risk of suicide, minimally once every three months

Reassessment of Suicide Risk

All residents will be reassessed for risk of suicide minimally once every three months or as their needs change (e.g., individual disclosure of suicidal ideation, recent discharge from acute mental health service, following a suicide attempt or self-harm, significant change in circumstances- recent major life events especially involving loss).

Through reassessment, PCH staff will gain an understanding of the resident's ongoing suicide risk, response to interventions, and goals of treatment.

- Complete the Quarterly Care Plan Review Form (CLI.6410.PL.003.FORM.08) or Annual Care Conference Review Form (CLI.6410.PL.003.FORM.07).
- Screen for depression using:
    - No cognitive impairment to mild dementia: Use the Geriatric Depression Scale (GDS) – Short Form (CLI.6410.PL.021.FORM.03); or
    - Moderate to severe dementia: use the SIG E CAPS – Screening for Depression (CLI.6410.PL.021.FORM.04).
- If the resident's depression screening is not suggestive of depression, note this on the correct review form (i.e. quarterly or annual) and file the screening tool in the health record.
- If the resident's depressing screening is suggestive of depression, the nurse or designate shares this finding with the prescriber.
- If the resident's depression screening is suggestive of depression, ask the resident:
    - Do you ever think about hurting or harming yourself? If yes, what would you do?
- If the resident is cognitively impaired and unable to answer the question, ask the SDM:
    - Has the resident ever communicated to you thoughts of hurting or harming him/herself? If yes, what would he/she do?
- If the resident/SDM answers "no", document this discussion in the Integrated Progress Notes (CLI.6410.PL.003.FORM.06).
- If the resident/SDM answers "yes", complete the RAST.

- Update the Integrated Care Plan (CLI.6410.PL.003.FORM.01) accordingly and document the implementation of treatment, intervention and monitoring strategies.

Monitor the resident's response to interventions and involve the resident in evaluating his or her progress.

Any resident may be screened at any time by any nurse or social worker if clinical presentation warrants the screening. This may be to help rule out other conditions, such as delirium, or to help understand symptoms a resident may be experiencing.

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