Pennsylvania Depression Quality Improvement Collaborative

Sponsored by

Southeastern Pennsylvania Association for Healthcare Quality (SPAHQ)

in partnership with the
Abramson Center for Jewish Life

Polisher Research Institute
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Learning Session 3
Suicidal Ideation
Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities
Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities
A Guide to Promoting Emotional Health and Preventing Suicide in Senior Living Communities

Contents:
- Getting Started
- Goals and Action Steps
- Tools for Implementing Action Steps

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

2011

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SAMHSA
Substance Abuse and Mental Health Services Administration
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## Facility Assessment Checklist

**For Mental Health Promotion and Suicide Prevention in Your Senior Living Community**

<table>
<thead>
<tr>
<th>Whole Population Approach Questions</th>
<th>If you answer No or Don’t Know, consider implementing the steps in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a variety of activities that promote intellectual, creative, spiritual, and physical well-being?</td>
<td>Yes  No  Don’t Know</td>
</tr>
<tr>
<td>Do you have programs and support services for residents that help them cope with loss?</td>
<td>Yes  No  Don’t Know</td>
</tr>
<tr>
<td>Have your staff received training on the value of engaging residents in intellectual, social, physical, and creative activities?</td>
<td>Yes  No  Don’t Know</td>
</tr>
<tr>
<td>Do you have programs that are designed to promote social networks and community building among your residents?</td>
<td>Yes  No  Don’t Know</td>
</tr>
<tr>
<td>Are you familiar with initiatives recommending improvements in the social and physical environment of a senior living community to increase resident well-being and satisfaction?</td>
<td>Yes  No  Don’t Know</td>
</tr>
<tr>
<td>Do you have policies related to resident access to lethal means, (i.e., weapons and other methods they could use to harm themselves), as well as building design and security standards that restrict or minimize the potential for individuals to access areas that could lead to a fatal act?</td>
<td>Yes  No  Don’t Know</td>
</tr>
</tbody>
</table>

**Goal 1.1: Activities**

**Goal 1.2: Social networks**

**Goal 1.3: Environment**

**Goal 1.4: Lethal means**
Fact Sheets for Residents

Look Out for the Well-Being of Yourself and Others

No matter what age you are, it is important to look out for your own emotional well-being. This is especially true for older adults because of the special challenges at this stage of life. Taking charge of your emotional well-being can make a big difference.

- Are you in pain? Do you feel depressed?
- Are you lonely? Have you experienced a loss?
- You don’t have to feel this way. Read on . . .

Take Care of Yourself

Your emotional well-being is affected by your health. If you need help or support, staff at your senior living community can help you see a medical or mental health provider. Your facility may also offer health and wellness activities.

Here are some suggestions to take care of your health:

- Make an appointment with a medical provider if you are in pain or have a physical illness.
- Seek treatment or talk to a counselor if you have depression or another mental health issue, or if you drink too much or abuse medications.
- Join a support group to help you cope with the loss of family and friends, financial problems, or other personal issues.
- Stay active and exercise regularly. Try taking a group exercise class or going on walks.
- Eat a healthy diet. Avoid too much sugar, salt, fat, and caffeine.

Taking care of your physical and mental health will help you feel better and reduce feelings of helplessness.

Mrs. Williams

At 80 years old, Mrs. Williams was just settling into a senior living community when she broke her hip. Since she couldn’t walk, she slept most of the day and seemed very withdrawn. She said she felt her life was over.

Another resident was concerned that Mrs. Williams was depressed and told the staff. They talked with her children and decided she needed to see a counselor. Mrs. Williams did not like the idea, but her children insisted.

The counselor had Mrs. Williams take anti-depressants for six months and go to physical therapy. Her family provided support to her.

The staff encouraged her to get involved in activities she could do, such as arts and crafts and welcoming new residents. These activities gave her a sense of purpose and helped her build relationships.

Now Mrs. Williams is feeling better physically and emotionally and enjoys spending time with other residents and staff.

After a Suicide: How to Help Yourself and Others

When a person dies by suicide, it can have a huge impact on family members, friends, other residents, and staff. Whether you have lost someone by suicide or want to help another person who has, it is useful to know what to expect and how to best help someone else.

How to Help Yourself

Coping with a suicide can cause many emotions. Strong feelings are normal. No one has the same reaction, and emotions can change.

Take time to figure out how you feel. You may be feeling any of the following:

- Diabolical
- Denial
- Grief
- Guilt
- Anger
- Shame

An attempted suicide can often bring up some of these same emotions.

Here are some tips for coping:

- Give yourself time to deal with the loss and accept whatever emotions you feel.
- Everyone grieves differently.
- Talk about the person who died with someone you trust—a family member, resident, or staff.
- Honor the memory of the person who died—eat pictures of the person in your room or write something about him or her.
- Express your feelings with a counselor or in a support group with others who are likely to understand what you are going through.
- Stay with your daily routine and take care of your basic needs—eat, sleep, and attend your regular activities.
- Be prepared for holidays and anniversaries, since they can be difficult emotionally—consider doing something special in memory of the person who died.

Know the Warning Signs of Suicide

Have you heard someone make these statements? Have you thought them yourself?

- “I think I’m going to end it all.”
- “I no longer want to live.”
- “Death seems like the only way out.”

Have you seen someone doing any of these things? Are you doing them?

- Hoarding pets. Getting a gun or knife. Looking for a high place from which to jump. Refusing food, medicine, or other treatment.

These behaviors and statements are warning signs of suicide. The person needs IMMEDIATE help. Contact a nurse, social worker, doctor, mental health professional, or clergy RIGHT AWAY.

- - -

Do either of these descriptions sound like your neighbor, a friend, or yourself?

- A resident has been drinking more than usual. He doesn’t think his life has any purpose now that his wife is gone. He yells at the food servers and maintenance staff for taking too long.
- Another resident has stopped coming to bridge club and exercise class. She paces around at night, unable to sleep. She says she feels hopeless, that nothing in her life will ever improve.

These residents may be showing warning signs that they are considering suicide. Get help if you notice any of these behaviors and moods in yourself or another resident.

Take Care of Yourself

The suicide of a family member, friend, or resident can affect your mental health. Get help if you feel suicidal yourself.

Warming Signs that a person could be considering suicide:

- Behavior:
  - Withdrawing from family, friends, or others
  - Sleeping all the time or unable to sleep
  - Acting reckless
  - Increasing use of alcohol or drugs
- Mood:
  - Hopeless or feeling trapped
  - No sense of purpose in life
  - Anxious or agitated
  - Rage, uncontrolled anger
  - Dramatic changes in mood

SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov • 1-800-662-HELP (4357)
The Framework

1. Whole population
2. At Risk
3. Crisis Response
# Whole Population Approach

## Section 1

### Whole Population Approach

**Goals**

<table>
<thead>
<tr>
<th>Goal 1.1: Activities</th>
<th>Residents have access to activities that promote their mental health and well-being.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1.2: Social networks</td>
<td>Social networks are established among residents.</td>
</tr>
<tr>
<td>Goal 1.3: Environment</td>
<td>The physical and social environment promotes mental health and well-being.</td>
</tr>
<tr>
<td>Goal 1.4: Lethal means</td>
<td>Residents’ access to methods of self-harm is limited.</td>
</tr>
<tr>
<td>Goal 1.5: Staff training</td>
<td>Staff receive training and support for their roles in promoting the mental health of residents.</td>
</tr>
</tbody>
</table>

This section of the Guide discusses how you can promote mental health and prevent suicide among all residents of your senior living community, regardless of their individual risk for mental health problems or suicide. Any comprehensive approach to these issues begins with implementing policies and activities to promote the...
## Section 2
### At-Risk Approach

#### Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>All staff are able to identify and respond to warning signs for suicide. Designated staff are able to screen individual residents for suicide risk and ensure that the appropriate action is taken when a resident may be at risk.</td>
</tr>
<tr>
<td>2.2</td>
<td>All staff are able to identify risk and protective factors for suicide.</td>
</tr>
<tr>
<td>2.3</td>
<td>All staff are able to recognize symptoms of depression. Appropriately designated staff are able to screen individual residents for depression and ensure that residents who are depressed receive treatment.</td>
</tr>
<tr>
<td>2.4</td>
<td>All staff are able to recognize symptoms of alcohol abuse and medication misuse. Appropriately designated staff are able to screen individual residents for these conditions and ensure residents with substance abuse problems receive treatment.</td>
</tr>
<tr>
<td>2.5</td>
<td>Appropriately designated staff establish effective connections in the community to support mental health of residents.</td>
</tr>
<tr>
<td>2.6</td>
<td>Residents are knowledgeable about and comfortable seeking help for mental health problems, including suicidal ideation, depression, and substance abuse.</td>
</tr>
</tbody>
</table>
Section 3
Crisis Response Approach

Goals

<table>
<thead>
<tr>
<th>Goal 3.1: Immediate response</th>
<th>Policies and protocols for systematic and effective responses to suicide attempts and deaths are created. Staff are trained in these policies and protocols and their responsibilities in the event of a suicide crisis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 3.2: Postvention</td>
<td>Plans for postvention to support residents, families, and staff after a suicide crisis are developed.</td>
</tr>
</tbody>
</table>

This section of the Guide explores responding to suicide deaths and attempts in senior living communities. It includes information on creating and implementing crisis response policies and protocols and a plan to provide support for residents, their families, volunteers, the staff, and others who are affected by a suicide death or attempt.
Tool 2.b: Suicide Screening Tools for Older Adults

Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

SAFE-T is a pocket card for mental health clinicians and health care professionals that provides protocols for conducting a comprehensive suicide assessment, estimating suicide risk, identifying protective factors, and developing treatment plans and interventions responsive to the risk level of patients. The pocket card includes triage and documentation guidelines for clinicians. It was developed through collaboration between Screening for Mental Health, Inc. (SMH), and the Suicide Prevention Resource Center (SPRC). Douglas Jacobs, CEO and Founder of SMH, originally conceived the model of the SAFE-T pocket card. The protocols and guidelines featured on the card were developed based upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. [http://www.sprc.org/library/safe_t_pcktcrd_edc.pdf](http://www.sprc.org/library/safe_t_pcktcrd_edc.pdf)
Tool 2.b: Suicide Screening Tools for Older Adults

Geriatric Suicide Ideation Scale

The Geriatric Suicide Ideation Scale was developed because the standard SSI does not distinguish among acceptance of mortality, death ideation, and suicidal intent—important distinctions among older adults. The tool has 31 questions with 4 subscales: suicide ideation, death ideation, loss of personal and social worth, and perceived meaning in life. While several studies have pointed out its potential validity as a measure of suicide ideation among older adults, it has yet to be fully evaluated. (Heisel & Flett, 2006; Heisel, 2006)
Suicide Screening Tools

**Tool 2.b: Suicide Screening Tools for Older Adults**

**Suicidal Older Adult Protocol (SOAP)**

The Suicidal Older Adult Protocol (SOAP) is a guided clinical interview with 18 items. It is the third in a series of tools for teens, adults, and older adults. Items include demographics, history of attempts, physical and psychological clinical factors, life situation, and protective factors. The clinician determines suicide risk based on professional judgment, not a score. The tool then provides a list of actions to take, depending on the responses. It is still being evaluated. (Fremouw et al., 2009)
Tool 2.i: Programs for Managing and Treating Depression in Older Adults

*Depression management program:* Abramson Center for Jewish Life has a depression management program for nursing home residents that involves screening, activities, and exercise, as well as social work and psychology/psychiatry interventions if necessary. An informal evaluation showed that two-thirds of the participants experienced some improvement with this program. (*Provider,* AHCA newsletter Sept. 2008) Article online at: [http://www.ahcancal.org/News/publication/Provider/CaregivingSep2008.pdf](http://www.ahcancal.org/News/publication/Provider/CaregivingSep2008.pdf)
Ordering the Toolkit

The toolkit can be ordered on-line for free via the following link:

http://store.samhsa.gov/product/SMA10-4515
Contact Information

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240-276-1842
rosalyn.blogier@samhsa.hhs.gov
SAFE-T

Suicide Assessment Five-step Evaluation and Triage

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Screening for Mental Health, Inc

Developed by:
Douglas Jacobs, M.D.
President and CEO
Screening for Mental Health, Inc
Associate Clinical Professor of Psychiatry
Harvard Medical School

The SAFE-T is a collaboration between Screening for Mental Health & the Suicide Prevention Resource Center
Suicide Facts & Figures

- Although adults over age 65 compose 12.4% of U.S. population, they account for 14% of all suicides
- 90% to 95% have psychiatric illness
- 4:1 male to female for completions
- 3:1 female to male for attempts
- 75% of older adult suicide completion on 1st attempt (60% general population)
- Studies consistently find a close association between suicide and late life depression
Suicide: A Multi-factorial Event

- Psychiatric Illness Co-morbidity
- Neurobiology
- Personality Disorder/Traits
- Psychiatric Symptomotology
- Substance Use/Abuse
- Family History
- Severe Medical Illness
- Psychodynamics/Psychological Vulnerability
- Access To Weapons
- Life Stressors
- Suicidal Behavior
Questions about Suicide Assessment

- **What are the elements of a suicide assessment?**
- **Which diagnoses, risk factors and traits should most concern clinicians?**
- **What are the key determinants in assigning level of suicide risk?**
- **What are the basic steps in establishing treatment settings?**
- **What are the most important elements to document in a suicide risk assessment and how can that be helpful in liability prevention?**
Determination Of Risk

Psychiatric/Physical Examination

Risk Factors

Psychiatric & Medical

Protective Factors

Modifiable Risk Factors

Specific Suicide Inquiry

Risk Level

Determination Of Risk

Psychiatric & Medical

Psychiatric/Physical Examination

Risk Factors

Protective Factors

Modifiable Risk Factors

Specific Suicide Inquiry

Risk Level
SAFE-T

1. IDEN TIFY RISK FACTORS
   Note those that can be modified to reduce risk

2. IDEN TIFY PROTECTIVE FACTORS
   Note those that can be enhanced

3. CONDUCT SUI CI DE INQUI RY
   Suicidal thoughts, plans, behavior and intent

4. DETERMINE RISK LEVEL / INTERVENTION
   Determine risk. Choose appropriate intervention to address and reduce risk

5. DOCUMENT
   Assessment of risk, rationale, intervention and follow-up
<table>
<thead>
<tr>
<th>Identify Risk Factors</th>
<th>Demographic</th>
<th>male; widowed, divorced, single; increases with age; white</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychosocial</td>
<td>lack of social support; unemployment; drop in socio-economic status; <strong>firearm access</strong></td>
</tr>
<tr>
<td></td>
<td>Psychiatric</td>
<td><strong>psychiatric diagnosis;</strong> comorbidity</td>
</tr>
<tr>
<td></td>
<td>Physical/ Medical Illness</td>
<td>malignant neoplasms; HIV/AIDS; peptic ulcer disease; hemodialysis; systemic lupus erthematosis; pain syndromes; functional impairment; diseases of nervous system; alcohol drug abuse or withdrawal *delirium; agitation</td>
</tr>
<tr>
<td></td>
<td>Psychological Dimensions</td>
<td>hopelessness; psychic pain/ anxiety; psychological turmoil; decreased self-esteem; fragile narcissism &amp; perfectionism</td>
</tr>
<tr>
<td></td>
<td>Behavioral Dimensions</td>
<td>impulsivity; aggression; severe anxiety; panic attacks; agitation; intoxication; prior suicide attempt</td>
</tr>
<tr>
<td></td>
<td>Cognitive Dimensions</td>
<td>thought constriction; polarized thinking</td>
</tr>
<tr>
<td></td>
<td>Childhood Trauma</td>
<td>sexual/physical abuse; neglect; parental loss</td>
</tr>
<tr>
<td></td>
<td>Genetic &amp; Familial</td>
<td>family history of suicide, mental illness, or abuse</td>
</tr>
<tr>
<td></td>
<td>History</td>
<td>prior suicide attempts (multiple), aborted suicide attempts, or self-injurious behavior</td>
</tr>
</tbody>
</table>
SAFE-T Point 2: Identify Protective Factors

- **External**
  - Responsibility to children or beloved pets
  - Positive therapeutic relationships
  - Social supports

- **Internal**
  - Ability to cope with stress
  - Religious beliefs
  - Frustration tolerance

*Protective factors, even if present, may not counteract significant acute risk*
SAFE-T Point 3: Suicide Inquiry

- **Ideation**: Ask about frequency, intensity and duration in the last 48 hours, past month and worst ever. E.g., “Have you ever felt that life was not worth living?” “Have you ever reached the point that you’ve thought of harming yourself?”

- **Plan**: Ask about timing, location, lethality, availability, preparatory acts. E.g., “Have you ever made a specific plan to harm or kill yourself?”

- **Behaviors**: Ask about past attempts, aborted attempts, rehearsals (tying noose, loading gun)

- **Intent**: Ask about extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal
  - Explore ambivalence: reasons to die versus reasons to live
Specific Suicide Inquiry

- Begin with questions that address the patient’s feelings about living
- Follow-up with specific questions that ask about thoughts of death, self-harm or suicide
- Consider:
  - Specific methods: lethality (and expectation), as well as whether firearms are accessible
  - Alcohol or other substance use
  - Prior history of suicidal or self-damaging behaviors and worst episode of suicidal ideation
  - Intent: expectations of plan’s lethality
  - For individuals with psychosis, ask specifically about hallucinations and delusions
  - Thoughts, plans, or intentions of violence toward others
SAFE-T Point 4: Risk Level/Intervention/Referral

- **Assessment** of risk level is based on clinical judgment after completing steps 1-3
- **Intervention** based upon level of risk
- **Referral** or obtain consultation from a mental health specialist when risk level is moderate or above

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK / PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td>Low</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)
SAFE-T Point 5: Documentation

- Include: risk level, the basis for the determination of risk and the decision to treat/refer, follow-up visit, communication with significant others, consultation, and firearm instructions, if relevant.

- Treatment should address modifiable risk factors and incorporation of protective factors.
When to Document Suicide Risk Assessments

- At first psychiatric assessment or admission
- With the occurrence of any suicidal behavior or ideation
- Wherever there is any noteworthy clinical change
- For inpatients:
  - Before increasing privilege level
  - Before giving passes
  - Before discharge
When a Suicide Occurs

- Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice.
- Approximately, 12,000-14,000 suicides per year occur while in treatment.
- To facilitate the aftercare process:
  - Ensure that the patient’s records are complete
  - Be available to assist grieving family members
  - Remember the medical record is still official and confidentiality still exists
  - Seek support from colleagues / supervisors
  - Consult risk managers
## Table 1. Opportunities for suicide prevention interventions in senior living communities.

<table>
<thead>
<tr>
<th>Approach</th>
<th>Goal</th>
<th>Objective</th>
</tr>
</thead>
</table>
| **At-risk approaches**                        | Increase help-seeking behaviors           | • Increase residents’ knowledge of treatable risk factors, potential treatments, and available services  
• Address local barriers to help-seeking  
• Implement efforts to reduce stigma and normalize help-seeking                                                                                                                                 |
| Identify and refer distressed or at-risk residents |                            | • Increase the ability of other residents, staff, and families to identify and refer residents for help (i.e., “gatekeeper training”)  
• Increase case identification of depression, substance abuse, and suicidality (i.e., screening)  
• Increase clinicians’ capacity to identify and refer appropriately                                                                                                                                 |
| Increase access to mental health and substance abuse services | Create linkages with community-based mental health and substance abuse services  
Provide mental health and substance abuse services or supports |                                                                                                                                                                                                             |
| Promote effective treatment and management of mental health and substance abuse disorders | Adhere to geriatric-specific treatment guidelines  
Utilize effective models of geriatric care management  
Assess for suicidality  
Increase regular monitoring of at-risk residents |                                                                                                                                                                                                             |
| Effectively address medical conditions and pain | Employ treatment regimens designed to reduce symptoms and pain  
Help ill residents deal with specific types of disability and functional impairment |                                                                                                                                                                                                             |
| **Whole-population approaches**               | Promote effective coping and functioning   | • Promote coping with loss, bereavement  
• Promote coping with decreased functioning, role changes  
• Promote problem-solving skills  
• Provide assistance with financial or other matters                                                                                                                                 |
| Promote social networks and social support    | Encourage connection among residents  
Promote a sense of community on campus  
Provide or facilitate regular “check-ins”  
Facilitate contacts with family members |                                                                                                                                                                                                             |
| Promote engagement in positive activities     | Provide access to spiritual or faith activities  
Promote involvement in volunteer activities  
Provide recreational activities  
Promote engagement in physical activity |                                                                                                                                                                                                             |
| Decrease access to lethal means               | Restrict access to firearms  
Limit access and/or erect fences on roofs of buildings  
Replace windows or limit size of window openings  
Restrict access to stored chemicals and prescription drugs |                                                                                                                                                                                                             |

Source: Report on the 2008 Summit on Opportunities for Mental Health Promotion and Suicide Prevention in Senior Living Communities (2009). [29].
doi:10.1371/journal.pmed.1000254.t001
In Conclusion

- Suicide assessment is clinical judgment based on comprehensive psychiatric examination
- There is no “cookbook” approach to suicide assessment

“Suicide cannot be predicted and in some cases cannot be prevented, but an individual’s suicide risk can be assessed and a treatment plan can be designed with the goal of reducing the risk”—APA Guidelines

Additional resources can be found at www.stopasuicide.org

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Using the Geriatric Suicide Ideation Scale (GSIS) when Assessing Suicide Ideation among Older Adults

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Pennsylvania Depression Collaborative, Webinar Presentation, March 24, 2011
Background

- The WHO estimates that one million lives are lost to suicide worldwide every year (2% of all deaths)
- This exceeds the number of lives lost to war and homicide combined
- In North America, 20-25% of the population will be 65 years or older by 2031, exceeding an estimated 70 million people.
- Baby-boomers have higher rates of suicide than do prior generations.
• Adults 65 years and older have among the highest suicide rates of all age groups in Canada, the U.S., and worldwide (Bertolote, 2001; Heisel, 2006; Heisel & Duberstein, 2005).

• Over 6,000 individuals over the age of 65 die by suicide in North America every year.

• Older adults use highly lethal means of self-harm.

• The ratio of suicidal behavior to death by suicide is as low as 1-4:1.
Raw Number of Deaths by Suicide by Sex among U.S. Baby-Boomers, 1999-2007

WISQARS, CDC
U.S. SUICIDE RATES BY AGE, GENDER, AND RACIAL GROUP

2002

Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics
“Suicide prevention is everybody’s business”

• We all have a role to play in helping to prevent suicide in our communities.

• It is important to know what our specific roles are, and to work within our training and skill level, and to support one another.

• Key roles for staff in LTC and in nursing facilities:
  • identification of at-risk individuals
  • provision of emotional support
  • assistance with referral to specialized services
  • liaison with family members.
Assessment of Suicide Risk

• Assess Risk and Resiliency Factors
• Use Assessment Tools
• Be Vigilant to Suicide Warning Signs
Suicide risk and resiliency factors

- Suicide is a complex and multidimensional phenomenon with multiple determinants and contributing factors.
- Identification of suicide risk factors may aid in the detection of those at risk and inform intervention efforts.
- Many potential risk factors exist, and approaches are lacking as to how best to combine them.
Suicide Risk Factors

Demographic

• Gender: Male
• Age: Elderly
• Ethnicity: White/Caucasian
• Marital Status: Divorced/Separated/Single
• Living Status: Living alone or isolated
  Extreme changes in living status/conditions

• These risk factors are true at the aggregate level, but may be less relevant at the level of the individual.
Additional Risk Factors for Late-Life Suicide

- Mental disorders
- Personality disorders
- Severe medical illness and/or pain
- Psychosocial stressors (social and/or financial problems, losses and transitions, poor coping skills)
- Functional impairment/decline, fear of decline
- Absence of psychological resiliency and well-being (meaning in life, hope, satisfaction, spirituality, social support, optimism, joy, poor healthcare, hobbies/interests)
Indicators of Potential Suicide Risk

Behavioral

- Suicide ideation/communication of intent/suicide note
- Giving away prized possessions
- Presence of a suicide plan (with/without intent)
- History of suicidal behavior
- Self-harm
- Having access to/stockpiling lethal implements
  - (e.g., guns, knives, ropes, pills)
Why not just ask people if they are contemplating suicide?
• Of course, this is a necessity; however, it must be done sensitively, appropriately, and in the context of a trusting relationship.

• Clumsy assessment of suicide ideation may be worse than not asking the question at all.

• “Sugarcoating” the question can be just as bad as being overly blunt, but you do want to be specific (e.g., don’t ask about “thoughts of hurting yourself” if you really want to know about “thoughts of killing yourself”).
• Recent research indicates that three-quarters of current or recently-discharged mental health patients who died by suicide denied suicide ideation as a last communication before death.

• Some did so as little as 5-10 minutes before dying by suicide (Busch, Fawcett, & Jacobs, 2003).
Risk Assessment Tools

• Include research and clinical tools

• We must be aware of response biases (including over- and under-endorsement of risk)

• DO NOT use professional assessment tools without appropriate training and/or supervision in their use

• Recognize the limitations of assessment tools

• Just because someone denies suicide ideation doesn’t mean he or she isn’t contemplating suicide

• None “predict” death by suicide (low base-rate event)

• However, we can and MUST, assess suicide risk in our clients
The Geriatric Suicide Ideation Scale (GSIS)
Heisel & Flett, 2006 (AJGP)

- Assesses suicide ideation among older adults
- The GSIS is the first multidimensional measure developed to assess suicide risk and resiliency among older adults
- It has demonstrated strong measurement characteristics among older adults across levels of suicide risk and across settings
The Geriatric Suicide Ideation Scale (GSIS)

Developed:
- to assess suicidal thoughts among older adults
- to detect and assess suicide risk and resiliency
- for clinical risk assessment and monitoring, as a springboard for important clinical discussions, and as a therapeutic outcome measure
- for research purposes:
  - Theory building
  - Hypothesis testing
  - Correlational research
  - Clinical outcomes research
• Given the absence of a late-life suicide ideation scale, researchers had to rely upon:
  • single-item measurement
  • non-standardized clinical approaches
  • measures with low sensitivity to less extreme risk
  • conflation of suicide ideation, intent, and lethality
  • measures not developed or validated with seniors
  • Psychological guidelines on treatment of older adults warn against use of measures developed among younger adults (APA, 2004)
• We developed the GSIS using clinical experience, review of the literature, theoretical grounding in late-life suicide and its prevention, and a phenomenological approach

• We wrote an initial set of items to tap the domain of suicide ideation among older adults

• We sought out expert feedback

• We tested the initial 66 items with 172 older adults and revised the scale down to 31 items

• We tested these items with 107 older adults
• The GSIS was designed as a self-report measure, to be answered in the first person

• We anticipated having to administer it orally to participants with vision, hearing, literacy, and/or other limitations

• We worded its items to reflect the subjective experience of despairing and suicidal older adults
Listed below are a number of statements concerning your feelings and beliefs about your life. Please read each statement carefully, and decide whether you agree or disagree with it, and to what extent, as indicated below. Please be completely honest in your responses, and try to respond to every statement. Do not circle more than one number for each statement.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Strongly Disagree</td>
<td>2</td>
<td>Disagree</td>
<td>3</td>
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</table>
The GSIS Sample Items

- **Suicide Ideation** (10 items):
  “I want to end my life”

- **Death Ideation** (5 items):
  “I often wish that I would pass away in my sleep”

- **Loss of personal and social worth** (7 items):
  “I generally feel pretty worthless”

- **Perceived Meaning in Life** (8 items):
  “I feel that my life is meaningful”
# Reliability Estimates

<table>
<thead>
<tr>
<th>Scale</th>
<th>Internal Consistency</th>
<th>Temporal Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSIS Total Scale</td>
<td>$\alpha = .93$</td>
<td>$r = .86^{**}$</td>
</tr>
<tr>
<td>Suicide Ideation</td>
<td>$\alpha = .82$</td>
<td>$r = .78^{**}$</td>
</tr>
<tr>
<td>Death Ideation</td>
<td>$\alpha = .84$</td>
<td>$r = .76^{**}$</td>
</tr>
<tr>
<td>Loss of Worth</td>
<td>$\alpha = .82$</td>
<td>$r = .77^{**}$</td>
</tr>
<tr>
<td>Meaning in Life</td>
<td>$\alpha = .81$</td>
<td>$r = .75^{**}$</td>
</tr>
</tbody>
</table>

*a Validation sample (n = 107)

*b 1-2 month test-retest period (n = 32 nursing home residents)

** $p < 0.001$
Validity

Criterion Validity

- The GSIS was significantly associated with an existing SI scale ($r = .61$, $p < 0.001$)

- The GSIS was significantly associated with history of suicidal behavior ($r = .23$, $p < 0.05$)

- GSIS scores differentiated mental health patient from non-M.H.-patient groups
Concurrent Validity

- Convergence
- Depression
- Hopelessness
- Social Hopelessness
- Health ratings
- Wish to Hasten Death

- Non-Convergence
- Meaning in life
- Psychological well-being
- Satisfaction with life
- Coping
- Religiosity
- Reasons for living
Other Findings

- The GSIS has shown sensitivity to clinical change in our trial of Interpersonal Psychotherapy with suicidal older adults (Heisel et al., 2009).

- It has also shown sensitivity to change in a pilot study of cognitive therapy for adults 60+ with Generalized Anxiety Disorder (J. Mohlman, Ph.D.).

- It has shown predictive validity, predicting suicide ideation across a 1-2 year period of follow-up in a community-residing older adult sample (Heisel & Flett).

- It has been used in studies of SI by other researchers in Canada (Neufeld & O’Rourke, 2009), the U.S. (Jahn et al., 2011; Marty & Segal, 2010) and China (Chou et al., 2005).
A New Direction: GSIS Screening Items

1. I feel that my life is meaningful.
2. I generally feel pretty worthless.
3. I often wish that I would pass away in my sleep.
4. I want to end my life.
5. I have tried ending my life in the past.
Findings with Nursing and Retirement Home Residents (N=50)

• Internal consistency was acceptable (α = .73)

• Screening totals were significantly correlated with:
  - GSIS totals: \( r = .92, p < 0.0001 \)
  - GSIS suicide ideation: \( r = .88, p < 0.0001 \)
  - GSIS death ideation: \( r = .85, p < 0.0001 \)
  - GSIS loss of worth: \( r = .76, p < 0.0001 \)
  - GSIS meaning in life: \( r = .59, p < 0.0001 \)
  - History of suicidal behavior: \( r = .29, p < 0.05 \)
- GSIS screening totals significantly differentiated individuals recruited from community, retirement, nursing, medical, and psychiatric settings ($F_{(4,293)} = 53.2$, $p<0.0001$).

<table>
<thead>
<tr>
<th>Setting</th>
<th>M</th>
<th>SD</th>
<th>n</th>
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</thead>
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<tr>
<td>Psychogeriatric a</td>
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<td>4.38</td>
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<tr>
<td>Hospital a</td>
<td>7.80</td>
<td>2.22</td>
<td>25</td>
</tr>
<tr>
<td>Nursing Home ab</td>
<td>9.63</td>
<td>3.37</td>
<td>41</td>
</tr>
<tr>
<td>Retirement Home a</td>
<td>7.56</td>
<td>2.46</td>
<td>9</td>
</tr>
<tr>
<td>Community ab</td>
<td>6.57</td>
<td>2.01</td>
<td>181</td>
</tr>
</tbody>
</table>

**Note**: Superscripts identify significant between-group differences.
Data from our longitudinal study with community-residing older adults showed significant negative association between the GSIS screen and meaning in life, life satisfaction, and psychological well-being, and positive associations with depression, hopelessness, and suicide ideation.

The GSIS screen also predicted total GSIS scores:

- After 2-4 weeks, $r = .55$, $p < 0.0001$ ($n = 139$)
- After 6-12 months, $r = .51$, $p < 0.0001$ ($n = 126$)
- After 1-2 years, $r = .40$, $p < 0.0001$ ($n = 85$)
Additional Resources

• Canadian Coalition for Seniors’ Mental Health (CCSMH) Knowledge Translation Tools

• American Association of Suicidology (AAS) Suicide Warning Signs
Canadian Coalition for Seniors’ Mental Health

In 2006 released 4 federally funded (Public Health Agency of Canada) National Guidelines for the care of mental health issues affecting older adults:

• Assessment and Prevention of Suicide
• Delirium
• Depression
• Mood and Behavioural Problems in LTC
# Guideline Development Group Members: Suicide

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Marnin J. Heisel</td>
<td>Co-Chair</td>
<td>Psychology</td>
</tr>
<tr>
<td>Dr. Sharon Moore</td>
<td>Co-Chair</td>
<td>Psychology &amp; Nursing</td>
</tr>
<tr>
<td>Dr. Adrian Grek</td>
<td>Co-Chair</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Ms. Fae Jackson</td>
<td>Group Member</td>
<td>Nursing</td>
</tr>
<tr>
<td>Ms. Gayle Vincent</td>
<td>Group Member</td>
<td>Administrator/Public Health</td>
</tr>
<tr>
<td>Dr. Barry Hall</td>
<td>Consultant</td>
<td>Social Work</td>
</tr>
<tr>
<td>Dr. Paul Links</td>
<td>Consultant</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Dr. Isaac Sakinofsky</td>
<td>Consultant</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Ms. Nona Moscovitz</td>
<td>Consultant</td>
<td>Social Work</td>
</tr>
<tr>
<td>Ms. Myra Morrant</td>
<td>Consultant</td>
<td>Librarian</td>
</tr>
<tr>
<td>Ms. Simone Powell</td>
<td>Consultant</td>
<td>Senior Policy Analyst</td>
</tr>
</tbody>
</table>
CCSMH Toolkit Components

- 2006 CCSMH guideline “The Assessment of Suicide Risk and Prevention of Suicide”
- An abbreviated version of the guideline in a special supplement to the Canadian Journal of Geriatrics
- The clinician pocket-card “Suicide Assessment & Prevention for Older Adults”
- Interactive case-based DVD with instructor’s manual
- A guide for family members
DOWNLOAD THE TOOLKIT AT WWW.CCSMH.CA

To promote seniors mental health by connecting people, ideas and resources.

Promouvoir la santé mentale des personnes âgées en reliant les personnes, les idées et les ressources.

CCSMH
Canadian Coalition for Seniors Mental Health

English
Welcome

CCSMPA
Coalition Canadienne Pour la Santé Mentale des Personnes Âgées

François
Bienvenue
• Remember “IS PATH WARM?”
  • I  Ideation
  • S  Substance Abuse
  • P  Purposelessness
  • A  Anxiety
  • T  Trapped
  • H  Hopelessness
  • W  Withdrawal
  • A  Anger
  • R  Recklessness
  • M  Mood Change

-American Association of Suicidology
Ultimately, you need to talk with your residents:

- first establish rapport
- respect their dignity as human beings
- ask about their current life experiences, learn about the context of their life
- empathize with their difficulties
- try to use emotion-focused language
- indicate that most people, when feeling this way, may question the value of going on, or feel weary of living, or even think of death or suicide, ask how often they feel this way
• then be supportive (of them, not of suicide)
• listen to your gut or the little voice in your head
• don’t assume all is well…question
• listen to what they have to say
• ask whether they have felt like this in the past, and what they did about it (both positive-looking for resources or resiliency, and negative-assessing past self-harm)
• ask what makes them feel like this-what makes it worse
• ask what makes it better-then encourage it
• spend time with them and be supportive
• try to normalize their feelings, but never normalize or support suicidal behavior
• don’t be preachy (although optimism is o.k.)
• don’t “go it alone”
  • involve site clinicians/administrators
  • refer to mental health or crisis services
  • involve family if available
  • consult with others, if possible
• document, document, document
• enhance your education regarding suicide, risk assessment, and appropriate interventions and clinical management strategies
• surround yourself with supports-professional and personal
Thank You
Funding Acknowledgements

• American Foundation for Suicide Prevention
• Canadian Coalition for Seniors Mental Health
• Canadian Institutes for Health Research
• Lawson Health Research Institute
• Ontario Mental Health Foundation
• Ontario Ministry of Research and Innovation
• Public Health Agency of Canada
• Social Sciences and Humanities Research Council of Canada
• UWO, Department of Psychiatry
The Hopemont SOAP

Assessing Suicide Risk in Long-Term Care Facilities

Alisa O’Riley, PhD
University of Rochester Medical Center

NIH NRSA Award 5T32MH020061-10
Overview

- Purpose of suicide risk assessment
- Background of the Hopemont SOAP
- Aspects of the Hopemont SOAP risk assessment
- The Decision Tree
The Purpose of Suicide Risk Assessment...

• ...is NOT to predict death by suicide

• The purpose of suicide risk assessment is PLANNING
The Importance of Planning

- May prevent deaths by suicide
- Ensures resources are used appropriately
- Limits liability
Background of the Hopemont SOAP

- Modified version of the Suicidal Older Adult Protocol (Fremouw et al., 2009)
- Designed to help staff (particularly staff without extensive training in risk assessment) assess different levels of risk and respond appropriately
Background of the Hopemont SOAP

http://www.cdc.gov/ncipc/dvp/social-ecological-model_DVP.htm
Background of the Hopemont SOAP

Rudd, 2006
# Aspects of the Hopemont SOAP: Individual

## Background Risk Factors
- Gender/Race/Age (white, older, males)
- Prior Suicide Attempts
- Recent, Planned, Serious, Attempts
- High level of chronic pain/disability

## Acute Risk Factors
- Plan for suicide
- Indirect self-destructive behaviors
- Unresolved psychiatric illness
- Hopelessness/helplessness/worthlessness
- Moral objections to suicide
- Treatment for mental health
- Other personal reasons for living
Aspects of the Hopemont SOAP: Relationships

**Background Risk Factors**
- Marital Status

**Acute Risk Factors**
- Recent Loss
- Social Isolation
- Difficulties with roommates
- Relationships that would prevent the resident from dying by suicide
Aspects of the Hopemont SOAP: Community

**Background Risk Factors**
- How recently the resident was admitted
- Size of the facility
- Staff turnover
- Involvement of activity staff, social work, access to mental health care
- Staff training 😊

**Acute Risk Factors**
- Access to lethal means:
  - Hanging/suffocation
  - Jumping
  - Pills/Poison
  - Drowning
  - Cutting
  - Indirect means
Suicide Protocol Instructions
When a resident threatens to harm him/herself, start at the top of the flow chart and follow each step.

Take threat seriously. Immediately provide one-on-one supervision.

Notify charge nurse in house. Nurse will assess patient using the S.O.A.P.

Notify Social Worker on call with S.O.A.P. score.

Take the following steps, based on S.O.A.P. score...

---

**Low Risk**

Refer to psychology and psychiatry for further assessment.

If someone who is at low risk is repeatedly threatening suicide, develop individualized care plan to address behavior.

Document action taken.

**Medium Risk**

Provide one-on-one supervision until emergency care plan meeting can be arranged.

Remove potentially dangerous items (belts, electrical cords, glass, etc.) from resident’s room.

Limit the resident to finger foods (resident should not have access to silverware or plasticware).

**Nurse** should notify resident’s physician, and psychiatrist. **Social work** should notify psychology and resident’s guardian/family.

Hold emergency care plan meeting to develop individualized plan ASAP.

Document all actions taken.

---

**High Risk**

Provide one-on-one supervision until resident is transferred to a safer environment.

Remove potentially dangerous items (belts, electrical cords, glass, etc.) from resident’s room.

Social work should arrange to have resident transferred to a more restrictive environment ASAP.

**Nurse** should notify resident’s physician, and psychiatrist. **Social work** should notify psychology and resident’s guardian/family.

Document all actions taken.

---

Remember:
DOCUMENT ALL ACTIONS TAKEN!!
Questions?

Alisa O’Riley, PhD
Alisa_Oriley@umc.rochester.edu
(585) 273-4482
Next Steps

Q&A and Sharing Best Practices (optional)

Format: Regular Conference Call (NOT Webinar)

When: Thursday, August 18th 2011, 10AM

Cost: No Charge

Who shall I invite?
- Project Lead
- Other team members as appropriate/available

First Data Submission
- March 2011 Data – due April 5th, 2011
- 5th day of the month thereafter
Collaborative Milestones

- NHA Commitment Letter
- Overview Learning Session
- Learning Session 1
- Learning Session 2
- Learning Session 3
- Wellness Rounds Start-up Date
- Monthly Data Submissions
Next Steps

Association Contacts
Confirmation - Feedback

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