Susan Wehry MD Sample protocol developed for Long Term Care Ombudsman Program (LTCOP)
Revised for use by all staff working in long term care

Suggested Protocol for Resident Verbalizing Suicidal Ideation or Plan

Rationale: In the event a [resident] verbalizes suicidal thoughts or even a plan, the carer will know what steps to take for safety of the client and themselves.

Summary: For all residents who express thoughts of suicide or wishing to be dead staff will:
1) perform a *preliminary* risk assessment using a standard set of questions
2) communicate risk according to protocol
3) determine which supports or crisis assistance to involve
4) assist client in accessing supports
5) discuss with a supervisor
6) If the risk of self-harm is imminent, notify the charge nurse or director of nursing

Introduction

It is not unusual for individuals to express frustration or disappointment by sometimes making statements such as "I wish I were dead" and yet have no intention of taking their own lives. Others, making the same or similar statements, such as "I'd be better off dead", may very well be communicating suicidal ideation. How are you supposed to know 'when to take it seriously'. The answer is actually simple: ALWAYS.

In other words, while not every statement means the person is going to take his or her life, every statement is worthy of some follow-up questions to determine:
1) is the person thinking if taking his or her life? And,
2) how likely is he or she to act on those thoughts?

In these situations, the role of the carer is to systematically inquire about thoughts of self-harm and to make an appropriate referral. The carer is NOT RESPONSIBLE for making the final determination of suicide risk OR for single-handedly protecting a person from his or her suicidal thoughts. You are RESPONSIBLE for asking the appropriate questions and making an appropriate referral. The ombudsman may also play role in educating a resident and helping him or her access the necessary supports and interventions.

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Basically, you will encounter two types of situations in which you need to do a preliminary suicide risk assessment:

One in which your resident spontaneously expressed suicidal FEELINGS or THOUGHTS and, one in which he or she may not have expressed any suicidal feelings but you have reason to believe he or she is depressed.

Here is how to proceed

A) **Person verbalizes thoughts of suicide**

ASK

Have you told your doctor or anyone about these thoughts?

Regardless of the answer, **ASK**

Do you feel these feelings and thoughts are a problem for you, or something you might act on?

1) If the person answers NO, **SAY**:

You know I am not a clinician and I am not qualified to fully evaluate these thoughts and feelings. I'm glad this is something you feel you would not act on, but these thoughts and feelings are possibly part of a depression.

It is important that we get proper medical attention for you. Whom should we talk to on your care team?

Make the referral to the nurse or the resident's physician.

2) If the clients answers YES or answers equivocally, (such as "I don't know or I'm not sure" to the question: Do you feel these feelings and thoughts are a problem for you, or something you might act on? **SAY**

[You know I am not a clinician and I am not qualified to fully evaluate these thoughts and feelings.] I am concerned about you. I would like to ask you a few more questions

Then ASK

1. [Is there a plan?] Have you thought about how you would hurt yourself?
2. [Is there access to the means to carry out the plan?] Eg., Do you have a gun?
3. [Deterrents] What has helped you not act on these feelings? Is there someone who can keep your gun for you?

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4. [Intent] How likely do you think you are to act on these thoughts are you to act on these thoughts?

Based on the client's responses you will form a preliminary impression of whether or not the client is at low, medium or high risk of acting on their feelings and will proceed according to protocol.

B) The person has not spoken of suicide but you think the person may be clinically depressed. **ASK**

Over the last two weeks, have you had thoughts that you would be better off dead or that you want to hurt yourself in some way?

If the client answers YES, **SAY**
You know I am not a clinician and I am not qualified to fully evaluate these thoughts and feelings. I am concerned about you. I would like to ask you a few more questions and then help put you in touch with professionals who can help you.

Then ASK:
1. [Is there a plan?] Have you thought about how you would hurt yourself?
2. [Is there access to the means to carry out the plan?] Eg., Do you have a gun?
3. [Deterrents] What has helped you not act on these feelings? Is there someone who can keep your gun for you?
4. [Intent] How likely do you think you are to act on these thoughts?

Based on the client's responses, the ombudsman will form a preliminary impression of whether or not the client is at low, medium or high risk of acting on their feelings and will proceed according to protocol.

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Preliminary Suicide Risk Assessment

Check all that apply

Low

No plan
Has vague plan but has no access or idea on how to carry it out OR has very strong deterrents for not pursuing suicide
States NO INTENTION of acting on suicidal thoughts or feelings
Does not abuse alcohol or other drugs

Medium

Has plan but it is vague
Has specific plan but no access to the means for carrying it out
Has some deterrents
States LITTLE INTENTION of acting on suicidal thoughts or feelings but cannot say for sure
Uses alcohol or other drugs to point of intoxication
Score is >6 on GDS

High

Has clear plan (how, when, where)
Plan involves use of a firearm
Score is >6 on GDS
Has no or few strong deterrents
STATES INTENTION of acting on suicidal feelings regardless of when or where

NEXT STEPS
If client scores in LOW RISK category

1) Document your assessment
2) Advise the client whom to call if suicidal thoughts become more of a problem
3) Facilitate referral to primary practitioner if screening for depression is positive; include your preliminary risk assessment suicide assessment in your Healthy IDEAS referral letter
4) Identify clients supports and encourage use of them
5) Initiate behavioral activation
6) Discuss with your supervisor within the week

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You may say something like:
I am concerned about you. I understand from what you've told me, that it is unlikely that you would act on the thoughts about suicide you've had. Nonetheless, I think it would be helpful for you to talk to someone. May I help you arrange it?

The ombudsman may also want to think through with the client as to what additional supports they have or could use in their lives.

If client scores in MEDIUM RISK category
1) Document your assessment
2) Facilitate referral to primary practitioner or mental health professional. At a minimum, have the client place the call while you are there or make it for them if they wish. If the client is unwilling to make the call while you are there, ask them to call as soon as possible and check in the next day to make sure they have made the call.
3) Advise the client whom to call if suicidal thoughts become more of a problem
Wherever possible, give the client a specific name and number of the crisis clinic
4) Identify clients supports and generate a specific plan to rally them. The ombudsman may say something like: **I don't think it is a good idea for you to be alone with these thoughts right now.** Whom can we call?
5) Initiate behavioral activation
6) Notify the appropriate crisis agency in your community of the at-risk individual and discuss your assessment with a mental health professional within 24-48 hours
7) Discuss with your supervisor within 24-48 hours

MEDIUM RISK SITUATION:
I am concerned about you. I understand from what you've told me, that these thoughts of suicide are a problem for you. I think it would be helpful for you to see your Doctor or mental health professional.

If client scores in HIGH RISK category
1) Document your assessment
2) Advise the client of your concerns
3) Call the crisis service to determine the next steps
4) Call the police if you believe yourself or the client to be in imminent risk of harm.
5) If you are not in imminent danger, stay with the client until other supports arrive
6) Discuss with your supervisor before leaving the client's home

HIGH RISK SITUATION:
I am concerned about you. I believe you are at risk for hurting yourself and want to get some additional assistance. Do you have mental health counselor I can call or should I call the mental health center (crisis clinic)?

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ADDENDUM

To complete the suicide risk assessment, the mental health professional will also be looking at the following factors.

SUICIDE RISK ASSESSMENT PARAMENTERS FOR MENTAL HEALTH PROFESSIONALS

Psychiatric Illnesses	Mood Disorders, Alcohol / Substance Abuse, Schizophrenia
History	Any suicidal behavior Medical diagnoses, Family history of suicide / attempts / mental illness
Individual strengths / vulnerabilities	Coping skills; personality traits; past responses to stress; capacity for reality testing; tolerance of psychological pain
Psychosocial situation	Acute and chronic stressors; changes in status; quality of support; religious beliefs
Suicidality and Symptoms	Past and present suicidal ideation, plans, behaviors, intent; methods; hopelessness, anhedonia, anxiety symptoms; reasons for living; associated substance use; homicidal ideation

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RISK FACTORS ASSSOCIATED WITH SUICIDE

Demographic	**male; widowed, divorced, single; increases with age; white**
Psychosocial	**lack of social support; unemployment; drop in socio-economic status; firearm access**
Psychiatric	**psychiatric diagnosis; comorbidity**
Physical Illness	**malignant neoplasms; HIV/AIDS; peptic ulcer disease; hemodialysis; systemic lupus erthematosis; pain syndromes; functional impairment; diseases of nervous system**
Psychological Dimensions	**hopelessness; psychic pain/anxiety; psychological turmoil; decreased self-esteem; fragile narcissism & perfectionism**
Behavioral Dimensions	**impulsivity; aggression; severe anxiety; panic attacks; agitation; intoxication; prior suicide attempt**
Cognitive Dimensions	**thought constriction; polarized thinking**
Childhood Trauma	**sexual/physical abuse; neglect; parental loss**
Genetic & Familial	**family history of suicide, mental illness, or abuse**

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Risk factor checklist

Suicide notes ✏Family problems ✏Loss of an important person or relationship
✏Making final arrangements ✏Legal problems ✏Family history of suicide
✏Giving away possessions ✏Poor coping skills ✏Friend has attempted suicide
✏Reading or writing about death ✏Limited support system ✏Previous suicide attempts, cutting
✏Sad or depressed affect, hopelessness ✏Increased risk taking ✏Plan to commit suicide
✏Sexual identity issues or sexual abuse ✏Drug and alcohol use ✏Sense of desperation
✏Social withdrawal or isolation ✏Humiliation or rejection ✏Access to a means to harm self

Tips for Ombudsmen

Things you might say following your risk assessment.

LOW RISK SITUATION:
I am concerned about you. I understand from what you've told me, that it is unlikely that you would act on the thoughts about suicide you've had. Nonetheless, I think it would be helpful for you to talk to someone. May I help you arrange it?

The ombudsman may also want to think through with the resident as to what additional supports they have or could use in their lives.

MEDIUM RISK SITUATION:
I am concerned about you. I understand from what you've told me, that these thoughts of suicide are a problem for you. I think it would be helpful for you to see your Doctor or mental health professional.

HIGH RISK SITUATION:
I am concerned about you. I believe you are at risk for hurting yourself and want to get some additional assistance. Do you have mental health counselor I can call or should I call the mental health center (crisis clinic)?

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