Assessment and Initial Management of Suicidal Ideation Across Long Term Care Settings

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CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Today's Event Host

Nikki Harris, MA, CBHC-BS

COE-NF TRAINING AND EDUCATION LEAD

Nikki serves as the training and education lead for the Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF). For the past 20 years, Nikki has provided program implementation, development, management, external and internal trainings, policy development, quality assurance, and managed training coordination and technical support throughout the southeast region.

Previously, she served as the program manager for the Division of Behavioral Health and Substance Use Services within the South Carolina Department of Corrections.

She has a B.A. in psychology from the University of South Carolina, a M.A. in counseling from Webster University and is a certified behavioral specialist.

Today's Presenter

Allison Villegas, PA-C

PHYSICIAN ASSISTANT, LONGEVITY HEALTH PLAN

Allison has been providing post-acute and long-term care in Denver nursing homes for the last 10 years.

She serves on the board for CMDA: Colorado's Society for Post-Acute and Long-Term Medicine. She is on the AMDA board of directors and is involved in multiple AMDA committees.

Today's Presenter

Megan Pesansky, MSW, LSW, LAC

SOCIAL WORKER/MENTAL HEALTH THERAPIST, WELLPOWER

Megan is a licensed social worker and mental health therapist who works with older adults who reside in skilled nursing facilities.

She is employed by Wellpower, a behavioral health non-profit in Denver, Colorado. She is currently working toward licensure as a licensed clinician social worker, as well as a licensed addictions counselor.

During her training, she was a graduate research assistant at the University of Denver Knoebel Institute for Healthy Aging (KIHA).

Learning Objectives

1. Describe at least two risk factors and protective factors for suicidal ideation in long term care settings.

2. Discuss best practices for screening and comprehensive assessment of suicidal ideation in long term care settings.

3. Develop an initial management plan for a long-term care resident who is experiencing suicidal ideation.

Source: National Institute of Mental Health

Epidemiology

- Research is limited on prevalence of suicidal ideation and completion in the long term care communities.
- Review of data from 1995-2010 does reveal a wide range of of SI prevalence, ranging from 11-43% (O'Riley, 2013).
- Death from suicide rates among LTCF residents varies from 16.5-34.8 per 100,000 residents per year (O'Riley, 2013)
  - This is higher than community dwelling adults aged 65 or older, whose rate was 14.9 per 100,000 in 2010.
- Meta-analysis examining data 1989-2020 found that 6.4% of geriatric residents of LTCF have exhibited suicidal behaviors (Shi, 2020).

Preventative Factors

- Reasons to live (friends, family, children, pets, hobbies, interests, etc.)
- Purpose
- Effective coping mechanisms, problem solving skills and ability to adapt to change
- Cultural or religious rejections to suicide
- Hope for the future
- Connection with community

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Risk Factors

- Previous suicide attempts
- Hx of depression or SPMI
- Serious illness/chronic pain
- Legal concerns
- Substance use or hx of
- Adverse childhood experiences -ACE's
- Social isolation
- Loss of a loved one
- Conflict with loved ones
- Anniversaries
- Family history of suicide
- Exposure to violence or abuse

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Risk Factors

- Unique to LTF residents? Larger buildings with higher staff turnover (Osgood, 1992).
- Typically rates are higher in men than women but CDC reports that rates of suicide in women 60-64 increased 60% from 1999-2010 (O'Reily, 2013).
- Completed suicide rates for men are often higher due to more lethal means and unwillingness to talk about it beforehand.
- Methods in LTCF are different than community dwelling older adults- jumping, hanging, drowning, and drug overdose are most common methods used in LTCF.

Warning Signs

- Giving away belongings (without the presence of a terminal illness).
- Writing goodbye letters or saying goodbye to people (without the presence of a terminal illness).
- Increase in depression, anxiety, or stress.
- Expressed hopelessness and/or worthlessness.
- Talking about wanting to die.
- Working to obtain access to lethal means.
- Increase in substance use - at a substantial amount.
- Talking about feeling trapped or there being no solution.

Approaches to Screening

How is suicidal ideation caught?

1) Clinical changes
   a. Staff reports
   b. Direct interactions with residents
   c. IS PATH WARM

2) Routine screening:
   a. MDS requires PHQ 2 screening on every resident quarterly
   b. I-SNP MOC reviews

3) Psychotropic pharmacy committee reviews/follow up to changes

Screening Tools

- **Patient Health Questionnaire (PHQ) 2 and/or 9**
  - Predominant screening tool used for screening adults
  - The preferred screening tool based on the validity, reliability, and brevity. (Siniscalchi, 2020).
  - Publicly available

- **Beck Depression Inventory (BDI)**
  - Appropriate screen for ages 18-80, takes about 10 minutes
  - Validity and reliability of the BDI has been tested across populations, worldwide.
  - Requires licensing

- **Center for Epidemiologic Studies Depression Scale (CES-D)**
  - Can be used for ages 6– "older adulthood", takes about 20 minutes
  - has been tested across gender and cultural populations and maintains consistent validity and reliability.
  - Publicly available

Screening Tools

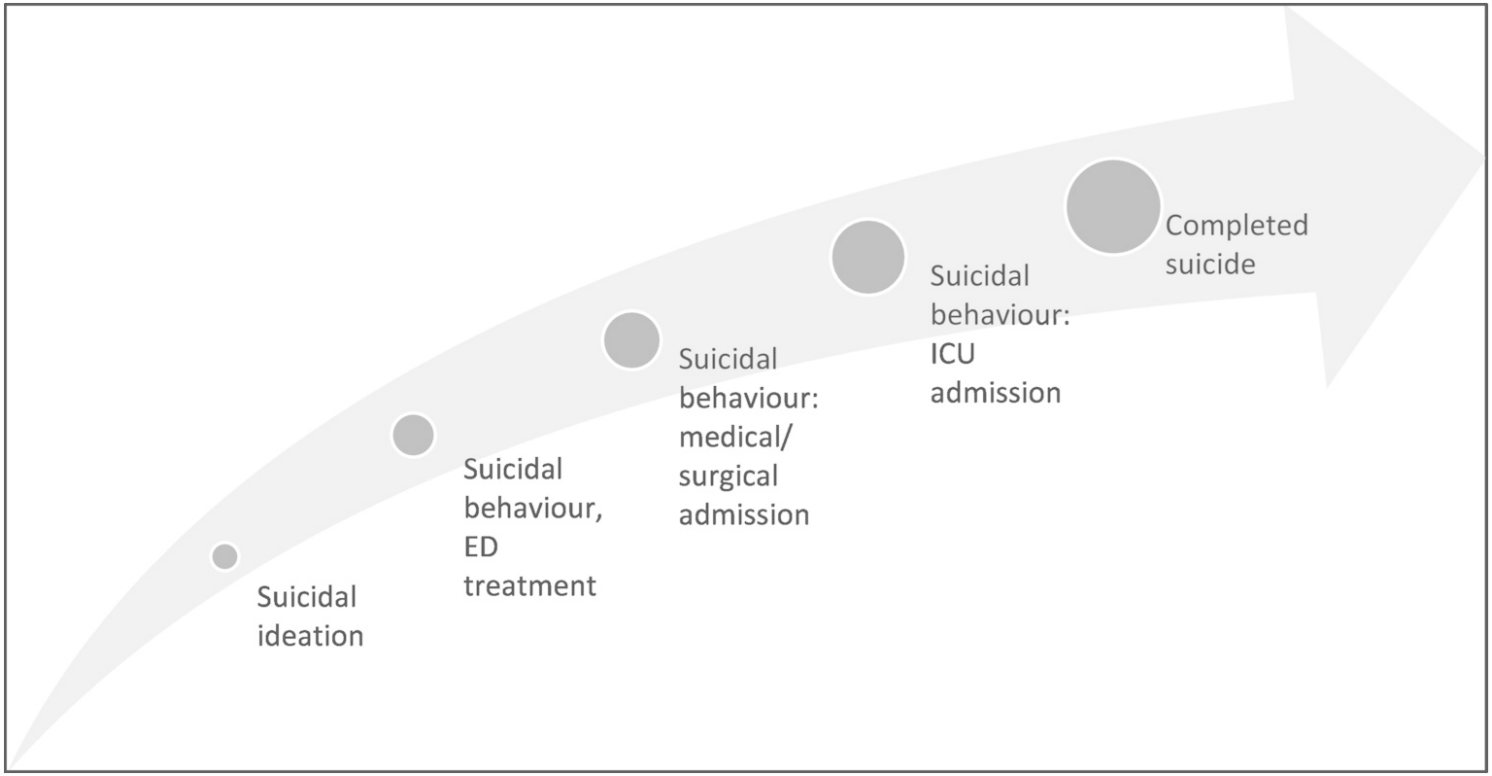
- **EQ-5D**
  - Quality of life assessment
  - Used for research, population studies, and healthcare screens
  - More valuable on assessing treatment outcomes
  - Used for ages 16 and up, takes about 5 minutes
  - Requires licensing

- **Hamilton Rating Scale for Depression (HAM-D)**
  - Measures severity of symptoms before, during, and after treatment
  - Takes 15-20 minutes
  - Publicly available

- **Montgomery-Asberg Depression Rating Scale (MADRS)**
  - Adapted from HAM-D, more sensitive to detecting changes of symptoms over time
  - Ages 18 and up, takes 20-30 min
  - Used clinically and in research
  - Publicly available

- **Geriatric Depression Scale (GDS)**
  - Designed for older adults
  - "Yes" or "No" options, preferred for adults with cognitive dysfunction
  - Takes about 5-7 minutes
  - Publicly available

Suicidal behaviors are a spectrum



NSSI vs. Suicidal Behaviors

Non-suicidal Self-injury

- Intent is immediate relief from negative emotions or relieve psychological pain.
- Often uses less lethal methods but potential lethality is there.
- Occurs frequently.
- Ex. scratching, cutting, biting, hitting, abrading skin, head banging.

Suicidal Behaviors

- Intent is to permanently escape emotional and psychological pain.
- More lethal methods used.
- Occurs less frequently.

Passive vs Active

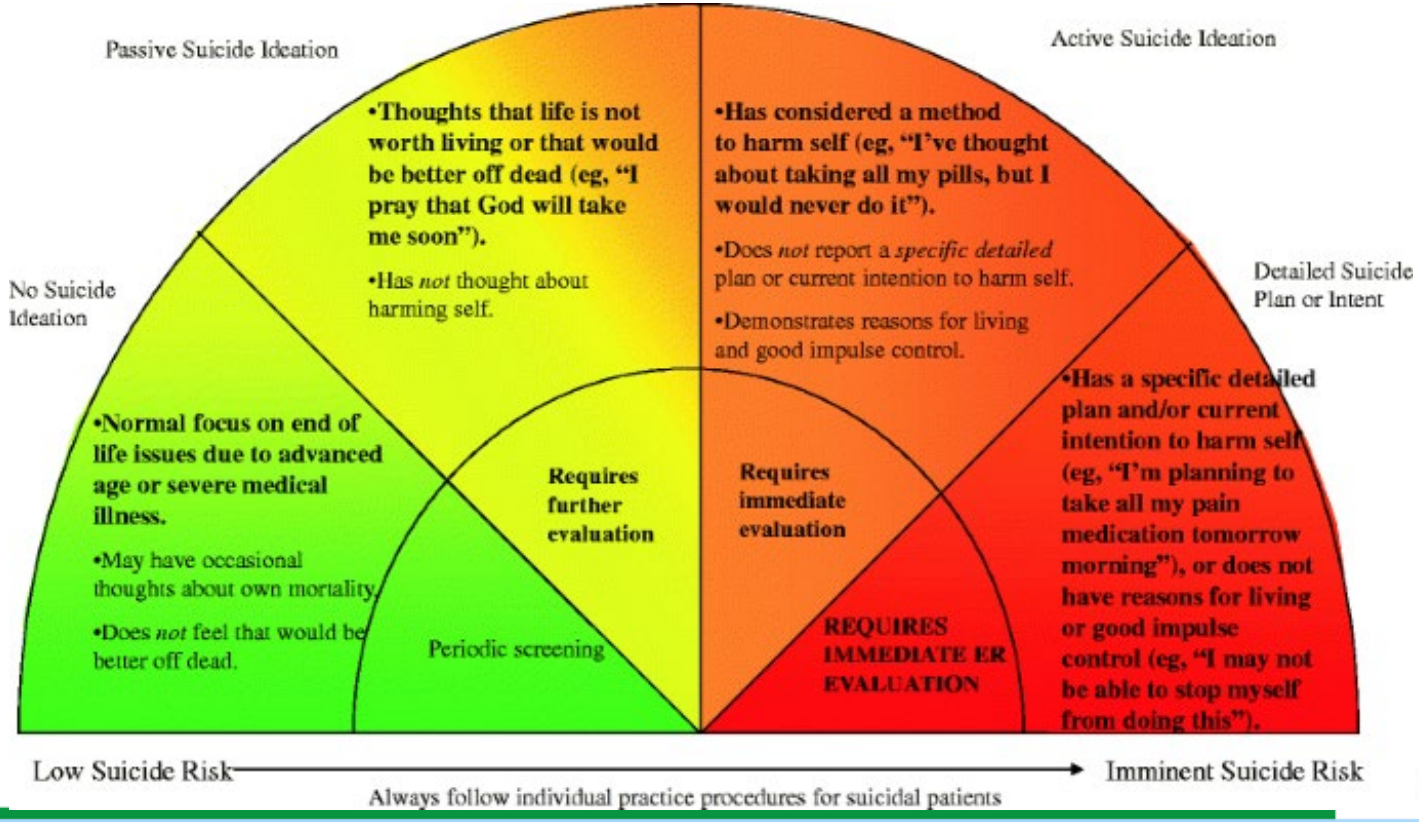
Passive death ideation

- Expressing a desire to be dead or statements that they would not be sad if their lives ended.
- Have no plans to actively end their life.
- Common among older adults or individuals living with chronic illness.
- May also include residents who are near end of life and have accepted this.
- Considered low risk for suicide

Active suicidal ideation

- Can present as a sudden exacerbation of a chronic desire to die.
- Can be triggered by a life-altering event.
- Can also occur unexpectedly.
- Requires immediate assessment.

Risk Assessment



Risk Assessment

- **Brief Suicide Cognition Scale (B-SCS)**
  - Six questions on likert scale
  - Only one item uses the word suicide
  - Has good incremental validity with unique predictive value

B-SCS predictive value.

	Follow-up suicide attempt	No follow-up suicide attempt	Totals
B-SCS above cutoff 13	**16**	**51**	**67**
B-SCS below cutoff 13	**0**	**27**	**27**
Totals	**16**	**78**	**94**
Negative predictive value	1.00		
Positive predictive value	0.239		
Sensitivity	1.00		
Specificity	0.346		

Bold values indicate number of participants reporting either suicide attempts or no suicide attempts at follow-up.

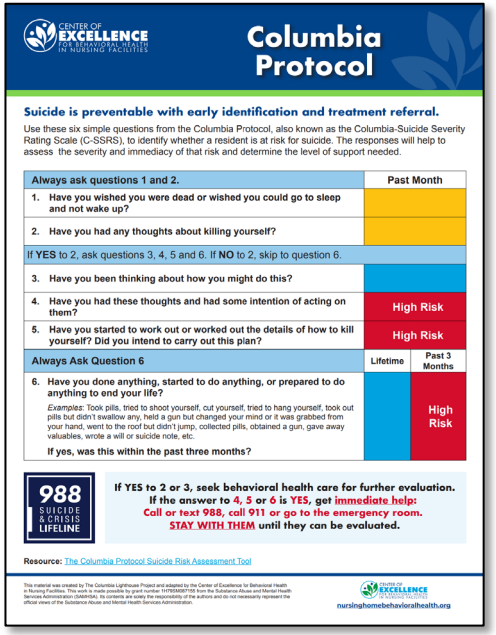
Risk Assessment

Columbia-Suicide Severity Rating Scale (C-SSRS)

- Has validity across multiple settings including ED and outpatient settings.
- Can be used in ages as young as five and has been tested in multiple subpopulations.
- Best used to risk stratify residents with SI using constructs of severity, intensity, behavior and lethality.

Scan the QR code or visit the link below to view this resource.

https://nursinghomebehavioralhealth.org/news-events/site_resources/columbia-protocol/



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Columbia Protocol

Suicide is preventable with early identification and treatment referral.

Use these six simple questions from the Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), to identify whether a resident is at risk for suicide. The responses will help to assess the severity and immediacy of that risk and determine the level of support needed.

Always ask questions 1 and 2.	Past Month
1. Have you wished you were dead or wished you could go to sleep and not wake up?	
2. Have you had any thoughts about killing yourself?	
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.	
3. Have you been thinking about how you might do this?	
4. Have you had these thoughts and had some intention of acting on them?	High Risk
5. Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk

Always Ask Question 6	Lifetime	Past 3 Months
6. Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples:* Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. If yes, was this within the past three months?		High Risk

988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral health care for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help:
Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Resource: The Columbia Protocol Suicide Risk Assessment Tool

nursinghomebehavioralhealth.org

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Main Points in a Risk Assessment

1. Suicidal Ideation
2. Plan
3. Means
4. Access/Lethality
5. Intent

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Main Points in a Risk Assessment - Suicidal Ideation

Three (3) main questions to assess for the level of suicidal ideation:

- ***"Are you having thoughts that you may be better off dead?"***
  - Yes to this may indicate passive or active SI, further questioning is needed.

- ***"Are you having any thoughts of harming yourself?"***
  - Yes to this indicates concern for at LEAST self harm such as cutting, burning, etc. further questioning needed.

- ***"Are you having thoughts of killing yourself?"***
  - Yes to this indicates need for FULL risk assessment.

A Hard Truth.

YOU HAVE TO ASK AND SAY THE WORDS…
"…thoughts of killing yourself!!"

- You **cannot** only ask, "Do you wish you weren't here anymore?" or anything that does not directly specify death/harm.
- People are not often comfortable volunteering this information to you without you asking.
- People can read your nerves if you are not comfortable asking the question.
- **DO NOT** argue with the suicidal person, and **DO NOT** try to convince them not to kill themselves.

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Main Points in a Risk Assessment - Plan

If someone answered *yes* to having thoughts of killing themselves it is highly likely they have thought about a plan.

- Ask "*What are some ways you have thought about killing yourself?*" instead of "*Have you thought of ways to kill yourself?*"
- If resident does not give detail in the plan then ask some clarifying questions: "*How would you go about doing this?*" "*Have you planned out a day or time you want to do this?*"
- Ask any other questions you have that the person may have left out - remember is it okay to sound curious.

Main Points in a Risk Assessment - Means

Goal of this is to find out more specifics if its not covered when you ask about their plan:

Questions will be specific to the plan the person presents.

Some examples:

- Plan - Overdose. Means question - *"Have you thought about what you would overdose on?"*
- Plan - Hanging. Means question - *"Have you thought about anything specific you would use to do this?"*
- Plan - Walk in front of car. Means question - *"Have you thought about how you would get outside?"*

Main Points in a Risk Assessment - Access/Lethality

Goal of this step is to assess if their plan is feasible.

- Do they have access to their means?
  - Ex. SNF residents may have access to a cord, but likely will not have access to medications for overdose and will not have access to a knife or gun

- It is important to ask questions about access to their means, sometimes residents think of things we wouldn't.
  - Ex. Resident with plan to overdose. Ask *"how/where would you get the pills to take?"*

- If means are not accessible, then there is NOT immediate safety concern.

Main Points in a Risk Assessment - Intent

Goal is to assess if the resident has intent to implement their plan.

- If there are warning signs you can assume there is intent. Warning signs include: giving away belongings, saying goodbye to loved ones, writing letters, etc.
- Assess intent by asking: *"Do you plan to act on your plan?"*
- If the answer is yes then assess for timing: *"When do you plan to do this?"*
- Assess for if the plan is ready to be implemented: *"What actions have you taken to prepare to kill yourself?"*

What to do if resident refuses to tell you any info?

- Attempt to ask every question even if they refuse to answer all of them.
- Attempt to safety plan with an assumption that there is intent.
- See if there is someone they may be more comfortable talking to including family, staff, providers or MH partners.
- Call your local crisis line or 988 will direct you there.

Risk Assessment - Pro Tips

1. Make sure to be in a quiet place where you are alone with the resident.
2. Sit down and be eye-to-eye, don't forget about your nonverbal communication skills.
3. Don't rush. Just like advanced care planning conversations, take time and allow silence.
4. Try to start with open-ended questions and narrow down if needed.
5. Watch your language. Word choice matters.
6. Recognize your own biases and stigmas around suicide.
7. Utilize scaling questions to help assess severity.

Risk Assessment:

Lethality assessment:

Low	• Passive SI <u>without</u> plan **and** no intent • Unable to engage in self harm
Medium	• Active SI with plan but **no** intent • Past attempt with current passive SI
High	• Active SI *with plan and intent* • Past attempt with current active SI, with or without plan/intent

Plan: To send or not to send?

Lethality assessment:

Low	• Safety plan in facility • Increase monitoring (q15min) • Regularly assess risk • Identify coping techniques
Medium	• Remove access to means • 1:1 Companion • Regularly assess risk • Attempt safety plan in facility • Work on coping techniques
High	• Remove access to means • 1:1 Companion • Attempt safety plan in facility • Consider M1

Does the resident require involuntary hospitalization for mental health evaluation/72 hr hold?

Start by asking:

1. Do they have SI?
2. Do they have a plan?
3. Is their plan feasible?
4. Do they have access to their means?
5. Do they have intent?
6. Have you tried numerous options for a safety plan?

If the answer is YES to every question then ask:

Is the person willing to go to the hospital for an evaluation voluntarily?

If the answer is NO the resident need to be placed on a hold

If the answer is YES then send resident voluntarily to hospital

What to know if you are placing resident on M1 hold:

- An M1 hold is an **involuntary** mental health hold for 72 hours **BUT** the hospital evaluating provider can choose to end the M1 hold prior to 72 hours if they do not feel it is fit.

- Once you decide to place someone on an M1 hold, you cannot let them leave your line of sight.

- An M1 hold **CANNOT** be used as a "just to be safe" measure, you need to be **SURE** they fit criteria. An M1 takes away rights of an individual and this cannot be taken lightly.

Safety Measures in Long-term Care

In a long term care facility there are some different options we can implement, some examples include:

- Plastic utensils.
- Limited access to cords.
- **15-minute checks -** *most common and always used after SI.*
- 1:1 companion.
- Informing overnight staff of concerns to keep and eye out for resident.
- Room checks to make sure there is no suicide means available.
- Wanderguard.
- Supervised smoking.
- Always involve mental health professionals if they are available at facility.

Safety Planning

Main point is *"What can we do to keep you safe <u>today</u>?"*

What are my strengths and reasons to live and thrive?

- Ex. things that are meaningful to me and make my life worth living

What things happen in my life that negatively affect my well-being?

- Ex. triggers that cue unhealthy or ineffective behaviors

What are things I can do to keep my environment safe?

- Ex. reducing access to lethal means and increasing protective factors

What can I do to promote my wellbeing?

- Ex. skills, techniques, activities, work, relationships, community engagement

Staff buy-in.

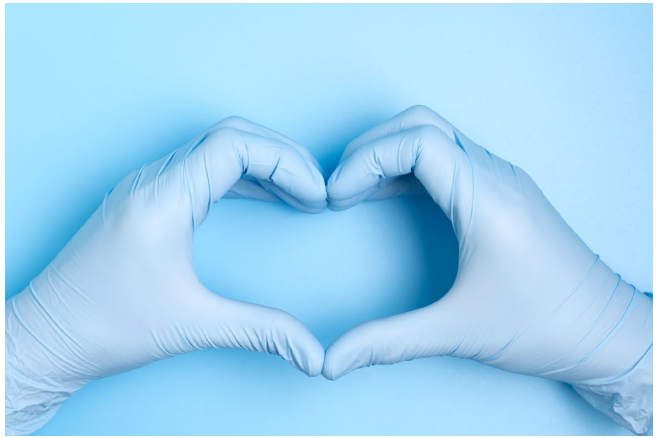
This is crucial.

Remember, nothing that we do is in a bubble.

Consider staff trauma and triggers.

Be aware of their limits.

Offer support!



Documentation

- Important to document every element of the risk assessment (plan, means, access, intent). **Include YOUR ASSESSMENT results** (low, medium, high).
- Include everything the resident told you about their plan.
- Document all safety plan details, including what was considered and implemented.
- List everyone who you informed about resident's SI, including those involved in the safety planning or the decision to send to hospital for evaluation.
- Include specifics written in your M1 paperwork and make sure to keep a copy for medical records as paramedics will take the original.
- Details are important when documenting SI.

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Caveats

- How does this process change if you practice in a rural setting?
- How does this process change if you practice in an ALF?
- What role, if any, does telehealth play in this process?
- How does risk assessment look different if resident is having SI due to psychosis?
- How does the risk assessment look different if resident has cognitive impairment?
- How to discuss suicide with terminally ill residents?

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Case #1

J.W. is a 67-year-old male who resides in a LTCF. He has a guardian to help his medical decision making 2/2 his etoh dementia. He admitted without any psychotropics but routinely reports SI because he is "bored" and he "would rather live on the streets, or in a shelter until he can get a job." He frequently asks to go to bars or "where all the hot women are." He does have h/o past suicide attempts, once by hanging and again with electrocution. Upon his admit here he was started on mirtazapine to help with his SI, recently rotated to citalopram due to side effect of weight gain.

Today you are asked to evaluate J.W. due to SI. He states he wants to kill himself by jumping out the window or down the stair well. There is, unfortunately, a broken window on the third floor of the facility, which is accessible.

Case #1

What is J.W.'s risk assessment?

Plan?

Means?

Intent?

What would be your next steps for J.W.?

Case #2

D is a 56-year-old male who resides in a SNF. He has a diagnosis of schizoaffective bipolar type. He informs you that he is hearing voices that are telling him he needs to kill himself. He tells you he has been head banging against the window in order to break it so that he can jump out. He reports "this is my only option." Current medications are Invega Sustenna and Zoloft. These were meds present upon admit from hospital. You are the only staff present with the knowledge for an SI evaluation.

What are the important questions to ask?

Case #2

What is D.S.'s risk assessment?

Plan?

Means?

Intent?

What would be your next steps for D.S.?

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Questions?

Resources:

1. https://www.selfinjury.bctr.cornell.edu/perch/resources/the-relationship-between-nssi-and-suicide-5.pdf
2. BDI
3. CES-D
4. EQ-5D
5. HAM-D
6. MADRS
7. PHQ
8. GDS
9. C-SSRS

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Thank You!

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