

3-390 Loneliness and suicidal expressions

TIPS Question:

Resident has verbally expressed feelings of loneliness, worthlessness, wanting to kill himself. Resident has not exhibited any physical aspects of injury to himself. How is the behaviour to be monitored and how often? How can the family and health team be involved in the seriousness of the behaviour?

Response:

When a resident verbally expresses such statements as the ones you describe, staff become anxious. As care providers, we worry that we may not do a thorough suicide assessment and may miss something important. This anxiety is a normal and necessary reaction. The situation needs to be assessed and a plan of action outlined. You ask “how to monitor the behaviour and how often”. There are a variety of suicidal assessments on the market that are useful. It would be beneficial to use this client as a reason to formulate facility guidelines regarding suicidal behaviours. If staff felt they had a reference or guideline to use when they are presented with suicidal behaviours they would not feel as anxious. These guidelines, or template of assessment questions, could be used to measure the suicide risk. This type of measurement of risk would help when you want to “involve the family and health team in the seriousness of the behaviour”. Common concepts regarding suicide prevention are the following:

1. COMMUNICATE WITH CLIENT

Let client hear from you that you recognize how they are feeling. Using appropriate, non-threatening language, you might ask:

- It must be pretty hard for you right now
- You seem pretty sad or hurt
- Ask if person is thinking of suicide
- Ask what are you feeling now?
- What do you think happened that precipitated your desire for suicide right now?
- Maybe it's recent loss or the need for someone to hear them or to simply gain peace.

2. ASK ABOUT THE PLAN

Do they have a plan? When and where will the plan be accomplished?

- By what method – pills – gun – care?
- Have they obtained the method?
- How lethal is the method?

3. FOCUS AND AMBIVALENCE

All persons experience conflict about suicidal act.

- Usually part of the person wants to live
- It is helpful to call to this part and emphasize the ambivalence

What are the conflicts they have about suicide? (What stops them from going through with suicide?)

- Religion
- Fear of injury
- Do they speak of future events?
- Do they have hope that things will improve?
- Are they willing to contract to stay alive for the next hour or day or until next meeting?

4. PROBLEM SOLVE WITH THE PERSON

How will the suicide solve their problem? To whom will the problems be transferred by the suicide?

- Brainstorm for new solutions
- Give hope that the problems are solvable and that you or another professional are willing to work with them to problem solve.

5. EXPLORE THE SUPPORT NETWORK

- Friend
- Can I help? Am I hearing them?

6. INQUIRE RE: PREVIOUS ATTEMPTS & SUICIDE IDEATION

What happened then? How has this situation resolved?

7. REFER FOR PROFESSIONAL HELP

Convince client that you or others are willing to share the responsibility for problem solving.

- Focus on the anticipation of relief from distress
- Sell the value of counselling or getting help.

8. PROVIDE FOR THE PERSON'S SAFETY

Remove possibility of self-injury by removing method. Talking can help to decrease hopelessness and helplessness and the tunnel vision that is characteristic of the suicidal person. It can provide other options for the solution of the problem.

- The greatest life saving tool in suicide prevention is to talk about it.
- Openly, calmly, acceptingly with suicidal person.

With your care team, draft an easy-to-read framework on what steps should be taken if someone exhibits suicidal behaviours. Decide who is responsible on which shift to monitor and how often. Decide on how this can be realistically documented.

A formal guideline such as this would also help staff when they don't know if they should take behaviour seriously. Sometimes clients will verbalize passive suicidal comments and staff do not know if they are supposed to act on them or not. If a suicidal assessment is initiated and appropriate interventions taken, then the staff feel they have done what they should. This is helpful even if it appears that the client is not truly suicidal, but requires an assessment for depression/pain/boredom, etc. These needs would be discovered during the suicidal assessment.

I hope you are able to facilitate designing a facility guideline on suicide assessments to decrease the associated anxieties around this issue!

Please note: TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.