2023

Designated Living Option (DLO) Suicide Risk Management Resource Guide

For more information
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Covenant Health

Seniors Health & Continuing Care

Policy, Practice, Access & Case Management

Acknowledgements

This resource guide has been prepared by the Designated Supportive Living Suicide Risk Assessment working group and AHS program representatives.

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Applicability

This resource guides is intended for leaders, educators, and all members of the health care team within Alberta Health Services (AHS) and Covenant Health **designated living options** (DLO) to understand evidence-informed best practices, and provincial recommendations for managing **suicide** risk. Other program areas and contracted service providers can adopt all materials related to this topic, including this resource guide and related education.

Purpose

This resource guide is intended as a reference for regulated health care providers who assess **resident** suicide risk within Alberta's continuing care designated living options (DLO) settings, including designated supportive living and long term care.

This guide is not intended for residents wishing to pursue Medical Assistance in Dying (MAID). While this information may be discovered during the suicide risk assessment process, there is a distinct difference in approach to care. Please refer to available guidance on this topic: https://www.albertahealthservices.ca/info/page13497.aspx.

This resource and the *DLO Suicide Risk Screening/Assessment Tool* does not provide guidance for Emergency Medical Services and other health care providers providing initial time sensitive emergency response. Refer to the established processes in the care setting (e.g., intervene, contact EMS) and relevant resources for resident care (e.g., *Goals of Care Designation Orders and Personal Directives During Response to Apparent Attempted Suicide*).

Introduction

The Public Health Agency of Canada identifies **suicide** as the 12th leading cause of death in adults over 65 years of age and older. Suicide rates are approximately three (3) times higher among men compared to women. Males over age 85 experience the highest rate of suicide among seniors. For additional details, see Suicide in Canada: infographic and Suicide in Canada: Key Statistics (infographic).

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Within Continuing Care, reports of three (3) resident deaths and 51 safety incidents related to intended self-harm were captured in the AHS Reporting and Learning System (RLS) between 2014-2020. Unrecognized and/or untreated depression contributes to increased risk of suicide. Additional **risk factors** for individuals over age 65 include social isolation, unmanaged health concerns, and multiple life changes. Suicide prevention is an Accreditation Canada required organizational practice (ROP).

As identified in the AHS Provincial Clinical Knowledge Topic Suicide Risk Assessment, Adult – Inpatient (*Non-Psychiatric*):

> "Suicide risk assessment should be viewed as a part of the therapeutic process that creates an opportunity for discussion between the clinician, the person and their **family** and other supports. Levels of risk of suicide should be clearly identified and available for clinicians and provide guidance on creating a safety plan for the person."

The foundational values to guide suicide risk management include:

- promoting a resident and family centred care approach
- practicing **harm reduction** and **trauma informed care**
- minimizing risk of harm
- managing uncertainty
- reducing stigma
- maintaining confidentiality

NOTE: The first reference to bolded terms that are used through the document (except titles) are defined terms that can be found in the Definitions section at the end of this document.

Suicide Risk Management Overview

Residents within DLO settings are screened to identify if they are at risk for suicide.

Regulated health care providers screen for residents at risk for suicide:

- within 36 hours of admission to a DLO
- with interRAI assessment or reassessment
- when indicated by clinical judgement

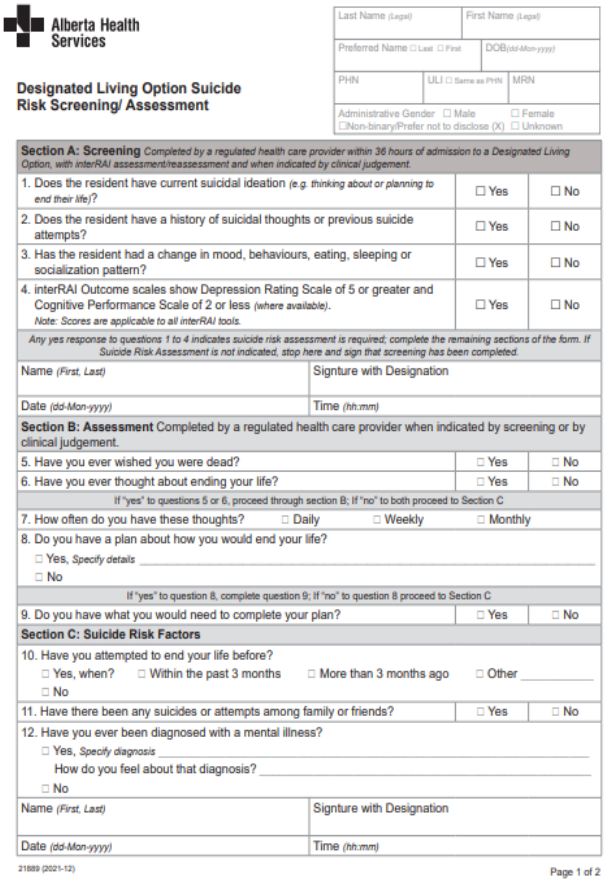
Resident assessment is completed when suicide risk is identified through screening or when indicated by clinical judgement. Following an assessment, the resident care plan is developed with interventions to meet resident care needs and monitor status. The resident is reassessed for suicide risk at regular intervals.

While the process is guided by a regulated health care provider, all members of the health care team are involved. In a blended care setting, such as designated supportive living (DSL), the health care team collaborates to determine who is responsible to complete the resident suicide risk screening and assessment. This may be completed by the regulated health care provider in the care setting (e.g., licensed practical nurse [LPN]), the AHS home care case manager, or completed collaboratively.

The DLO Suicide Risk Management Algorithm (Appendix 1) provides an overview of the process and may be used as a quick reference.

Suicide Risk Screening/Assessment

Documentation of suicide risk screening/assessment is completed in accordance with established process in the care setting, such as an electronic documentation system (e.g., LTC Suicide Risk Assessment flowsheet in Connect Care, *Designated Living Option Suicide Risk Screening/Assessment* form [#21889]). The information in this resource is intended to guide the regulated health care provider completing suicide risk screening/assessment.



Alberta Health Services

Designated Living Option Suicide Risk Screening/ Assessment

Last Name (Legal) | First Name (Legal)
Preferred Name ☐ Last ☐ First | DOB (dd-Mon-yyyy)
PHN | ULI ☐ Same as PHN | MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown

Section A: Screening *Completed by a regulated health care provider within 36 hours of admission to a Designated Living Option, with interRAI assessment/reassessment and when indicated by clinical judgement.*

1. Does the resident have current suicidal ideation *(e.g. thinking about or planning to end their life)*?	☐ Yes	☐ No
2. Does the resident have a history of suicidal thoughts or previous suicide attempts?	☐ Yes	☐ No
3. Has the resident had a change in mood, behaviours, eating, sleeping or socialization pattern?	☐ Yes	☐ No
4. interRAI Outcome scales show Depression Rating Scale of 5 or greater and Cognitive Performance Scale of 2 or less *(where available)*. *Note: Scores are applicable to all interRAI tools.*	☐ Yes	☐ No

Any yes response to questions 1 to 4 indicates suicide risk assessment is required; complete the remaining sections of the form. If Suicide Risk Assessment is not indicated, stop here and sign that screening has been completed.

Name *(First, Last)* | Signture with Designation
Date *(dd-Mon-yyyy)* | Time *(hh:mm)*

Section B: Assessment Completed by a regulated health care provider when indicated by screening or by clinical judgement.

5. Have you ever wished you were dead?	☐ Yes	☐ No
6. Have you ever thought about ending your life?	☐ Yes	☐ No

If "yes" to questions 5 or 6, proceed through section B; If "no" to both proceed to Section C

7. How often do you have these thoughts? ☐ Daily ☐ Weekly ☐ Monthly
8. Do you have a plan about how you would end your life?
☐ Yes, *Specify details* _____
☐ No

If "yes" to question 8, complete question 9; If "no" to question 8 proceed to Section C

9. Do you have what you would need to complete your plan?	☐ Yes	☐ No

Section C: Suicide Risk Factors

10. Have you attempted to end your life before?
☐ Yes, when? ☐ Within the past 3 months ☐ More than 3 months ago ☐ Other _____
☐ No

11. Have there been any suicides or attempts among family or friends?	☐ Yes	☐ No

12. Have you ever been diagnosed with a mental illness?
☐ Yes, *Specify diagnosis* _____
How do you feel about that diagnosis? _____
☐ No

Name *(First, Last)* | Signture with Designation
Date *(dd-Mon-yyyy)* | Time *(hh:mm)*

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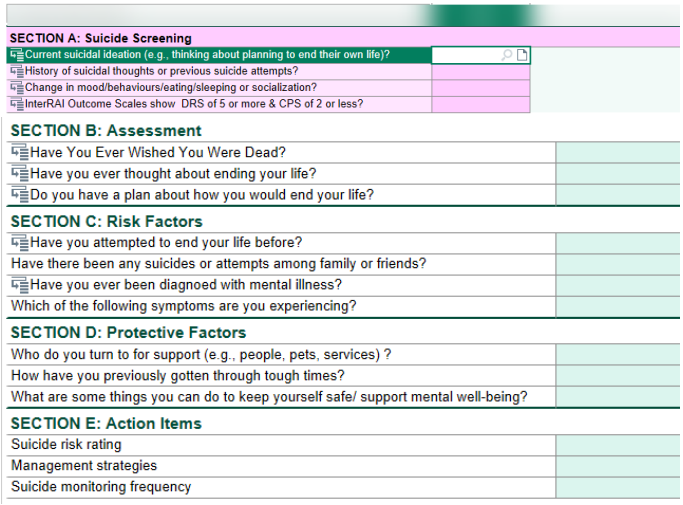
Note: The form is available here: https://www.albertahealthservices.ca/frm-21889.pdf and also located on Insite and the Continuing Care Connection website.



SECTION A: Suicide Screening
- Current suicidal ideation (e.g., thinking about planning to end their own life)?
- History of suicidal thoughts or previous suicide attempts?
- Change in mood/behaviours/eating/sleeping or socialization?
- InterRAI Outcome Scales show DRS of 5 or more & CPS of 2 or less?

SECTION B: Assessment
- Have You Ever Wished You Were Dead?
- Have you ever thought about ending your life?
- Do you have a plan about how you would end your life?

SECTION C: Risk Factors
- Have you attempted to end your life before?
- Have there been any suicides or attempts among family or friends?
- Have you ever been diagnoed with mental illness?
- Which of the following symptoms are you experiencing?

SECTION D: Protective Factors
- Who do you turn to for support (e.g., people, pets, services) ?
- How have you previously gotten through tough times?
- What are some things you can do to keep yourself safe/ support mental well-being?

SECTION E: Action Items
- Suicide risk rating
- Management strategies
- Suicide monitoring frequency

Note: The rows within the flowsheet in Connect Care "cascade" open based on the response recorded.

The DLO Suicide Risk Screening/ Assessment may appear in other electronic documentation systems (e.g., Meditech, PARIS, Point ClickCare).

Section A: Suicide Risk Screening

Suicide warning signs may be easy to identify, however, that is not always the case. Section A: Screening with four (4) elements has been established within the DLO Suicide Risk Screening/Assessment.

The regulated health care provider uses various information sources to answer the screening questions, including, but not limited to:

- pre-admission documentation
- resident health record (e.g., interdisciplinary notes)
- interRAI assessment/reassessment and outcomes scales*
- interaction with the resident and observation of behaviour
- information/reports from health care team members, and **family**

A "yes" response to <u>any</u> element indicates suicide risk assessment is required.

1. Does the resident have current **suicidal ideation** (e.g. thinking about or planning to end their life)?
2. Does the resident have a history of **suicidal thoughts** or previous suicide attempts?
3. Has the resident had a change in mood, behaviours, eating, sleeping or socialization pattern?
4. interRAI Outcome scales* show Depression Rating Scale of 5 or greater and Cognitive Performance Scale of 2 or less (where available).

If the response to <u>all</u> elements is "no", the screening is completed. However, the regulated health care provider may choose to complete a suicide risk assessment, based on clinical judgement.

*interRAI Outcome scales:

- Depression Rating Scale (DRS) is a scale of 0-14. A score of 3 or more may indicate a potential or actual problem with depression.
- Cognitive Performance Scale (CPS) is a scale of 0-6. A higher score indicates more severe cognitive impairment

<u>Interpretation:</u> A resident with a DRS of 5 or greater and CPS of 2 or less may indicate depression and cognitive ability to plan suicide

Section B: Assessment

The suicide risk assessment section obtains information regarding suicide planning. Responses are considered when determining suicide risk level and care planning interventions.

5. Have you ever wished you were dead?
   Tip: A person who wishes they were dead could be considered low risk for suicide, however this could progress to suicidal thoughts at a later time.

6. Have you ever thought about ending your life?
   Tip: A "yes" response may indicate someone who is preparing to end their life.

If "yes" to either question 5 or 6, proceed through this section. If "no" to both questions, proceed to the next section (Section C: Risk Factors), skipping questions 7, 8 and 9.

7. How often do you have these thoughts?
   Tip: This can be challenging to measure so these descriptions explain what daily, weekly and monthly mean:
   - Daily = thoughts occur frequently, may be intense (strong) and impossible to dispel/get rid of
   - Weekly = thoughts occur regularly, may vary in strength and may be difficult to dispel/get rid of
   - Monthly = thoughts occur periodically or occasionally, may be of low **intensity** and last a short time

8. Do you have a plan about how you would end your life?
   Tip: A "yes" response means more details about the resident's plan for suicide must be obtained by the regulated health care provider.

If "no" to this question, proceed to the next section (Section C: Risk Factors), skipping question 9.

9. Do you have what you need to complete your plan?
   Tip: A "yes" response is important when considering the resident's suicide risk level and care planning interventions for safety.

Section C: Suicide Risk Factors

The suicide risk factors section gathers additional information to consider when determining suicide risk level and care planning interventions.

10. Have you attempted to end your life before?
    Tip: A **suicide attempt** within the past three (3) months is associated with an increased risk of suicide.

11. Have there been any suicides or attempts among family or friends?
    Tip: any exposure to suicide is a risk; the impact appears to be higher within the first year of the event but can vary based on other risk factors present.

12. Have you ever been diagnosed with a mental illness?
    Tip: This may be a challenging question for some residents to answer. An example of mental illness is depression.

13. Are you feeling any of the following: multiple selections
    Tip: residents experiencing multiple challenges, losses, or difficult feelings may be at increased risk of suicide. Select all that apply and others the resident may identify that are not listed.

Section D: Protective Factors

Protective factors are positive aspects of someone's life that can protect against suicide (e.g., sense of belonging, strong social network, support system). This information is also considered when determining suicide risk level and care planning interventions.

14. Who do you turn to for support?
    Tip: This may include past or present supports such as friends, family, pets or services such as counselling or support groups.

15. How have you gotten through tough times previously?
    Tip: This information can be helpful for identifying care planning interventions.

16. What are some things you can do to help keep yourself safe or support mental well-being?
    Tip: This information can be helpful for identifying care planning intervention such as a personal safety plan.

Action Items:

This section of the form or flowsheet is intended to cue the regulated health care provider to select from a range of appropriate interventions. Detailed documentation for interventions are required in the resident health record, such as the care plan, narrative notes, consultations, etc. Action items may be completed simultaneously and involve other members of the health care team. The following sections provide additional information for each sub-section.

Suicide Risk Level

Once all information has been gathered, the resident's suicide risk level is determined.

Suicide risk level is based on the resident's presentation, information gathered and clinical judgement of the regulated health care provider in the context of the situation. Provincially agreed upon suicide risk level definitions, developed for Connect Care, guide the regulated health care provider to determine the resident's risk for suicide. Suicide Risk Level Criteria also provides additional information to consider.

Suicide Risk Level Definitions *The criteria below is only a guide. The documented level of risk should be based on clinical judgement and does not require the resident to match all risk indications.*		
Low Risk	**Moderate Risk**	**High/Imminent Risk**
• no apparent **suicidal ideation** • suicidal ideation of limited frequency, **intensity**, and **duration** • no identifiable plan(s) • no apparent **suicidal intent** • few risk factors • multiple protective factors	• frequent suicidal ideation with limited intensity and duration • suicide attempt(s) more than 3 months ago • limited or vague plan(s) • no apparent suicidal intent • limited access to lethal means • some risk factors • some protective factors	• frequent, intense and enduring suicidal ideation • current and/or suicide attempt(s) within the last 3 month • specific plan(s) • intent to act • rehearsal behaviour or prepatory behaviour • access to **lethal means** • severe distress • acute precipitating event • multiple risk factors • few, if any, protective factors

The resident's risk for suicide must be communicated to health care team members (including the most responsible health provider [MRHP], case manager and family*, as appropriate):

- immediately and no longer than 24 hours when the resident has been assessed as moderate or high/imminent risk of suicide
- based on clinical judgement for residents assessed as low risk for suicide

* It is important to promote a collaborative approach to sharing resident information with family, however there may be instances where confidentiality must be maintained. Sharing information and/or involving anyone who is not an alternate decision-maker is dependent on many factors, including resident permission to disclose information. *AHS Guidelines for Disclosure of Health Information* provides key information regarding disclosure in accordance with the *Health Information Act*.

Tips: Designated Supportive Living

- When the resident resides in designated supportive living (DSL) and the on-site regulated health care provider assesses the resident to be at any risk for suicide, the regulated health care provider in a case management role must be notified.
  - Directions for after-hours on/call notifications must be accessible for each site.
- When there is no regulated health care provider on-site (e.g., DSL3), unregulated health care providers (Health Care Aides, recreation therapy, etc.) are accountable to report:
  - resident observations and any reported concerns to the regulated health care provider in a supervisory or case management role
  - contact emergency medication services (EMS) for urgent resident care needs (e.g., resident found unresponsive, in process of an apparent suicide attempt)

Refer to the DLO Suicide Risk Management Algorithm (Appendix 1) as a quick reference to the process.

Management Strategies

The resident's suicide risk level (low, moderate or high/imminent) and context of the situation will determine interventions to implement. Management strategies listed in the *DLO Suicide Risk Screening/Assessment* are cues for the regulated health care provider to consider implementing. Any items selected here will require additional documentation on the resident health record.

The resident care plan is a core communication tool used in continuing care to direct resident care. The care planning process is followed to identify problems the resident wishes to work on, and interventions to help the resident meet their goal in addressing those problems. Care planning interventions must be specific, realistic and identify who

<table>
<tr><th colspan="2">Examples of care plan interventions/safety strategies for residents at risk for suicide</th></tr>
<tr><td>Support the resident to develop a Personal Safety Plan* with strategies to promote the resident's own safety.</td><td>Contact MRHP to discuss resident care needs, need for consult/referral and discuss treatment plan to maintain resident safety.</td></tr>
<tr><td>Reinforce resident use of positive coping strategies.</td><td>Relocate resident to a care space near a highly visible location, if possible.</td></tr>
<tr><td>Encourage resident participation in activities (diversional, recreational, therapeutic).</td><td>Keep door to resident room open and/or curtain around bed drawn back.</td></tr>
<tr><td>Engage family/friends to support care/safety as appropriate (e.g., with resident consent or when involved as alternate decision-maker)</td><td>Check for any unsafe articles in the resident's environment (e.g., lethal means of suicide) and determine best approach for securing such item(s), considering resident needs, culture, established policy, procedure and/or process in the care setting</td></tr>
<tr><td>Encourage resident to verbalize thoughts, feelings and identify concerns</td><td>Ensure resident is accompanied when off unit/site</td></tr>
<tr><td>Implement care for assessed unmet needs (e.g., pain, sleep, functional abilities, etc.)</td><td rowspan="2">Consultation/ referral for assessment or intervention as clinically indicated:
- Gerontologist
- Geriatric psychiatry/psychiatry
- Senior's Mental Health
- Social Worker
- Spiritual Care Practitioner
- Others (e.g., Addiction & Mental Health Recreation Therapy, Occupational Therapy, etc.)</td></tr>
<tr><td>Monitor resident for new or change in symptoms, including but not limited to:
- mood changes
- lack of interest
- anxiety/ agitation
- anger
- health concerns
- pain
- sleep/ appetite disruption
- hopelessness
- withdrawal from activities
- suicidal ideation</td></tr>
</table>

is responsible for implementing the intervention. Refer to established care planning resources in the care setting.

A **Personal Safety Plan* may be helpful for residents who are able to use safety strategies independently. A regulated health care provider supports the resident to develop a personalized plan for the resident's own use. Additional information on developing and supporting residents to use a Personal Safety Plan is available in the *Safety Planning for Suicide Risk Companion Guide*.

Tip: Interventions/safety strategies need to be implemented with care and consideration of potential unanticipated harms to the resident. For example, removing "unsafe" items (i.e., lethal means of suicide) from the resident's environment may cause the resident distress and/or loss of dignity. Others in the setting may notice if the resident has 1:1 (one to one) monitoring, the resident is relocated or the resident's door is left open. Maintaining confidentiality in a shared environment while balancing potential harm is often

challenging, but necessary. When there is uncertainty or a conflict in values, consider if a consultation with Clinical Ethics would be helpful. Consult with your organizational Ethicist.

Consultation* or referral to other health care providers for resident assessment or care may be clinically indicated. The timeline for consultation should be discussed with members of the health care team (e.g. MHRP, case manager).

- Urgent consult/referral or transfer to a higher level of care may be indicated for a resident assessed as moderate or high/imminent risk of suicide.
- Urgency of consult/referral for a resident assessed as low risk of suicide is based on clinical judgement.

*Do not delay consultation or referral to other health care providers because the resident is assessed as "low risk". Each situation is different. It is better to communicate a concern than leave a resident at risk.

The frequency for evaluation/review is determined by the health care team and established in the care plan. Care strategies for residents must be reviewed:

- every 3 (three) months at minimum for residents at moderate or high/imminent risk of suicide
- more frequently based on the resident care needs and the context of the situation.

Refer to the DLO Suicide Risk Management Algorithm (Appendix 1) as a quick reference to the process.

Resident Monitoring Frequencies

The *DLO Suicide Risk Screening/Assessment* prompts the regulated health care provider to consider the frequency of monitoring the resident requires. This must be identified on the care plan and communicated to all members of the health care team.

Suicide monitoring frequency is determined based upon the resident's care needs. A resident may need to be transferred to a higher level of care.

- If constant or 1:1 care is required while the resident is on-site (e.g., awaiting transfer to acute care), a prescriber order may be required.
  Note: 1:1 care should be provided while awaiting a prescriber order
- Any monitoring identified on the form must be implemented and communicated according to processes in the care setting. This includes identifying monitoring on

the care plan, informing all health care providers and ensuring documentation of monitoring is completed.

The regulated health care provider identifies the method and frequency of monitoring on the resident's care plan. The resident should be monitored for suicidal ideation, mood and behaviour changes, including changes in eating, sleeping or socialization and other indicators identified on the care plan (e.g., signs of agitation such as pacing, expression of fear, crying, etc.). All members of the health care team should be aware of what and how frequently to observe/monitor, where to document, and who to report observations or concerns. In a blended care setting, such as DSL where the resident has an AHS case manager and receives care from onsite health care providers (regulated and unregulated), the health care team collaborates in resident care and communication. Processes may vary from setting to setting.

Evaluation/review of resident suicide risk includes:

- review of resident assessment/reassessment information, including the *DLO Suicide Risk Screening/Assessment* and documentation in the health record
- update/ review of resident care plan interventions to ensure care reflects the resident's current assessment and care needs
- use of the interRAI Outcome Scales Report to evaluate resident changes (e.g., DRS, CPS and other relevant scales)
- communication of any changes (e.g., modifications to care plan, suicide risk level) to all members of the health care team

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Talking to residents about suicide can be stressful. Additional resources are available to support health care providers to gain knowledge about suicide and how to talk to residents about suicide. Recommended resources are identified in Education Resources (Appendix 2) and Additional Resources (Appendix 3).

Definitions

Designated living option means publicly funded residential accommodation that provides health and support services appropriate to meet the resident's assessed unmet needs. The level of care is accessed through a standardized assessment and single point of entry process and consists of Designated Supportive Living Level 3 (DSL3), Designated Supportive Living Level 4 (DSL4) and Designated Supportive Living Level 4 Dementia (DSL4D) and Long-Term Care (LTC).

Duration is the amount of time one has thoughts of suicide and/or self-harm. May be fleeting to extensive.

Family means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including but not limited to, family members, legal guardians, friends, and informal caregivers.

Harmful and lethal means includes items and/or substances that have the potential to cause significant harm or death, either accidentally or deliberately. Identification of harmful and lethal means should consider multiple modes of use, including but not limited to asphyxiation, ingestion, and laceration/puncture.

Harm reduction means those policies, programs, and practices that aim primarily to reduce the adverse health, social or economic consequences of the use of legal and illegal psychoactive substances without necessarily reducing consumption. A harm reduction approach to substance use accepts that abstinence may or may not be a realistic or desirable goal for an individual patient, and explicitly acknowledges that the cessation of substance use is not a prerequisite for accessing health or social services. Interventions may be targeted at the individual, the family, community, or society.

Intensity refers to the degree of thoughts of suicide and/or self-harm.

Protective factors *are* positive aspects of someone's life that can protect against suicide (e.g., sense of belonging, strong social network).

Resident means someone who receives or has requested health care or services from Alberta Health Services and its health care providers. Resident also means, where applicable: a) a co-decision-maker with the person; or b) an alternate decision-maker on behalf of the person.

Suicide is considered a conscious or deliberate attempt to end one's life.

Suicide attempt is a potentially self-injurious behaviour with a non-fatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some level to kill him/her-self. A suicide attempt may or may not result in injuries.

Suicidal ideation refers to having thoughts about killing oneself.

Suicidal behaviour is a spectrum of activities that include suicidal ideation, suicide attempts, and death by suicide.

Suicidal intent refers to active suicidal thoughts of killing oneself and having some intent to act on such thoughts.

Suicidal thoughts refers to general non-specific thoughts of wanting to end one's life/die by suicide.

Suicide warning signs are things people say, do or how they behave which may indicate suicidal ideation (e.g., talking about death, giving away possessions, uncharacteristic changes in behaviour).

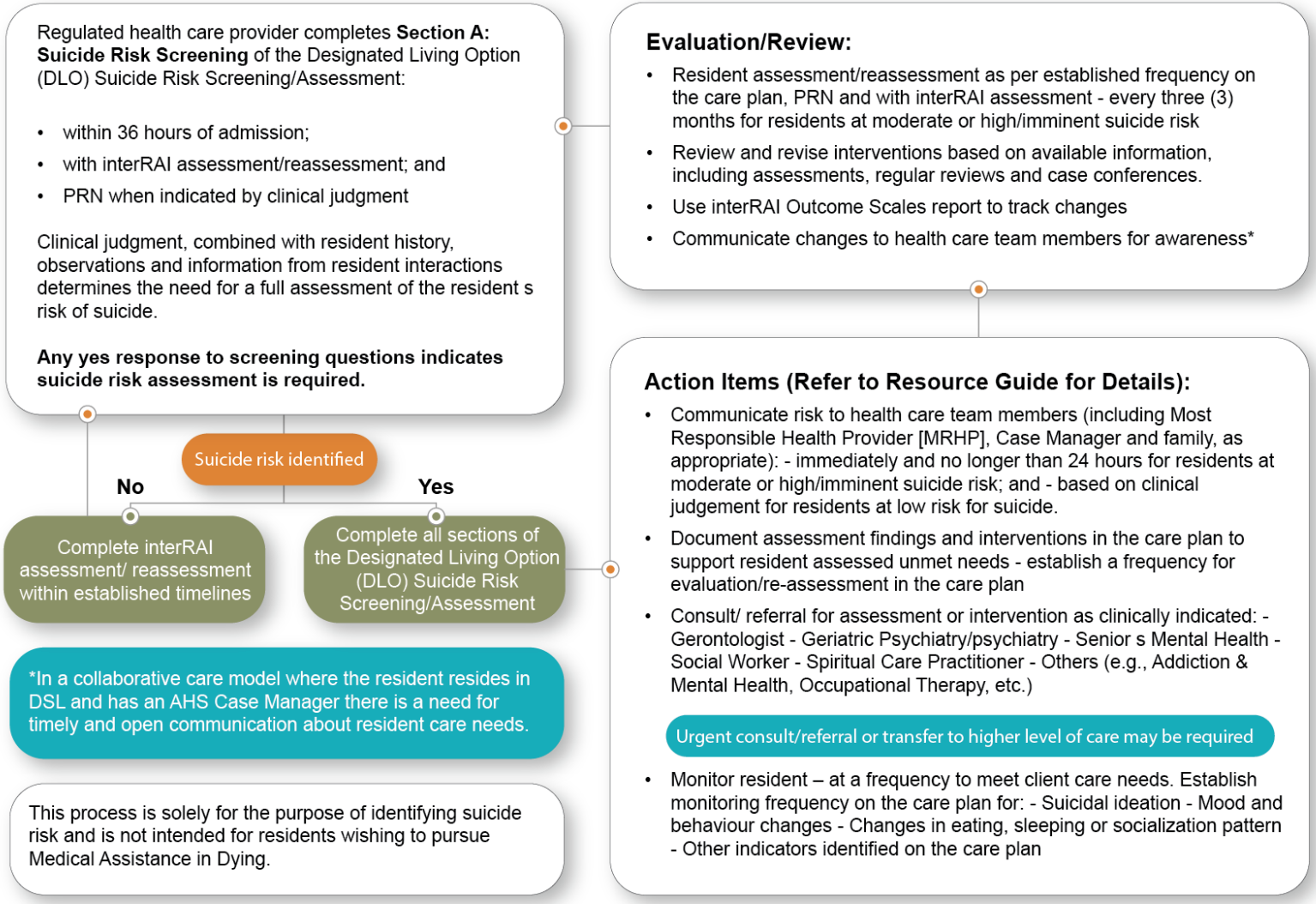
Self-harm is the various methods by which individuals injure themselves, without the intent to die, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness. It is a risk factor for suicide but does not mean the individual is having suicidal ideation.

Trauma informed care means using a systematic approach which ensures that all people who come into contact with the health care system receive care and services that are sensitive to the impact of trauma.

Risk factors are characteristics that make it more likely that an individual may engage in suicidal behaviours, they may encompass biological, psychological, or social factors in the individual, family, and environment.

Designated Living Option (DLO) Suicide Risk Management Algorithm

Includes Designated Supportive Living and Long Term Care



Education Resources

AHS Natural Allies Suicide Prevention Training

This education is for staff who work with patients, residents or members of the public on a regular basis and who have little experience in suicide prevention, or who are experienced and would like a refresher.

- Learn how to identify someone who may have suicide ideation and help them connect to the longer-term support that they need. This is not a course about formal suicide risk assessment or long-term management.
- Learning objectives are:
    - identifying risk factors, warning signs, protective factors and populations with higher rates of suicide
    - understanding the concept of personal window of tolerance and practice strategies to support personal wellness
    - utilizing techniques to build rapport and engage with someone who may be struggling
    - asking about suicidal intent and respond appropriately if thoughts of suicide are disclosed or not
    - connecting a person to appropriate supports and resources using collaborative and person-centered strategies

AHS staff register on MyLearningLink; Teams and contracted service providers can request sessions by contacting SPEAKS@ahs.ca

AHS Suicide Prevention, Risk Management Assessment & Management (SPRAM)

SPRAM is a web-based, interactive e-Learning series which consists of seven sequential learning modules. Modules one to three provide learners with an awareness of suicide prevention and are recommended for all AHS staff.

- Upon completing three awareness modules within SPRAM, the learner will:
    - understand suicide as a public health issue
    - recognize common suicide warning signs
    - identify suicide risk factors and protective factors
    - understand risk factors associated with populations at higher risk of suicide (e.g., Indigenous youth, middle-age men, LGBTQ+)

Find modules here: https://www.albertahealthservices.ca/info/Page14579.aspx
Note: SPRAM is considered an Accredited Self- Assessment Program (Section 3) as defined by the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada

Mental Health Commission of Canada Courses

Mental Health First Aid-Supporting Older Adults

- Mental Health First Aid (MHFA) is the help provided to a person who may be experiencing a crisis or a decline in their mental well-being. The course is designed for people who have frequent contact with older adults (e.g., family members, friends, public and private caregivers, community health workers, and volunteers).

  To learn more, visit: https://mhfa.ca/

Additional Resources

AHS Addiction & Mental Health Information for Health Professionals
Information on initiatives and programs, links to resources and education and service directories. To learn more, visit:
https://www.albertahealthservices.ca/info/Page11536.aspx

AHS Help in Tough Times
Addiction and Mental Health Resources for patients and families. To learn more, visit:
https://www.albertahealthservices.ca/amh/Page16759.aspx

AHS Pain & Mood Toolkit
eLearning modules and supporting resources to address resident pain and mood distress. To learn more, visit: https://www.albertahealthservices.ca/info/Page17547.aspx

AHS Preventing Suicide Resources
Suicide prevention resources, including the REACH (Recognize, Engage, Ask, Connect, and Heal) pathway. To learn more, visit:
https://www.albertahealthservices.ca/injprev/Page4875.aspx

AHS Tips for Communicating About Suicide
To learn more, visit: https://www.albertahealthservices.ca/assets/healthinfo/ip/hi-ip-pipt-chc-how-to-communicate-about-suicide.pdf

Canadian Coalition for Senior's Mental Health
Resources with additional information to guide practice on a number of topics relevant to older adults, including:

- Suicide Risk and Prevention of Suicide
- Delirium, Depression
- Mental Health in LTC
- Substance Use and Addiction
- Suicide Assessment & Prevention for Older Adults (brochure)

To learn more, visit: https://ccsmh.ca/

Centre for Suicide Prevention
The website has a menu that lists workshops, resources and events, including materials for download, such as the Senior's Suicide Prevention Resource Toolkit and a video on How to Talk to Someone About Suicide. To learn more, visit: https://www.suicideinfo.ca/

Transfer Trauma when moving to a facility available on MyHealth.Alberta.ca. To learn more, visit: https://myhealth.alberta.ca/Alberta/Pages/Transfer-trauma-when-moving-to-a-facility.aspx

References

Accreditation Canada. Suicide Prevention (2018).

AHS *Collaborative Practice Principles Supporting Patient and Family Centred Care* (2016).

AHS *Goals of Care Designation Orders and Personal Directives During Response to Apparent Suicide Attempt* (2021) https://www.albertahealthservices.ca/assets/info/acp/if-acp-guidance-document-on-gcd-orders-and-pds-during-response-to-an-apparent-suicide-attempt.pdf

AHS *Guidelines for Disclosure of Health Information* (2021). https://www.albertahealthservices.ca/assets/info/lp/if-lp-ip-guidelines-for-disclosure-of-health-information.pdf

AHS *Personal Safety Plan* form (2021). https://www.albertahealthservices.ca/frm-18600.pdf

AHS *Preventing Suicide.* Injury Prevention & Safety, Information for Health Professionals. https://www.albertahealthservices.ca/injprev/Page4875.aspx

AHS Provincial Clinical Knowledge Topic: *Suicide Risk Assessment, Adult – Inpatient* (*Non-Psychiatric*) Version 1.0. https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-suicide-risk-assessment-adult-inpatient-non-psychiatric.pdf

AHS *Safety Planning for Suicide Risk Companion Guide* (2022). https://www.albertahealthservices.ca/assets/info/amh/if-amh-safety-planning-for-suicide-risk-companion-guide.pdf

AHS Suicide Risk Level Criteria (2022). https://www.albertahealthservices.ca/assets/info/amh/if-amh-suicide-risk-level-criteria.pdf

AHS *Trauma Informed Practice* (2013). Information and Evaluation Services.

Canadian Coalition for Seniors Mental Health (CCSMH) (2006). *National guidelines for seniors' mental health: the assessment of suicide risk and prevention of suicide.*

Canadian Coalition for Seniors Mental Health (CCSMH) (2009). Suicide prevention among older adults: a guide for family members.

Centre for Suicide Prevention (2014). *Seniors' Suicide Prevention Resource Toolkit.*

Mental Health Commission of Canada (MHCC) (n.d.). Older adults and suicide fact sheet.

Public Health Agency of Canada (2016). Suicide in Canada: infographic. https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-infographic.html

Public Health Agency of Canada (2020). Suicide in Canada: Key statistics (infographic). https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-key-statistics-infographic.html

The Ontario Hospital Association & the Canadian Patient Safety Institute (CPSI) (2011) Suicide risk assessment guide: a resource for health care organizations. https://www.patientsafetyinstitute.ca/en/toolsResources/SuicideRisk/Documents/Suicide%20Risk%20Assessment%20Guide.pdf