SECTION 13: MENTAL HEALTH
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### SECTION 13: MENTAL HEALTH

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KEY POINTS

1. Anxiety is a normal reaction to stress and can be beneficial in some situations.

2. The term anxiety encompasses four aspects of experiences an individual may have:
   a. Mental apprehension
      1) Worries and fears
      2) Rumination
      3) Cognitive effects/distortions
         a) Decreased concentration
         b) Distractibility
         c) Dysfunctional thoughts
   b. Physical tension
   c. Physical symptoms
      1) Diaphoresis
      2) Shortness of breath
      3) Tremors
      4) Heart pounding (palpitations)
      5) Panic attack
   d. Dissociative anxiety

3. Clinically significant anxiety is when anxiety becomes excessive and difficult to control, impacting and interfering with day-to-day functioning.

4. Sub threshold anxiety is defined as clusters of clinically significant symptoms that do not meet the full diagnostic criteria for being an anxiety disorder, but requires monitoring especially in the presence of other major mental illness.

5. Anxiety disorders can include a wide variety of disorders including:
   a. Generalized anxiety disorder (GAD)
   b. Post-traumatic stress disorder (PTSD)
   c. Obsessive-compulsive disorder (OCD)
   d. Panic disorder
   e. Phobic disorder
   f. Social phobia (or social anxiety)
   All symptoms cluster around excessive, irrational fear and dread.

6. Anxiety disorders probably result from a combination of factors:
   a. Genetic
   b. Environmental
   c. Psychological
   d. Developmental

7. Characteristics of anxiety disorders:
   a. Several parts of the brain, such as the amygdala and the hippocampus, are key factors in the production of fear and anxiety (can be based on real or imagined events).
   b. Anxiety disorders are characterized by anxiety of greater than 6 months duration. Such anxiety tends to worsen without treatment.
   c. Women are 60% more likely than men to experience an anxiety disorder over their lifetime.
   d. Other disorders, such as depression, cognitive impairment, dementia or substance abuse, may underlie the anxiety. These disorders should be identified and treated frequently before the anxiety disorder is treated.

8. OASIS Question M1720 screens for clinically significant anxiety.
   a. M1720 asks how often the patient has been anxious over the past 14 days.
   b. Patients with scores of 2 (daily, but not constantly) or 3 (all the time) should be further evaluated for an anxiety disorder.
   c. Clinically significant anxiety can compromise the patient's ability to adhere to the treatment plan, jeopardizing patient outcomes.

9. Two scales which clinicians can use to help determine the significance and severity of a patient's anxiety are:
   a. GAD-7:
      1) The GAD-7 (Generalized Anxiety Disorder) screening scale is similar to the PHQ-9, used to screen for depression.
      2) The score for the seven items ranges from 0-21, with 21 indicating overwhelming anxiety.
      3) This tool identifies patients at risk for all types of anxiety disorders, including PTSD and OCD.
   b. Subjective Units of Distress Scale (SUDS):
      1) SUDS is exactly like the numeric pain scale. It uses a 0-10 scale, coordinated with “no distress” to “worst distress imaginable.”
      2) Non-verbal cues such as tensing of body parts may indicate a higher SUDS score than reported.
      3) SUDS enables regular self-assessments and can be used to gauge progress in the therapeutic process.

10. Treatments for anxiety disorders include:
    a. Medications:
       1) Selective serotonin reuptake inhibitors (SSRI's): sertraline, fluoxetine, escitalopram, citalopram
       2) Selective norepinephrine serotonin reuptake inhibitors (SNRI's): venlafaxine, duloxetine
       3) Tricyclic Antidepressants: amitriptyline, imipramine
       4) Benzodiazepines: lorazepam, alprazolam
       5) Non-benzodiazepine anxiolytics: buspirone, azapirone, prochlorperazine, piperazine, phenothiazine
       6) Beta Blockers: metoprolol, propranolol,
    b. Psychotherapy:
       1) Cognitive behavioral therapy (restructuring thoughts/beliefs)
       2) Supportive psychotherapy
       3) Group therapy

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c. Lifestyle Changes
   1) Dietary changes (e.g., eliminate caffeine)
   2) Sleep hygiene
   3) Mind-body therapies (i.e., breathing and relaxation exercises, yoga, mindfulness, meditation)
   4) Spiritual interventions
   5) Relapse prevention

EQUIPMENT
   GAD-7
   Subjective Units of Distress Scale (SUDS)

PROCEDURE
   Assessment of anxiety
   1. Identify patients who are at risk for anxiety disorder such as patients with scores of 2 or 3 on OASIS question M1720.
   2. Administer either the GAD-7, SUDS scale, or both to determine if symptom should be discussed with primary care provider.

GAD-7
   1. Either:
      a. Give a copy of the GAD-7 to the patient to complete or
      b. Ask patient the seven questions on the GAD-7 and record answers.
   2. Score the patient's responses by:
      a. Obtain sum for each of the 4 columns.
      b. Add the sums together to obtain a total score.
   3. Interpret the Total Score according to the following descriptors.
      a. 0—4: Minimal anxiety
      b. 5—9: Mild Anxiety
      c. 10—14: Moderate Anxiety
      d. 15—21: Severe Anxiety
   4. A score greater than 10 should be further evaluated for possible treatment.

SUDS
   1. Tell the patient, “You mentioned you were feeling anxious...”
   2. Ask, “On a scale of one to ten (where one is the best you can feel and ten is the worst) how do you feel right now?”
   3. Interpret the patient's score as:
      a. 1—3: Mild anxiety
      b. 4—6: Moderate anxiety
      c. 7—10: Severe anxiety

Management of anxiety
   1. If patient's score indicates moderate or severe anxiety, consult with primary care provider.
      a. Discuss GAD-7 and SUDS scores, and concern about patient's level of anxiety.
      b. Request further medical evaluation:
         1) Rule out physical problems such as hyperthyroidism.
         2) Determine patient's symptom clusters/type of anxiety disorder.
   2. Inquire about appropriateness of treating the disorder with medications or psychotherapy.
   3. Ask for a referral for a psychiatric nurse or MSW, or to a community mental health program.
   4. Advise patient in lifestyle therapies using following procedures and resources:
      a. Breathing and Relaxation Exercises procedure
      b. Guided Imagery and Visualization procedure
      c. MyPlate Method procedure
      d. Eat the MyPlate Way handout

AFTER CARE
   1. Communicate with primary care provider:
      a. Positive screen on evidence-based anxiety screening tool and patient's score
      b. Request for treatment plan with medication or referral for psychotherapy
   2. Communicate with team members about need to assess for signs/symptoms, response to treatment, and participation in anxiety reduction strategies and lifestyle changes.
   3. Instruct the patient/caregiver to:
      a. Engage social support system.
      b. Engage in relaxation and diversion activities.
      c. Utilize medications as prescribed and to report medication effects/responses.
      d. Consider referral for psychotherapy and psychiatric/behavioral health follow up as recommended.
      e. Report signs and symptoms of worsening anxiety, panic attacks, and distressing behaviors to the primary care provider.
   4. Document:
      a. Anxiety scale used and patient's score
      b. Instructions given to patient/caregiver to manage symptoms and when to call nurse or primary care provider
      c. Communication with primary care provider about patient’s status and plan of care

REFERENCES
KEY POINTS

1. Dementia is a decline in mental ability severe enough to interfere with daily life.
   a. Symptoms of dementia vary greatly person to person.
   b. At least two of the following core functions must be significantly impaired to be considered dementia:
      1) Memory
      2) Communication and language
      3) Ability to focus and pay attention
      4) Reasoning and judgment
      5) Visual perception

2. The Alzheimer's Association identifies 10 common warning signs for dementia:
   a. Memory changes that disrupt daily life
   b. Challenges in planning or solving problems
   c. Difficulty completing familiar tasks at home, work or at leisure
   d. Confusion with time and place
   e. Trouble understanding visual images and spatial relationships
   f. New problems with words in speaking and writing
   g. Misplacing things and losing the ability to retrace steps
   h. Decreased/poor judgment
   i. Withdrawal from work or social activities
   j. Changes in mood and personality

3. Early signs of dementia, also called "mild cognitive impairment," can be caused by:
   a. Progressive diseases such as Alzheimer's, Lewy body dementia and vascular dementia.
   b. Reversible conditions such as depression, delirium, normal pressure hydrocephalus or nutritional deficiencies.

4. Cognitive impairment and dementia affect:
   a. 10% of people over 65
   b. 50% of people over 85
   c. Many older adults who remain undiagnosed, putting them at risk for accidents and injuries.

5. Home health clinicians may be the first to identify early signs of cognitive impairment. Examples:
   a. Difficulty with medication regime
   b. Decreased attention to IADLs
   c. Difficulty with Teach-Back

6. The OASIS assessment includes several questions which indicate the patient may be affected by dementia:
   a. M1700: Cognitive function, including concentration and memory for simple command
   b. M1710: Confusion over the past 14 days
   c. M1740: Cognitive, behavioral and psychiatric symptoms, including memory deficit and impaired decision-making
   d. M1745: Frequency of behaviors that could jeopardize personal safety

7. The Mini-Cog is a simple test which uncovers early evidence of dementia:
   a. It consists of two parts:
      1) Patient's ability to recall three words.
      2) Patient's ability to draw the face of a clock.
   b. Test takes about 3 minutes or less.
   c. No special tools or forms are necessary to take the test.
   d. Test is an evidenced-based tool with demonstrated ability to screen for dementia of various types.
   e. Test is not skewed by education or culture.

EQUIPMENT

Mini-Cog Test or follow instructions below

PROCEDURE

1. To perform the test:
   a. Ask patient to remember three words.
   b. Speak the three words. Examples:
      1) Banana, sunrise, chair
      2) Captain, garden, picture
   c. Ask patient to repeat the three words.
      1) If patient has difficulty repeating the three words, repeat them again.
      2) Move to next step if patient cannot repeat the three words after three tries.
   d. Ask patient to draw the face of a clock.
      1) Give the patient a blank piece of paper or a paper with a preprinted circle.
      2) A clock should not be visible.
   e. After the numbers are on the face of the clock, ask patient to draw hands to read 10 minutes after 11 o'clock.
      1) Move to the next step if patient has not completed the task within 3 minutes.
      2) If patient refuses to complete the task, move to next step.
   f. Ask patient to recall the three words.

2. To score the test:
   a. Tally the number of correct words: 0 to 3.
   b. The clock is scored normal or abnormal.
      1) Normal means all numbers are placed in approximately the correct position, and hands of clock are pointing at 11 and 2.
      2) Abnormal is either the number placement or clock hands are incorrect (the hands do not need to be different lengths).
      3) Refusal to draw a clock is scored as abnormal.
   c. The test is negative—no cognitive impairment.
      1) 3 words recalled or
      2) 1 – 2 words recalled and clock is normal
   d. The test is positive for cognitive impairment if:
      1) Only 1-2 words recalled and clock is abnormal:
      2) 0 words recalled.
3. A positive Mini-Cog—indicating impairment—indicates the patient needs additional evaluation.
   a. Report the positive Mini-Cog to the primary care provider.
   b. Tell patient/caregiver that the test results mean the patient needs additional evaluation.

AFTER CARE
1. Communicate with the primary care provider about:
   a. Medical evaluation to determine cause of cognitive impairment and possible treatment for reversible causes
   b. Need for additional referrals to promote patient safety:
      1) Speech therapy for memory strategies
      2) MSW for safety planning
      3) Community resources for assistance
2. Evaluate patient's safety in home and with activities, including safety with medication plan.
   a. Alert family/caregiver to safety concerns and need to develop safety strategies.
   b. Instruct patient and caregiver in strategies to promote correct medication administration.
3. Document in patient's medical record:
   a. Administration of Mini-Cog and results
   b. Patient's response to test
   c. Safety evaluation concerns
   d. Instructions given to patient/caregiver to address concerns
   e. Communication with primary care provider
   f. Coordination of care with team members
   g. The homecare RN needs to perform a comprehensive safety evaluation to ensure that the patient is in a safe living situation either alone or with caregivers.

REFERENCES


CLINICIAN RESOURCE
KEY POINTS

1. The Behavioral and Psychological Symptoms of Dementia (BPSD) are distressing to patients and caregivers.

2. BPSD includes:
   a. Agitation and aggression
   b. Delusions and hallucinations
   c. Depression
   d. Sleep disturbances
   e. Wandering

3. Long-term effects of BPSD include:
   a. Caregiver stress, burden and burnout
   b. Increased functional disability
   c. Rapid dementia progression
   d. Nursing home admission
   e. Negative impact on multiple OASIS assessment items, especially M1700 – 1745, which measure psychological and behavioral problems

4. Dementia patients with BPSD are frequently treated inappropriately.
   a. Evidence suggests overuse of antipsychotics, sedatives, and other neuroleptics.
   b. Pharmacologic treatments are generally effective for the following conditions:
      1) Depression (SSRIs)
      2) Negative hallucinations, delusions or other psychosis (atypical antipsychotics)

5. Evidence indicates that the best treatments in general for BPSD are:
   a. Pain management
   b. Exercise
   c. Music and art therapy
   d. Recreational and brain stimulating activities
   e. Aromatherapy and bright light therapy
   f. Massage and light touch
   g. Environmental modifications

6. Most common cause of reversible BPSD is pain.
   a. Many dementia patients with BPSD are affected by osteoarthritic pain and other conditions that cause chronic pain.
   b. Dementia patients are at high risk of inadequate pain assessment and management.
   c. Treating pain relieves BPSD symptoms in 50% of patients with BPSD.

7. Home healthcare clinicians can make a significant positive impact on the quality of life of dementia patients and their caregivers.
   a. The key is to identify, treat and monitor BPSD.
   b. Assess dementia patients for pain with an appropriate tool such as PAINAD (Pain Assessment in Advanced Dementia) tool.
   c. Assess for other BPSDs with a tool like the HABC-M (Healthy Aging Brain Care Monitor) tool.

8. Pain assessment for dementia patients:
   a. Mild dementia: Patients can usually self-report, using a scale like numeric pain scale.
   b. Moderate/severe dementia: Assess with a validated tool for this population such as the PAINAD, CNPI, or PACSLAC tools.

9. The HABC-M is a well-validated tool.
   a. It is completed by the patient's primary caregiver.
   b. It requires only moderate literacy skills.
   c. It takes about 3 – 5 minutes to complete.
   d. It consists of four subscales:
      1) Cognitive subscale
      2) Functional subscale
      3) Behavioral and mood subscale
      4) Caregiver stress scale

EQUIPMENT

HABC-M or other tool for identifying BPSD
PAINAD scale, or other tool for pain assessment

PROCEDURE

1. Ask the patient's caregiver to complete the HABC-M.
2. Instruct to complete by thinking about how often each listed symptom has occurred over the past two weeks.
3. While caregiver completes the HABC-M, perform a comprehensive patient assessment, assessing for signs of physical illness or discomfort.
4. Perform a pain assessment using an appropriate tool.
   a. If patient has moderate/severe dementia, use PAINAD or comparable tool.
   b. Determine the level of patient's pain – none, mild, moderate, severe.
   c. If patient has pain, look for sources: Arthritic joints? When was last bowel movement? Does patient have symptoms of inflammation or infection?
   d. Review patient's pain management plan and when pain medications taken.
5. When caregiver completes HABC-M, review and note the pattern of responses especially in the Behavioral (green) section.
   a. Note the BPSD the patient experiences and which are most problematic.
   b. Ask questions about the BPSD symptoms:
      1) When did it start?
      2) Does it happen at a particular time of day?
      3) What seems to make it better or worse?
   a. If sudden onset or worsening of BPSD:
      1) Etiology could be pain, delirium secondary to infection (e.g. pneumonia, UTI), a new medication, or many other causes.
2) Interventions:
   a) Treat pain.
   b) Assess for sources of pain or infection.
   c) Review for medication change.

b. If patient has BPSD symptoms and a condition or illness that causes pain (osteoarthritis, vertebral fractures, herpes zoster, etc.):
   1) Administer currently ordered pain medications.
   2) Consult with primary care provider about a trial of advancing pain medication.
   3) Provide non-pharmacologic pain management interventions (massage, distraction, etc.) or other therapies to treat pain.

c. If BPSD symptoms persist despite ruling out pain, infections and other causes, use specific interventions which mitigate BPSD symptoms.

7. Instruct caregiver in strategies to address each specific BPSD:
   a. Agitation and aggression are often associated with fear, discomfort, frustration with complex tasks, unfamiliar caregivers, environmental factors or disruption of routines. Strategies include:
      1) Set a positive mood, give simple directions one at a time, keep voice calm, and speak with affection and reassurance.
      2) Distract and redirect. Start a different activity or modify environment.
      3) When trying to accomplish a task – toileting, dressing, etc. – avoid a confrontation; walk away and try the task again in a different way in 10 or 15 minutes.
      4) Evidence shows aggression decreases with exercise regimens (e.g. walking, stationary bike), music therapy, massage, and aromatherapy.
      5) Benzodiazepines should rarely be used since they can lead to rebound agitation as well as falls.

b. Delusions and hallucinations:
   1) Do not treat if they are pleasant and do not scare the patient.
   2) Treat negative and frightening ones with antipsychotics, acknowledging they increase risk of stroke and death.
   c. Depression:
      1) Frequently associated agitation and sleep disturbance, which decrease when depression is treated.
      2) Engage patients in stimulating activities and music therapy.
      3) SSRIs (citalopram or sertraline) can improve symptoms.

d. Sleep Disturbances:
   1) Patients often develop diurnal sleep patterns, sleeping during the day and awake at night.
   2) Stimulate with activities during day.
   3) Allow no more than one 1-2 hour nap.
   4) Flood rooms with natural light during day or use bright lights to help regulate sleep-wake cycle.
   5) Daily melatonin may be helpful in improving nighttime sleep.
   6) Sleep medicines increase risk of falls, delusions, hallucinations and other adverse events.

e. Wandering:
   1) Recommend enrolling in the Alzheimer’s Association Safe Return Program.
   2) Modify the home: Place a curtain over doors, install door alarms, and use monitoring devices.
   3) Structure activities when patient is most likely to wander.
   4) Keep car keys out of sight.

AFTERCARE
1. Communicate with primary care provider:
   a. Types and frequency of BPSD symptoms
   b. Pain scores and effectiveness of pain meds
   c. Effectiveness of meds for depression, delusions and hallucinations
   d. Referrals for MSW for long-term planning and community assistance programs.

2. Provide ongoing support of caregiver and monitoring of patient’s symptoms.
   a. Consider using the HABC-M every two weeks to monitor need for additional interventions.
   b. Refer to the Alzheimer’s Association.

3. Document in patient’s medical record:
   a. Assessment data, including HABC-M scores
   b. Pain assessment and tool used
   c. Instructions provided to caregiver
   d. Communication with primary provider

REFERENCES


**PATIENT EDUCATION RESOURCES**


**CLINICIAN EDUCATION RESOURCE**

KEY POINTS
1. Research indicates approximately 16%-46% of homebound elderly home care patients are clinically depressed, resulting in increased morbidity, mortality, and poor health outcomes. This includes re-hospitalization, poor self-management of other conditions, higher emergent care utilization, risk for falls, and lowered OASIS functional outcome scores.

2. Common signs and symptoms of depression include:
   a. Persistent sadness, anxiety or “empty” feelings
   b. Sleeping too much or insomnia, early morning awakening or awakening frequently
   c. Reduced or increased appetite and/or weight loss or gain
   d. Loss of interest or pleasure in activities
   e. Fatigue, lack of energy, irritability or restlessness
   f. Aches, pains, headaches, cramps, digestive problems that are not improved with treatment
   g. Difficulty thinking or concentrating, remembering or making decisions
   h. Thoughts of death or suicide, or suicide attempts
   i. Feelings of inappropriate guilt, worthlessness, helplessness or hopelessness

3. Screening tools for depression include:
   a. **PHQ-2**, included in OASIS-C, M1730. If a patient is positive for depression on this screening tool (score of 3 or greater), a more in-depth depression scale is indicated.
   b. **PHQ-9** (Patient Health Questionnaire-9) is a nine-item self-administered depression scale.
   c. **GDS-15** (Geriatric Depression Scale Short Form) is a fifteen-item depression scale developed for adults age 65 and older.

4. Both the PHQ-9 and GDS-15 are:
   a. Dual purpose instruments that establish the existence of a depressive disorder and grade the severity of the depression
   b. Available in multiple languages
   1) **PHQ-9**
   2) **GDS-15**

5. Avoid using the word “depression” when introducing the scale to patients. This will minimize patient issues around depression stigma:
   a. **PHQ-9** is called a “patient health questionnaire.”
   b. **GDS** is also referred to as a “Geriatric Mood Scale.”

6. The clinician should demonstrate sensitivity and preserve patient privacy during test administration. The questions and responses may be difficult for a patient to answer. Both instruments are easily understood, relatively simple to use, and can be administered in about 15 minutes or less time.

EQUIPMENT
- **PHQ-9** with score calculation instructions
- **GDS-15** with score calculation instructions
- Depression: What You Need to Know
- Self-Care Action Plan for Depression

PROCEDURE
Assessment of depression
1. Administer the PHQ-2 according to instructions on OASIS-C M1730.
2. Count number of points between the two questions:
   a. Range of points: 0 - 6
   b. Score of 3 or more indicates risk of depression; further evaluation is indicated.
3. If score is 3 or greater, administer a more intensive depression screening with the PHQ-9 or GDS-15.

**PHQ-9**
1. Either:
   a. Give a copy of the PHQ-9 to the patient to self-administer or
   b. Assist the patient by reading items on the scale and recording patient’s responses.
2. Calculate the score:
   a. Each of the 9 items are scored from 0 to 3.
   b. Add the scores of all 9 items.
   c. Range of points: 0 – 27
3. Interpret the score: The score corresponds with depression severity:
   a. Mild depression: 5 - 9 points
   b. Moderate depression: 10 – 14 points
   c. Moderately severe depression: 15 – 20 points
   d. Severe: 21 – 27 points
   e. Suicide risk: If Item 9 – thoughts of being better off dead or of hurting oneself — are answered with a score of 1, 2, or 3.

**GDS-15**
1. Either:
   a. Give the GDS-15 to the patient to self-administer.
   b. Assist the patient by reading items on the scale and recording patient’s responses.
2. Calculate patient’s score:
   a. Each of the 15 items is worth 0 – 1 point.
   b. Add the points for the 15 items.
   c. Range of points: 0 – 15
3. Interpret the score:
   a. **Score > 5 = highly suggestive of depression**
   b. Mild depression = 6 – 10
   c. More severe depression = 11+
Management of depression

1. If scores on PHQ-9, GDS, or other assessment data suggest the patient could be at risk for suicide:
   a. Consult and follow procedure for Suicide Risk Assessment.
   b. If unable to access Suicide Risk Assessment procedure, alert primary care provider immediately, despite limited data, to determine immediate plan.

2. If patient's score is greater than 5, on either the PHQ-9 or GDS, consult with primary care provider.
   a. Communicate that an evidence-based depression screening tool was administered, the severity score, and its interpretation.
   b. Discuss if:
      1) Further medical evaluation by primary care provider or psychiatrist appropriate.
      2) Medications for depression should be considered or changed.
   c. Request referrals as appropriate for:
      1) Psychiatric/mental health nurse or MSW
      2) Occupational therapist for meaningful manageable activities
      3) Physical therapy to develop aerobic exercise program appropriate for patient's abilities
      4) Chaplain or pastor for spiritual support
      5) Other community-based mental health services
      6) Other community resources for longer term diversional activities such as exercise and social/activity groups

3. Provide the patient and caregiver with information about depression such as Depression: What You Need to Know

4. Provide the patient with depression self-management resources such as:
   a. Self-Care Action Plan for Depression
   b. Plan to help patient work on one goal per week.

5. Instruct patient/caregiver:
   a. To engage social support systems and resources as available in community
   b. To participate in diversional activities to assist with reducing depressive episodes
   c. Signs and symptoms of worsening depression and suicidal risk, and need to report these to the primary provider

AFTER CARE

1. Plan follow-up visits to monitor patient's status and effectiveness of the plan to decrease depression.
2. Communicate with team members of depression care plan, ways to coordinate care, and need to monitor for worsening signs/symptoms or decreased ability to cope.
3. Instruct patient/caregiver to report worsening signs and symptoms, and how to reach assistance.

4. Document in patient's medical record:
   a. Depression scale used and patient's score
   b. Instructions given to patient/caregiver on how to manage symptoms and when to call nurse
   c. Communication with primary provider about the patient's status, depression score, and any recommended changes made to the plan of care.

REFERENCES


PATIENT EDUCATION RESOURCES


CLINICIAN EDUCATION RESOURCES


KEY POINTS

1. Home health patients have a higher risk for suicide than the general population. The purpose of this procedure is to help clinicians assess, identify and intervene appropriately when suicide risk is present.

2. Several OASIS questions may indicate that suicide risk should be assessed:
   a. M1036: Risk Factors: Alcohol and drug abuse/dependency
   b. M1730: Depression Screening PHQ2 score of 3 or greater
   c. M1740: Cognitive, Behavioral and Psychiatric Symptoms: Presence of abnormal thinking or acting can indicate suicide risk, e.g. hallucinations commanding self-harm.
   d. M1745: Frequency of Disruptive Behavior Symptoms: Presence of any physical, verbal or other disruptive/dangerous symptoms that are injurious to self or others can indicate poor impulse control.

3. If the PHQ-2 (M1730) is positive, administering the PHQ-9 is recommended in the literature:
   a. Question 9 asks, “Over the past two weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way?”
   b. A positive answer – responses 1, 2, or 3 – indicates suicide risk.
   c. A positive answer indicates a need for follow-up questions about suicidal thoughts.

4. A mnemonic used to identify risk factors for suicide is: SAD PERSONS.
   a. Many of the SAD PERSONS risk factors are included on the OASIS:
      1) Sex: Women are more likely to attempt suicide; men are more likely to be successful (M0069).
      2) Age: Men over 45, women over 55, and teenagers are at risk (M0066).
      3) Depression: Especially feelings of hopelessness and worthlessness (M1730)
      4) Previous suicide attempt
      5) Ethanol (alcohol) or drug use (M1036 – risk factors)
      6) Rational thinking loss. Consider responses to M1735 and M1740 about psychiatric and disruptive behaviors.
      7) Social support lacking. Lack of involvement with others (M2100)
      8) Organized plan, especially with lethal means available (gun, pills)
      9) No spouse. Living alone increases risk (M1100).
      10) Sickness, with chronic debilitating illnesses (M1020/1022)
   b. The more risk factors, the higher the patient’s suicide risk.

5. If suicide risk is identified:
   a. Clinician must decide how imminent/severe the risk is.
   b. Clinician must intervene appropriately to the degree of risk.
   c. Two tools for assisting in these decisions are
      1) SAD PERSONS Scale
      2) Weill Cornell Suicide Risk Spectrum

EQUIPMENT

PHQ-9 patient form with calculation instructions
SAD PERSONS with calculation instructions
Weill Cornell Suicide Risk Spectrum

PROCEDURE

1. Establish a therapeutic relationship with patient.
2. Ask patient questions about feelings in a conversational and caring way.
4. If PHQ-2 is positive or if other signs indicate depression, consider the following options:
   b. Perform SAD PERSONS risk assessment.
   c. Ask patient questions about level of hopelessness and thoughts of death.
5. To use PHQ-9:
   a. Give patient a copy of the PHQ-9 to complete or ask patient the questions from the PHQ-9.
   b. Score the PHQ-9, adding up points for all 9 items to determine severity of depression.
   c. Note response to question 9. If response is 1, 2 or 3, patient is at risk of suicide. Further questions must be asked.
6. To use SAD PERSONS:
   a. Complete SAD PERSONS assessment form, obtaining most answers from comprehensive OASIS assessment.
   b. Score patient’s risk, by assigning one point for each risk factor.
   c. Compare patient’s score to the SAD PERSONS intervention recommendations.
7. Script for asking questions about suicidal thoughts:
   a. Are you discouraged about your medical condition?
   b. Are there times when you think about your situation and feel like crying?
   c. During those times, what sorts of thoughts go through your head?
   d. Have you ever felt that it would not be worth living if the situation did not change? Have you thought about ending your life? If so, how often do you have such thoughts?
   e. Have you devised a plan to end your life? If so what is your plan? Do you have the necessary items to complete that plan readily available?
f. Have you ever acted on any plans to end your life in the past? Have you attempted suicide? If so, when did this occur? How many times has it occurred in the past? By what means? What was the outcome?

8. Compare data gathered through assessment and interview to the Weill Cornell Suicide Risk Spectrum. Determine where on the spectrum the patient falls:
   a. High Risk: Organized plan, lethal means available, psychotic or poor impulse control, extreme pessimism
   b. Moderate Risk: Thoughts of suicide, considered a plan, but plan is not organized or available
   c. Mild Risk: Thoughts of life not being worth living, but has not considered a plan
   d. Very Low Risk: Considering normal end-of-life issues

9. If High Risk:
   a. Tell patient that immediate mental health intervention is necessary.
   b. Alert primary care provider of how risk was assessed and recommend immediate hospitalization.
   c. If patient refuses intervention, call emergency services. Report immediate suicide threat. Stay with patient until services obtained.
   d. If patient poses a threat to clinician, clinician should secure personal safety immediately before taking any other actions.

10. If Moderate Risk:
    a. Tell patient that thoughts indicate extreme distress and you will help patient get help.
    b. Alert primary care provider and make arrangements for an urgent mental health referral.
    c. Involve family and caregivers if appropriate, and provide hotline and emergency numbers.
    d. Take steps to remove lethal means.
    e. Develop plan to provide ongoing monitoring and support.

11. If Mild Risk:
    a. Tell patient that thoughts are distressing and you can get the patient help.
    b. Alert primary care provider and determine a plan:
       1) Referral to psychiatric/mental health nurse, MSW or community mental health specialist
       2) Strategies to address depression. See Depression Assessment and Management.
    c. Involve family and caregivers if appropriate, and provide hotline and emergency numbers.

12. If Very Low Risk:
    a. Ask if patient would like to discuss concerns in more depth with a mental health specialist.
    b. Consult with primary care provider about:
       1) Strategies to address depression, including medications and psychotherapy

2) Referral for psych/mental health nurse, MSW or other mental health services

AFTER CARE

1. Communicate with team members and develop a plan for ongoing monitoring and support.
2. Instruct patient and caregiver:
   a. Signs and symptoms of increased suicide risk, and to call home health agency if thoughts/feelings worsen
   b. Provide numbers for hotline and emergency mental health services phone numbers.
3. Document in the patient’s medical record:
   a. Scores on depression and suicide risk scales
   b. Interventions taken to address risks
   c. Instructions given to patient/caregiver
   d. Communication with primary provider

REFERENCES


CLINICIAN EDUCATION RESOURCES
