

# Relapse Plan

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# Decompensation and Relapse Planning

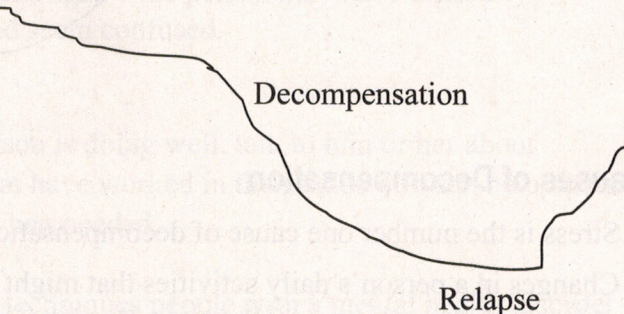
## Module Goals:

To provide caregivers and managers with information on:

- Determining baseline.
- Identifying decompensation, possible causes, and symptoms.
- Ways to help when a person is decompensating.
- Identifying relapse and developing a relapse plan.
- Dealing with the risk of violence.
- Intervening in crisis situations.

**Baseline** is described as the times when a person with a mental health disorder is managing his or her symptoms and is functioning at his or her own highest level.

## Baseline



Your goal is to help the resident get to his or her baseline, and to assist him or her to stay there.

You can help by:

- Encouraging the person to continue treatment and take his or her medications.
- Helping the person set realistic goals. Encourage the person to take small steps towards the goal.
- Creating an atmosphere of support.
- Empowering the person by encouraging and assisting him or her to use problem solving techniques to help cope with obstacles as they arise.
- Being respectful, supportive, and kind. Tell the person what he or she is doing well. This is the best way to help him or her move forward.
- Encouraging the person to identify what causes him or her stress and help the person find ways to reduce it.

## Baseline

**Baseline** —when the person is functioning at his or her highest level.



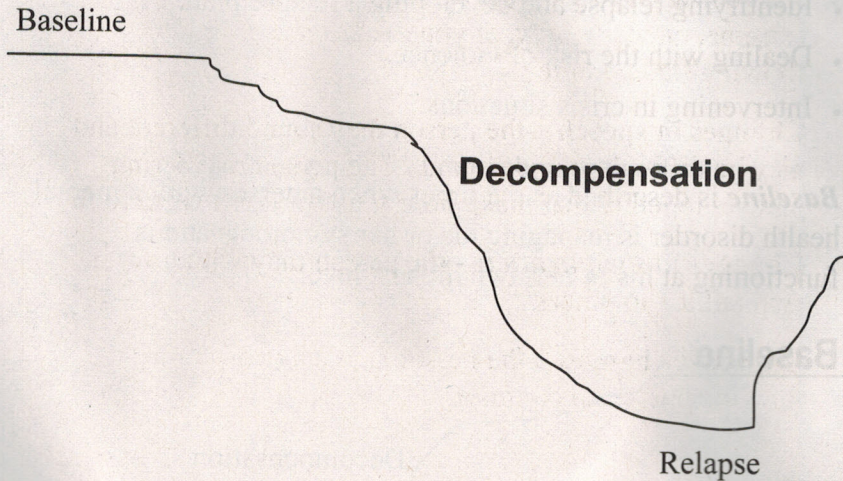


## Decompensation

**Decompensation** —downward slide in symptoms from the person's baseline.

**Decompensation** is when symptoms of the mental health disorder begin to be more prominent, and the person is unable to manage or cope with his or her symptoms.

Think of decompensation as a “downward slide” from the person's baseline. This “downward slide” leads to a decline in the person's ability to think and carry on with daily activities.



### Causes of Decompensation

- Stress is the number one cause of decompensation.
- Changes in a person's daily activities that might cause stress, including changes in the person's physical health, finances, relationships, or living environment.
- Fatigue.
- Illness.
- Life events, such as holidays, vacations, moving, or the death of someone close.

### Symptoms of Decompensation

Early identification that the person is decompensating is vitally important to get the person appropriate treatment. Without intervention, decompensation can lead to a relapse.

It is therefore critical that you stay alert to symptoms that the person is decompensating.

Symptoms of decompensation are unique to each person. It is important to find out what symptoms the individual has experienced in the past so that you can watch for them.

*Without intervention, decompensation can lead to a relapse.*



Some general symptoms include:

- **Sensory changes**—in what the person tastes, smells, hears, and sees.
- **Perceptual changes**—the person may misinterpret or distort what is going on around him or her, and may experience more frequent hallucinations or delusions.
- **Emotional changes**—the person's feelings may appear extreme, opposite of what you might expect, or flat, showing little emotion.
- **Changes in speech**—the person may sound different and may be difficult to understand. The person may string phrases together that make little sense or don't seem to fit.
- **Changes in socialization**—the person may withdraw and stop talking to others.
- **Cognitive changes**—the person may have difficulty thinking and seem confused.

When the person is doing well, talk to him or her about techniques that have worked in the past so you can be prepared to use them when needed.

Some typical techniques people with a mental health disorder use to help prevent a relapse include:

- Calling the mental health case manager or other mental health professional for support.
- Calling family or friends.
- Using positive self-suggestions to overpower unwanted thoughts.
- Doing an activity the person enjoys, such as reading or playing a game.
- Taking time to go for a walk, meditate, or pray.
- Getting adequate rest and sleep.

Some people may also use drugs or alcohol. This is not a good technique, as it makes symptoms worse and can be dangerous.

## How to Help a Person Who is Decompensating

*When the person is doing well, talk about techniques that have worked in the past so you can be prepared to use them when needed.*





Some things you can do to help the person include:

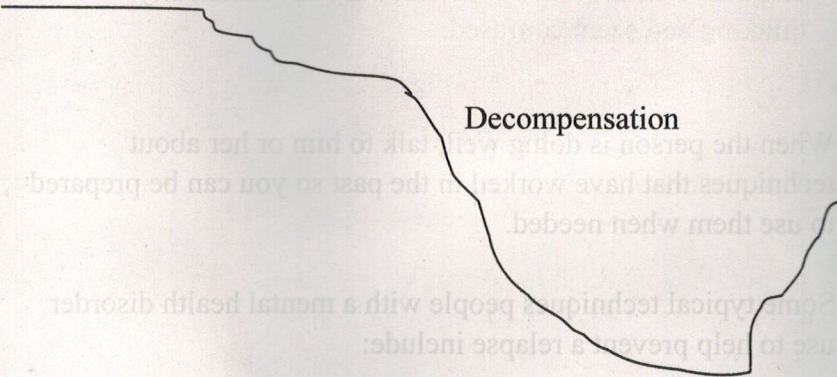
- Talking to the person about what he or she is feeling.
- Encouraging the person to try some of the techniques that have helped in the past.
- Involving the person in an activity.
- Helping the person to stay focused when doing tasks.
- Being consistent and non-judgmental.
- Calling for assistance when needed.

## Relapse

**Relapse** —symptoms are severe enough to require professional intervention.

A **relapse** is said to occur when the symptoms of the illness worsen or when previous symptoms return and are severe enough to require professional intervention.

Baseline



**Relapse**

Even with the best treatments and support, relapse can still occur. Sometimes, these symptoms come and go in cycles. Relapse may also occur without an apparent cause.

Since prevention is not always possible, it is imperative that you prepare ahead of time and develop a plan with the person on what to do in the event of a relapse.

Make a detailed written plan, then follow it if relapse occurs. This will make a difficult situation less stressful.

*Prepare ahead of time and develop a plan with the person on what to do in the event of a relapse.*



## Relapse Plan

A **relapse plan** is a prearranged plan for what to do when a person experiences a relapse. It is often called a “crisis plan”.

A relapse plan should include:

- Events or situations that have triggered a relapse in the past
- Early warning signs the person experienced in the past
- What has helped the person in the past when the person experienced those early warning signs
- Who the person wants contacted
- What each person’s role is in the plan

**Relapse plan** — a plan for what to do when a person experiences a relapse.

On page 66 is a simple sample personal relapse management plan.

A relapse plan may be more comprehensive and include information about the person’s preferences regarding:

- Treatment and facilities
- Physicians, mental health professionals, and other providers
- Hospitalization and alternative interventions
- Medication preferences and instructions

A mental health advanced directive is a comprehensive legal document that a person with the mental health disorder can use to spell out his or her wishes, in advance, for what he or she would like to happen in case of a relapse.

## Mental Health Advanced Directive

On pages 67-81 is a **sample** mental health advance directive. Remember, the law prohibits the use of physical restraints in facilities.



# Personal Relapse Management Plan

Resident Name: \_\_\_\_\_

Events or situations that triggered relapse in the past:
1.
2.
3.

Early warning signs that I have experienced in the past:
1.
2.
3.

What would help me if I experience early warning signs:
1.
2.
3.

Who I would like to assist me:	What I would like them to do:
NAME AND PHONE NUMBER	ROLE

\_\_\_\_\_  
*Signature of Resident/Date*

\_\_\_\_\_  
*Signature of Staff/Date*





# Mental Health Advance Directive

## NOTICE TO PERSONS CREATING A MENTAL HEALTH ADVANCE DIRECTIVE

This is an important legal document. It creates an advance directive for mental health treatment. Before signing this document you should know these important facts:

- (1) This document is called an advance directive and allows you to make decisions in advance about your mental health treatment, including medications, short-term admission to inpatient treatment and electroconvulsive therapy.

**YOU DO NOT HAVE TO FILL OUT OR SIGN THIS FORM.  
IF YOU DO NOT SIGN THIS FORM, IT WILL NOT TAKE EFFECT.**

If you choose to complete and sign this document, you may still decide to leave some items blank.

- (2) You have the right to appoint a person as your agent to make treatment decisions for you. You must notify your agent that you have appointed him or her as an agent. The person you appoint has a duty to act consistently with your wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your agent has the right to withdraw from the appointment at any time.

- (3) The instructions you include with this advance directive and the authority you give your agent to act will only become effective under the conditions you select in this document. You may choose to limit this directive and your agent's authority to times when you are incapacitated or to times when you are exhibiting symptoms or behavior that you specify. You may also make this directive effective immediately. No matter when you choose to make this directive effective, your treatment providers must still seek your informed consent at all times that you have capacity to give informed consent.

- (4) You have the right to revoke this document in writing at any time you have capacity.

**YOU MAY NOT REVOKE THIS DIRECTIVE WHEN YOU HAVE BEEN FOUND TO BE INCAPACITATED UNLESS YOU HAVE SPECIFICALLY STATED IN THIS DIRECTIVE THAT YOU WANT IT TO BE REVOCABLE WHEN YOU ARE INCAPACITATED.**

- (5) This directive will stay in effect until you revoke it unless you specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again unless you chose to be able to revoke it while you are incapacitated and you revoke the directive.

- (6) You cannot use your advance directive to consent to civil commitment. The procedures that apply to your advance directive are different than those provided for in the Involuntary Treatment Act. Involuntary treatment is a different process.

- (7) If there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

- (8) You should be aware that there are some circumstances where your provider may not have to follow your directive.

- (9) You should discuss any treatment decisions in your directive with your provider.

- (10) You may ask the court to rule on the validity of your directive.



# Mental Health Advance Directive

## PART I.

### STATEMENT OF INTENT TO CREATE A MENTAL HEALTH ADVANCE DIRECTIVE

I, \_\_\_\_\_ being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care. If a guardian is appointed by a court to make mental health decisions for me, I intend this document to take precedence over all other means of ascertaining my intent.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my agent should make the decision that he or she determines is in my best interest. I intend this directive to take precedence over any other directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if a court, two health care providers, or one mental health professional and one health care provider find that I am an incapacitated person, unless, when I executed this directive, I chose to be able to revoke this directive while incapacitated.

I understand that, except as otherwise provided in law, revocation must be in writing. I understand that nothing in this directive, or in my refusal of treatment to which I consent in this directive, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive.

I understand that there are some circumstances where my provider may not have to follow my directive.



# Mental Health Advance Directive

## PART II.

### WHEN THIS DIRECTIVE IS EFFECTIVE

*YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.*

I intend that this directive become effective (*YOU MUST CHOOSE ONLY ONE*):

\_\_\_\_\_ Immediately upon my signing of this directive.

\_\_\_\_\_ If I become incapacitated.

\_\_\_\_\_ When the following circumstances, symptoms, or behaviors occur:

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## PART III.

### DURATION OF THIS DIRECTIVE

*YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.*

I want this directive to (*YOU MUST CHOOSE ONLY ONE*):

\_\_\_\_\_ Remain valid and in effect for an indefinite period of time.

\_\_\_\_\_ Automatically expire \_\_\_\_\_ years from the date it was created.



# Mental Health Advance Directive

## PART IV.

### WHEN I MAY REVOKE THIS DIRECTIVE

*YOU MUST COMPLETE THIS PART FOR THIS DIRECTIVE TO BE VALID.*

I intend that I be able to revoke this directive (*YOU MUST CHOOSE ONLY ONE*):

\_\_\_\_\_ Only when I have capacity.

I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.

\_\_\_\_\_ Even if I am incapacitated.

I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

## PART V.

### PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS

#### A. Preferences and Instructions About Physician(s) to be Involved in My Treatment

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. \_\_\_\_\_ Contact information: \_\_\_\_\_

Dr. \_\_\_\_\_ Contact information: \_\_\_\_\_

I do not wish to be treated by Dr. \_\_\_\_\_



# Mental Health Advance Directive

## B. Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name \_\_\_\_\_ Profession \_\_\_\_\_

Contact information \_\_\_\_\_

Name \_\_\_\_\_ Profession \_\_\_\_\_

Contact information \_\_\_\_\_

## C. Preferences and Instructions About Medications for Psychiatric Treatment *(initial and complete all that apply)*

\_\_\_\_\_ I consent, and authorize my agent (if appointed) to consent, to the following medications:

\_\_\_\_\_

\_\_\_\_\_ I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:

\_\_\_\_\_

\_\_\_\_\_ I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include:

\_\_\_\_\_

and these side effects can be eliminated by dosage adjustment or other means.

\_\_\_\_\_ I am willing to try any other medication the hospital doctor recommends.

\_\_\_\_\_ I am willing to try any other medications my outpatient doctor recommends.

\_\_\_\_\_ I do not want to try any other medications.



# Mental Health Advance Directive

## Medication Allergies

I have allergies to, or severe side effects from, the following:

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## Other Medication Preferences or Instructions

I have the following other preferences or instructions about medications

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## Preferences and Instructions About Hospitalization and Alternatives

*(initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)*

\_\_\_\_\_ In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

\_\_\_\_\_ I would also like the interventions below to be tried before hospitalization is considered:

\_\_\_\_\_ Calling someone or having someone call me when needed.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_ Staying overnight with someone.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

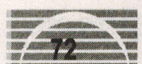
\_\_\_\_\_ Having a mental health service provider come to see me.

\_\_\_\_\_ Going to a crisis triage center or emergency room.

\_\_\_\_\_ Staying overnight at a crisis respite (temporary) bed.

\_\_\_\_\_ Seeing a service provider for help with psychiatric medications.

\_\_\_\_\_ Other, specify: \_\_\_\_\_





# Mental Health Advance Directive

## E. Preferences and Instructions About Pre-emergency

I would like the interventions below to be tried before use of seclusion or restraint is considered (*initial all that apply*):

- "Talk me down" one-on-one
- More medication
- Time out/privacy
- Show of authority/force
- Shift my attention to something else
- Set firm limits on my behavior
- Help me to discuss/vent feelings
- Decrease stimulation
- Offer to have neutral person settle dispute
- Other, specify \_\_\_\_\_

## F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (*choose "1" for first choice, "2" for second choice, and so on*):

- Seclusion
- Seclusion and physical restraint (combined)
- Medication by injection
- Medication in pill or liquid form

In the event that my attending physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part III C of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.



# Mental Health Advance Directive

## Authority to Consent to Inpatient Treatment

I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for \_\_\_\_\_ days (*not to exceed 14 days*)

(*Sign one*):

\_\_\_\_\_ If deemed appropriate by my agent (if appointed) and treating physician.

\_\_\_\_\_  
(*Signature*)

or

\_\_\_\_\_ Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(*Signature*)

or

\_\_\_\_\_ I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment.

\_\_\_\_\_  
(*Signature*)

## Hospital Preferences and Instructions

If hospitalization is required, I prefer the following hospitals:

\_\_\_\_\_

I do not consent to be admitted to the following hospitals:

\_\_\_\_\_



# Mental Health Advance Directive

## G. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

My wishes regarding electroconvulsive therapy are *(sign one)*:

\_\_\_\_\_ I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

\_\_\_\_\_  
*(Signature)*

\_\_\_\_\_ I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

\_\_\_\_\_  
*(Signature)*

\_\_\_\_\_ I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*(Signature)*

## H. Preferences and Instructions About Who is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

I understand that persons not listed above may be permitted to visit me.

## I. Additional Instructions About My Mental Health Care

Other instructions about my mental health care:

\_\_\_\_\_  
\_\_\_\_\_



# Mental Health Advance Directive

In case of emergency, please contact:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Work telephone: \_\_\_\_\_ Home telephone: \_\_\_\_\_

Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

The following may help me to avoid a hospitalization:

\_\_\_\_\_

I generally react to being hospitalized as follows:

\_\_\_\_\_

Staff of the hospital or crisis unit can help me by doing the following:

\_\_\_\_\_

## J. Refusal of Treatment

I do not consent to any mental health treatment.

\_\_\_\_\_  
(Signature)

## PART VI.

### DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)

*(Fill out this part only if you wish to appoint an agent or nominate a guardian.)*

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document and my agent does not otherwise know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.



# Mental Health Advance Directive

## A. Designation of an Agent

I appoint the following person as my agent to make mental health treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Work telephone: \_\_\_\_\_ Home telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

## B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Work telephone: \_\_\_\_\_ Home telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

## C. When My Spouse is My Agent (*initial if desired*):

\_\_\_\_\_ If my spouse is my agent, that person shall remain my agent even if we become legally separated or our marriage is dissolved, unless there is a court order to the contrary or I have remarried.

## D. Limitations on My Agent's Authority

I do not grant my agent the authority to consent on my behalf to the following:

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_



# Mental Health Advance Directive

## E. Limitations on My Ability to Revoke this Durable Power of Attorney

I choose to limit my ability to revoke this durable power of attorney as follows:

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## F. Preference as to Court-Appointed Guardian

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I nominate the following person as my guardian:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Work telephone: \_\_\_\_\_ Home telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

\_\_\_\_\_  
(Signature required if nomination is made)

## PART VII.

### OTHER DOCUMENTS

(Initial all that apply)

I have executed the following documents that include the power to make decisions regarding health care services for myself:

\_\_\_\_\_ Health care power of attorney (chapter 11.94 RCW)

\_\_\_\_\_ "Living will" (Health care directive; chapter 70.122 RCW)

\_\_\_\_\_ I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:



# Mental Health Advance Directive

## PART VIII.

### NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS

*(Fill out this part only if you wish to provide nontreatment instructions.)*

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them.

#### A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible when this directive becomes effective:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Day telephone: \_\_\_\_\_ Evening telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Day telephone: \_\_\_\_\_ Evening telephone: \_\_\_\_\_

#### B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

\_\_\_\_\_

#### C. Additional Preferences and Instructions:

\_\_\_\_\_

## PART IX.

### SIGNATURE

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_



# Mental Health Advance Directive

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

- (A) A person designated to make medical decisions on the principal's behalf;
- (B) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;
- (C) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;
- (D) A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;
- (E) An incapacitated person;
- (F) A person who would benefit financially if the principal undergoes mental health treatment; or
- (G) A minor.

Witness 1: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Telephone \_\_\_\_\_ Address \_\_\_\_\_

Witness 2: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Telephone \_\_\_\_\_ Address \_\_\_\_\_

## PART X.

### RECORD OF DIRECTIVE

I have given a copy of this directive to the following persons:

\_\_\_\_\_  
\_\_\_\_\_



# Mental Health Advance Directive

DO NOT FILL OUT PART XI UNLESS YOU INTEND TO REVOKE  
THIS DIRECTIVE IN PART OR IN WHOLE

## PART XI.

### REVOCATION OF THIS DIRECTIVE

*(Initial any that apply):*

\_\_\_\_\_ I am revoking the following part(s) of this directive (specify):  
\_\_\_\_\_

\_\_\_\_\_ I am revoking all of this directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN  
PART OR IN WHOLE**



## Module Goals:

To provide caregivers and managers with information on:

- The facts regarding suicide.
- Suicide warning signs.
- What to do if a person is suicidal.

There are many myths and misconceptions about suicide and it is often a difficult topic to discuss. The following are some of the things known about suicide.

- Suicide is the eleventh leading cause of death in the U.S.
- Four times as many men kill themselves as women, but three to four times as many women attempt suicide as do men.
- Suicide cuts across all ethnic, economic, social, and age boundaries.
- The suicide rate is higher for the elderly than any other age group. Among the highest rates, are white men age 85 and older.
- Suicide is preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems.
- Most suicidal persons give definite warning signs of their suicidal intentions.
- Talking to someone about suicide does not cause someone to be suicidal.

Although the great majority of people who suffer from a mental disorder do not die by suicide, having a mental disorder does increase the likelihood of suicide. Other risk factors include:

- Previous suicide attempts
- History of mental disorders, particularly depression
- Alcohol or substance abuse
- Family history of suicide or violence
- A serious or terminal illness
- Having experienced a recent, severe loss such as death, divorce, job, money, health

## Facts About Suicide

## Risk Factors



## Suicide Warning Signs

- Talking about committing suicide
- Withdrawing from friends and/or social activities
- Being preoccupied with death and dying
- Drastic changes in behavior
- Losing interest in hobbies, work, etc.
- Giving away prized possessions
- Taking unnecessary risks
- Arranging for care of pets
- Losing interest in personal appearance
- Preparing for death by making out a will or making final arrangements
- Beginning to feel better—a person with depression may be most likely to attempt suicide when a depression begins to lift

## Be Aware of Feelings

A person who is suicidal may express or experience some of the following:

- Intense emotional pain that he or she cannot stop
- Sadness that he or she cannot make go away
- Feeling trapped, like there is no way out
- An inability to eat, sleep, or work
- An inability to think clearly or make decisions
- Feeling worthless, hopeless, or guilty

## Depression

Studies consistently show depression substantially increases the risk for suicide.

Depression is also one of the most common conditions associated with suicide and older adults, yet it often goes untreated. In fact, several studies have found that up to 75% of older adults who die by suicide visited a physician within a month of their suicide.

## Suicide and Mental Disorders

*An estimated 2-5% of people diagnosed with **major** depression die by suicide.*



Because, in older adults, depression often co-occurs with other serious illnesses, health care providers, and the person suffering from depression, often mistakenly think it is a normal consequence of the physical problems.

These factors show how urgent it is to make sure that depression is detected and treated to reduce the risk of suicide in older adults.

Also at high risk are individuals who have depression at the same time as another mental disorder. Specifically, substance abuse, anxiety disorders, schizophrenia, and bipolar disorder put those with depression at greater risk for suicide.

## **Bipolar Disorder**

Both bipolar disorder and depression tend to co-occur with other disorders, such as anxiety, panic attacks, alcohol, and/or substance use, and insomnia. Any of these other disorders are considered to be risk factors for suicidal behaviors.

*An estimated 3-20% of people diagnosed with bipolar disorder die by suicide.*

People with bipolar disorder are at the highest risk, especially when they are in a mixed episode (symptoms of mania and depression occurring at the same time or alternating frequently during the day).

## **Schizophrenia**

Suicide is unfortunately one of the leading causes of death for people with schizophrenia.

- Studies have shown that 40%-53% of people with schizophrenia have had thoughts of suicide at some point in their lives.
- 23%-55% reported previous suicide attempts.
- Suicide is the leading cause of premature death in those diagnosed with schizophrenia. Between 75 and 95% of these individuals are male.

*An estimated 6-15% of people diagnosed with schizophrenia die by suicide.*

People with schizophrenia tend to be suicidal:

- In the earlier years of schizophrenia.
- During periods of depression.
- During periods when they are out of touch with reality.
- In a period of improvement after a relapse.



The risk of suicide continues throughout the person's life and seems to be higher when the person has a chronic physical illness, multiple psychiatric hospitalizations, or a previous suicide attempt.

### **Anxiety Disorders**

People with anxiety disorders are 6-10 times more likely than the general population to commit suicide. One study showed that 11% of people who committed suicide had an anxiety disorder. This estimate may be low due to factors that mask anxiety, such as alcohol use or other mental disorders.

### **Alcohol/Substance Use Disorders**

At least 30% of people who commit suicide were dependent on or abused alcohol. Unlike other mental disorders, the risk of suicide for people who abuse alcohol increases with age.

Between 40 to 60% of people who die by suicide have alcohol in their blood at the time of their death. Sometimes, a person may use alcohol or substances deliberately as part of an attempted suicide. While intoxicated, the person may also be more likely to act on a suicidal impulse.

Additionally, substance use can make some medications more lethal and make it more likely that a suicide attempt by overdose will be deadly.

When you see any warning signs that a person may be suicidal (see page 86), take it seriously and don't hesitate to take immediate action.

There is no set script of what to say and do in these situations. Each person and situation is different. The seriousness of the situation may make you uncomfortable or you may feel uncertain what to do. This is human nature.

It is important to remember the person is in intense emotional pain and needs your help. Most suicidal people don't want to die so much as he or she want the pain to end.

*Between 40 to 60% of people who die by suicide have alcohol in their blood at the time of their death.*

### **What to Do If a Person Is Suicidal**

*Always treat threats of self-harm seriously, regardless of how many times the person has threatened in the past.*



The following information will give you some suggestions on how best to handle the person and the situation. See pages 88-89 for more communication tips on handling a crisis.

If you are concerned that a person may be suicidal, learn as much as possible about what is going on in his or her mind. The more planning the person has put into a suicide, the greater the risk. If the person has a method and a time planned, the risk is very high.

Talk openly about the possibility of suicide. Ask the person directly,

- "Are you thinking about suicide?"
- If the answer is yes, ask, "Have you thought about how you would do it?"
- If the answer is yes, ask, "Do you have what you need to do it?"
- If the answer is yes, ask, "Have you thought about when you would do it?"

\*excerpted from [www.suicide.org](http://www.suicide.org).

*There are four important questions to ask a person you think may be suicidal.*

- 1. Thinking about suicide?*
- 2. Method?*
- 3. Have what you need?*
- 4. When?*

## **High Risk**

Your first priority is to keep the person safe if you feel the person is at high risk of suicide. Never leave a person at high risk for suicide alone. If you must leave for any reason, make sure there is another person you trust to stay with the person until you return.

If you feel the person is in immediate danger, there are several actions you should take depending on your situation. A person who is suicidal needs **immediate professional help**.

Depending on your situation, you should:

- Call 911.
- Call the crisis team at the facility.
- Take him or her to the hospital emergency room.

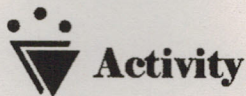
Always be familiar with your facilities policies and procedures for handing this type of crisis before it happens.



### **While Waiting For Help to Arrive or If the Person is Not in Immediate Danger**

- Remain calm and be as gentle and caring as possible. Comfort the person and let him or her know you care and he or she is not alone. Let the person know that you are very concerned.
- Listen and give the person your full attention. Allow the person to express his or her feelings and talk as much as he or she wants.
- Reassure the person that with time and help he or she will feel better and that problems can be solved.
- Remove any firearms, drugs, or sharp objects from the area.
- Do not moralize or make judgments. Do not say, “You will go to hell” or “You’re being selfish” or “Your family will be so hurt by this”.
- If the person is not at high risk, encourage him or her to get professional help as soon as possible. Help him or her arrange the appointment and take them there, if necessary.

Always report your concerns to the appropriate people in your situation once the situation and the person is safe.



#### **Suicide Scenario**

Mr. Jackson has a bi-polar disorder and appears depressed lately. He tells you he does not want to be a burden to his family and he thinks they would be better off without him.

#### **Describe:**

- What questions you could ask to determine if Mr. Jackson is at risk for suicide.
- What you would do to keep Mr. Jackson safe.
- At what point you would get outside help for Mr. Jackson.

#### **Demonstrate:**

Your interaction with Mr. Jackson.



## Caregiver Grief After Suicide

Despite everyone's best efforts at helping, the person may still commit suicide. This may be very difficult to deal with. It is important for you to take care of yourself while going through this process. You may experience:

- Intense feelings of grief. These feelings can be overwhelming and frightening, but they are normal. You are not going crazy—you are grieving.
- Feelings of guilt, confusion, anger, betrayal, or fear. These feelings are common responses to grief.
- Thoughts of suicide. Sometimes, this happens. It doesn't mean you'll act on the thoughts.
- Forgetfulness. This is often a side effect of grief.
- Nightmares and flashbacks — especially if you witnessed the suicide or found the person.

Grieving takes so much energy that other things may fade in importance. The path of grief is one of twists and turns. You may feel like you are getting nowhere, but healing takes time. Find ways to take care of yourself during the process.

### Finding Ways to Cope

If you try to ignore your feelings, deny yourself the time and space you need to grieve, or don't seek the support you need, other problems can develop. Try to find healthy ways to cope.

Remember to:

- Be patient with yourself. Grief has no predictable pattern or timetable.
- Allow yourself all the time you need to grieve.
- Seek out people who are willing to listen when you need to talk and who understand your experience.
- Make healthy choices in eating and get plenty of rest.
- If you think it might be helpful, talk to your supervisor or the case manager about professional help or support groups that may be available to help you deal with your grief.



## Resources

## National and State Suicide and Crisis Hotlines

**1-800-SUICIDE**

1-800-784-2433

**1-800-273-TALK**

1-800-273-8255

These hotlines operate 24-hours a day and are available to anyone in suicidal crisis. They will route the person to the closest possible crisis center in their area.

A listing of crisis centers throughout Washington State can be found at <http://suicidehotlines.com/washington.html>.

## Other Informational Resources

- The Center for Disease Control has an entire section on suicide at <http://www.cdc.gov/ncipc/dvp/suicide/>.
- [www.suicide.org](http://www.suicide.org) has a website with information on suicide prevention, awareness, and support.