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Suicide and Self-Harm in the Elderly

Teresa Fair-Field, OTD, OTR/L

Moderated by:
Amy Hansen, MA, CCC-SLP, Managing Editor, SpeechPathology.com

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Suicide and Self-Harm in the Elderly

Teresa Fair-Field, OTD, OTR/L

Learning Outcomes

After this course, participants will be able to:

- Describe the scope of suicide in older adults and the elderly.
- Identify risk factors and warning signs in the older adult population and describe important actions in suicide prevention during the first 7-8 weeks of a care stay.
- Describe appropriate assessment interview techniques and "the warm hand-off."

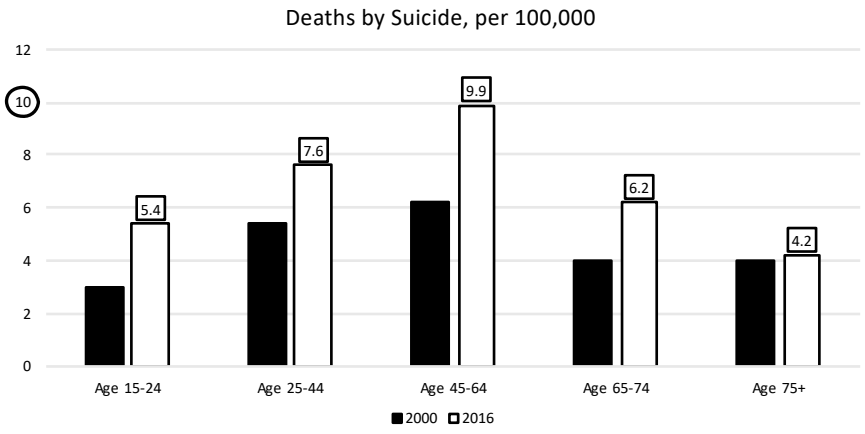
Terms

- Suicide = death caused by self-directed injurious behavior with intent to die
- Attempt = non-fatal, self-directed potentially injurious behavior with intent to die. May not result in injury
- Ideation = thinking about, considering, or planning suicide
- Direct self-harm = e.g. cutting, ingesting with known harm to self
- Indirect self-harm = e.g. refusing food & hydration with known harm to self

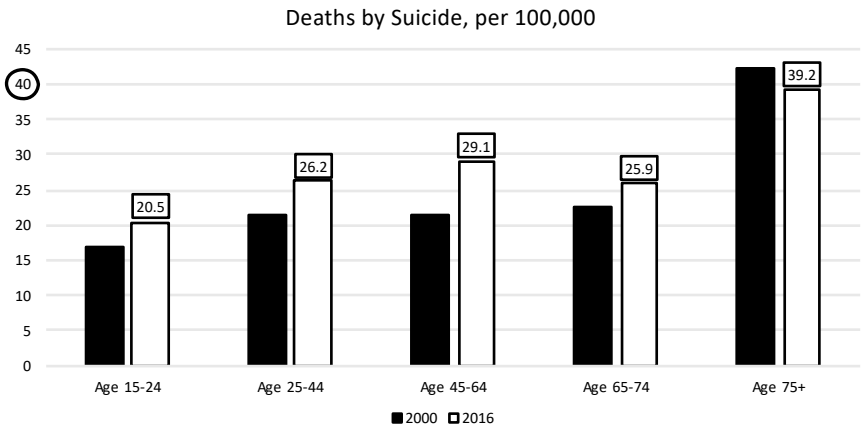
Q1

The Suicide Scope

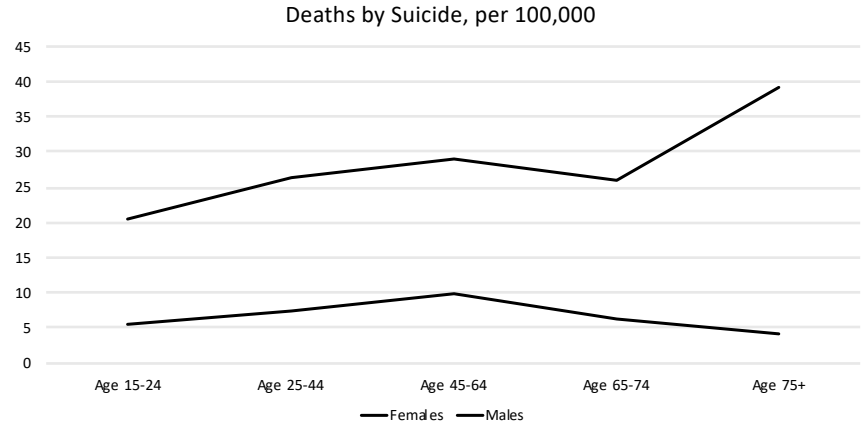
Females 2000 v. 2016



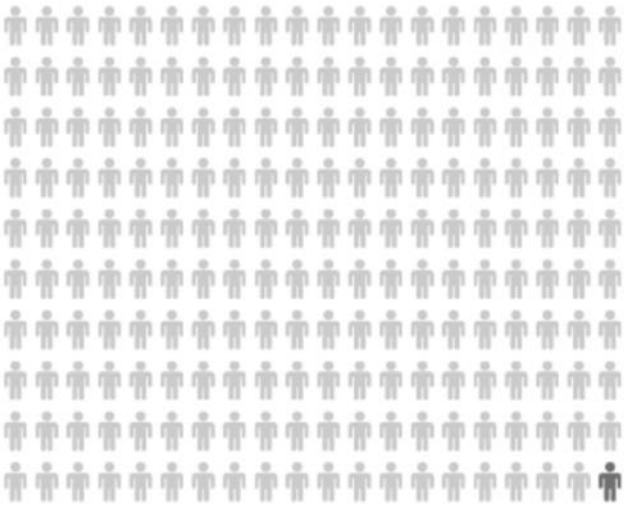
Males 2000 v. 2016



Males & Females, 2016



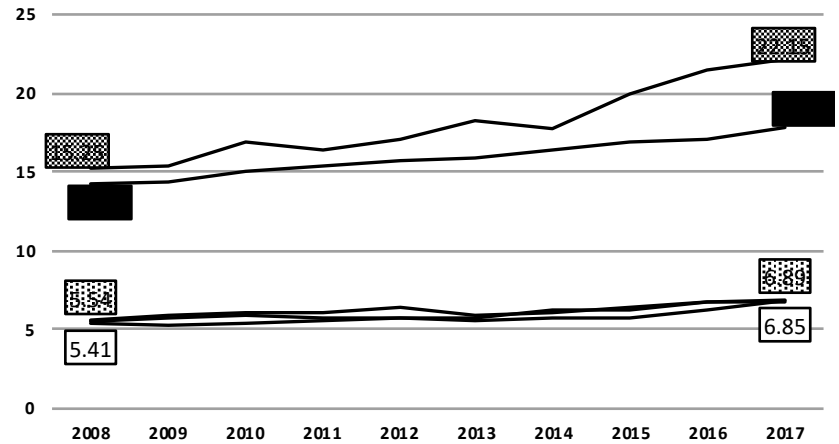
Deaths per attempt



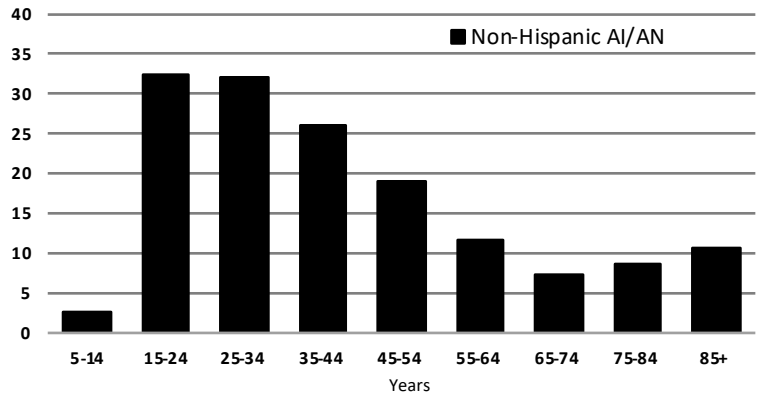
Deaths per attempt

Theories of Causation

Age-adjusted rate of suicide by Race/Ethnicity



Suicide Rate by Age AI/AN



Male Predictor Variables

- Work
- Dominance
- Risk-taking
- Heterosexual presentation
- Power
- Emotional control
- Playboy
- Violence
- Pursuit of status
- Winning
- Self-reliance

Baby Boomers and the Cohort Effect

- 60% higher than previous generations
- Began a decade before the recession
- Life factors as Boomers entered older ages
  - economic conditions
  - chronic unemployment or underemployment
  - increased out-of-pocket spending for healthcare
  - increasing chronicity of illness
- Generational paradigms: questioning purpose and meaning

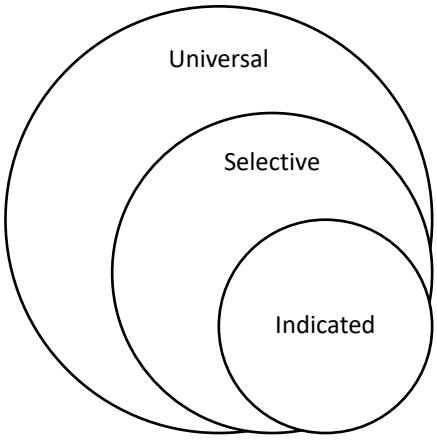
Suicide Cluster or 'Contagion'

- Several suicides or suicide attempts occur in a region or social group greater than would be expected by chance
- Some literature report as few as 2 or 3 comprise a 'cluster'

Celebrity Suicides

- Marilyn Monroe (1962)
  - age 36
  - depression
  - mental illness
  - ACEs
  - ↑ 12 % nationwide
- Kurt Cobain (1994)
  - age 27
  - clinical depression
  - drug and alcohol abuse
  - ↓ in 5, 10, 15 day counts
- Robin Williams (2014)
  - age 63
  - clinical depression
  - drug and alcohol abuse
  - new dx of Parkinson's
  - ↑ 9.85 % across age groups

Suicide Prevention Strategy



Universal Prevention

Community

- Reduce new cases in large populations
- Local, regional, national efforts
- Increased education & awareness
- Targets skills training

LTC / Residential

- All residents have access to programming that improves emotional health and coping
- Social networks are healthy between residents
- Access to lethal means is restricted
- All staff receives suicide prevention training appropriate to their level

Selective Prevention

General

- Targets high-risk groups
- Cumulative losses and life transitions
- Increased vulnerability

LTC / Residential

- Activities to engage men
- Residents with chronic pain and disease
- Residents with persistent sleep disorders
- Residents showing warning signs

Indicated Prevention

General	LTC / Residential
▪ Imminent risk ▪ Exhibit red flag behaviors ▪ Mental illness indicators	▪ Imminent risk ▪ Exhibit red flag behaviors ▪ Mental illness indicators

Q2

Risk Factors vs. Warning Signs

Building Awareness

Risk Factors

- Those things that increase the likelihood that a person *may* attempt suicide
- Demographic
- Historical
- Documented (EMR)

Warning Signs

- Red flags
- <80%
- Observable
  - noticeable behavior change
  - even sudden 'relief'
- Intuitive

Q3 Q5

Knowable Risk Factors

- Demographic
  - Age
  - Veteran status
  - LGBTQ status
  - Cultural clusters
- Medical Record
  - Mental health dx
  - Alcohol abuse
  - Substance use
  - Chronic health dx
  - Pain

Q4.1

Ask-able Risk Factors

- Undocumented History
  - Past attempts
  - Family hx of suicide
  - ACEs
- Access
  - to mental health svcs
  - to lethal means
- Coping
  - Access to mental health
  - Prolonged stress
  - Situational stress
  - Critical transitions
  - Loss

Q4.2

Observable Warning Signs

Feelings	Behaviors
▪ Depression	▪ Change in drug/alcohol use
▪ Anxiety	▪ New med seeking
▪ Anger	▪ Isolating self
▪ Persistent irritability	▪ Giving things away
▪ Hopelessness	▪ Sudden joy
▪ Helplessness	▪ Sleep changes
▪ Shame/Humiliation	▪ Dietary changes
	▪ Escalating self-harm
	▪ Non-verbal cues

Q5

The Four D's of Suicide Risk

- Depression
- Disease
- Deadly means
- Disconnectedness

Q9

Prevention Steps for Care Communities

ALL Staff, Every Level

- Identify and respond to warning signs
- Can demonstrate what to do when risk is detected
- Recognize alcohol abuse
- Recognize medication misuse
- Promote protective factors

Designated Staff Education

- Practice suicide screening interviews
- Know warning signs of elevated risk vs. imminent danger
- Activate appropriate actions when elevated risk is detected
- Understand facility policies
- Review training at appropriate intervals

Lethal Means

Community	LTC / Residential
▪ Firearms (more likely ♂) ▪ Medication (more likely ♀)	▪ Jumps/falls (more likely) ▪ Firearms (less likely) ▪ Medication (equally likely) ▪ Indirect self-harm…

Q6

Risk vs. Protection in Elderly

Risk Factors	Protective Factors

▪ Depression
▪ Number of medications
▪ Loss of a spouse within 1 year
▪ Perceiving themselves as a burden
▪ Chronic disease
  ▪ Alzheimer's disease
  ▪ Huntington's disease
▪ Chronic sleep disturbances
▪ Alcohol dependence or 'misuse' (35% of elder males)
	▪ Optimistic
	▪ Internal locus of control
	▪ Sense of belonging
	▪ Satisfaction with life
	▪ Emotional health programming

Q7

Elevated Risk of New Residents

- Highest at the point of transition from home
- Once relocated, ↑ risk within the first 7-8 months
- 12% of newly relocated LTC residents had suicidal thoughts
- 6% at the time of admission
- 2.3% at two weeks following
- 2.9 at two months following

Q8

Facility Policies re. Risk

- Policies need to limit lethal means, but not be activity limiting
- More intense facility security was positively associated with depressive symptoms and suicidal behavior

  (Low et al., 2004)
- Elevation of watch status over time is an important freedom and resident right
- Increased level of scrutiny

Cultivating Emotional Health

- Wellness programs
  - physical activity
  - mindfulness
  - sleep hygiene
- Activity programs
  - engagement
  - participation
- Resilience Training
  - What is it and how do I implement it?

Q10

Resilience Program Hypothesis

- "Since having reasons for living and leading a meaningful life are incompatible with suicide, it could be possible that the realization of important personal goals might enhance hope and meaning in life, two protective factors against suicide."
- …the…program would be effective in increasing psychological well-being and decreasing levels of depression in the participants with suicidal ideations."

(Lapierre et al., p.17)

Resilience Program Design

- Week 1: Meeting group members, self-introduction
- Week 2: Discussing the (transition) experience.
- Week 3: Inventory of personal goals, intentions, aspirations, and projects. Identification of irrational beliefs about goals.
- Week 4: Selection of goals that have a high priority and evaluation of each of them according to different characteristics (effort, stress, enjoyment, difficulty, resources, conflict, control, probability of attainment).

- Week 5: Description of the goal in concrete and precise terms as a target-behavior. Selection of one goal and personal commitment to its realization.
- Week 6-7: Planning of goal-related action (where, when, how), anticipating obstacles and identifying strategies to face them, identifying personal and social resources. Planning should be reevaluated regularly. Suggestions from the group are important at this time.
- Week 8-10: Execution of the plan, persistence toward the goal, facing difficulties with the emotional support of the group. Revision of goal-planning could be necessary and even questioning the priority of the goal.
- Week 11: Evaluation of the outcome and progress in reaching the goal. Evaluation of the learning process.

Transitioning Safely

Transition Checklist: Feelings/Mood

- ☐ Do you see or hear a change in level of depression or anxiety?
- ☐ Do you see or hear signs of new anger or irritability greater than usual?
- ☐ Do you see or hear statements of hopelessness or helplessness?
- ☐ Do you see or hear signs of shame or humiliation?

Transition Checklist: Behaviors

- ☐ Are you aware of new social isolation?
- ☐ Have you observed or are you aware of any change in drug or alcohol use?
- ☐ Have you observed or are you aware of giving away prized possessions, beyond expected 'downsizing.'
- ☐ Have you observed or are you aware of recent loss of interest or less engagement in favorite activities?
- ☐ Have you observed or are you aware of any changes in sleep?
- ☐ Are you aware of any new and unexpected weight loss or weight gain?
- ☐ Have you observed or are you aware of any new change in eating pattern?
- ☐ Have you observed or are you aware of any incident of self-harm?

Transition Checklist: Medications

- ☐ Have you observed or been asked to stockpile medications for any reason?
- ☐ Have you been asked to get larger pill counts or bigger bottles of medications?
- ☐ Does the home have a lock box for medication surplus?
- ☐ Reduce available quantities of over the counter medications.

Transition Checklist: Lethal Means

- ☐ Work with the resident to lock up, transfer ownership of, or take possession of firearms before the planned transition.
- ☐ Work with the resident to contact local agencies for hazardous materials collection events/sites and discard toxic chemicals (pesticides, poisons, etc.) from the home, under sinks, laundry areas, garage, and any outbuildings.
- ☐ Work with the resident to secure or limit access to belts, ropes, cords, hoses and the like.
- ☐ Work with the resident to secure car keys or limit unattended driving around the transition time.

Asking About Suicide

Setting up the PHQ-9 Interview

- Private setting
- Ensure resident can hear
- Sit facing the resident, minimize glare
- Give an introduction
- Assure them that you ask the same questions of everyone
- Explain purpose = helps design a custom care plan
- Accept refusals, move on to the next

Item D0200I: Suicidal Ideation

- Ask openly, directly, and without hesitation
- Ask exactly as worded

Asking about suicide does NOT put the idea in someone's head

How to Ask

PHQ-9: "(Over the last two weeks, have you been bothered by) thoughts that you would be better off dead, or of hurting yourself in some way."

How to Ask a Follow-up

"Are you thinking about suicide?"
"Do you have a plan to kill yourself?"

Direct Ask

"Are you thinking about suicide?"
"Do you have a plan to kill yourself?"

~~Avoidant Ask~~

~~"You aren't thinking about killing yourself, are you?"~~

If YES

- Thank them for their honesty & courage
- Recommended ways to ask next questions:
  - Have you thought about how you would end your life?
    - Have you already considered how you access those means?
  - Are you thinking of when you might end your life?
- Warm hand-off to staff in charge
- Follow facility policy

Direct Response

"Who can help you limit your access to_____?"

~~Avoidant Response~~

~~"Why would you do something like that? You have so much to live for."~~

If NO

- Does your intuition agree?
- Do you detect discrepancies between this conversation and others you have had?

Next Steps in Communication

Responding to a YES answer

"There's a person on our team who helps assess these feelings so we can provide you with the best care. Together, we can develop a plan to deal with this. I'll let [him/her] know to come talk with you further."

The Warm Hand-off

"I just completed the PHQ-9 with [Name] and I have a concern about their well-being.

…

They answered 'YES' they have thought about hurting themselves."

Identify Risk Throughout a Care Stay

"Who hasn't thought about it?"

- Casual 'death' talk appears to be an age-appropriate norm
- Staff may not be able to distinguish between casual talk vs. intentional harm
- Listen for specific intentionality
- If concerned, ask directly, without euphemism

Resources

Newscasts

- Bailey, M & Aleccia, J. (2019). Lethal plans: When seniors turn to suicide in long-term care. *Kaiser Health News*, Retrieved from : https://khn.org/news/suicide-seniors-long-term-care-nursing-homes/
- Public Broadcasting Service. (2019, April 9). The hidden mental health risks for seniors in long term care. [TV episode]. *PBS News Hour.* https://www.pbs.org/video/challenges-of-aging-1554851202/

Facility Tools

- Substance Abuse and Mental Health Services Administration. (2011). *Promoting emotional health and preventing suicide: A toolkit for senior living communities.* U.S. Department of Health and Human Services. https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515

National Suicide Prevention Lifeline

1-800-273-8255

CONTINUED

The Friendship Line

1-800-971-0016

CONTINUED

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- Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018. Data are from the Multiple Cause of Death Files, 1999-2017, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/ucd-icd10.html