Suicide and Self-Harm in the Elderly

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Presenter: Teresa Fair-Field, OTD, OTR/L

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- - [Amy] And at this time it is a pleasure to introduce Teresa Fair-Field, who is going to be presenting on Suicide and Self-Harm in the Elderly. Teresa graduated from Pacific University in Oregon with a Bachelor of Science degree in 1993 and from Chatham University with an OTD post-professional doctorate in 2016. She has worked throughout the lifespan, from early intervention through acute settings, home health, elder health, and end of life care. Her primary role is education specialist for Select Rehabilitation. So, welcome, Teresa. It's great to have you with us today.

- [Teresa] Thank you. You can see that I'm eager to begin participating. Yes, we are going to begin today by talking about what our learning objectives are for this course. So, we're going to be describing and beginning with the learning outcomes. So, talking about the scope of suicide in older adults as well as the elderly to identify the risk factors and warning signs in the older adult population that you can either discover in the medical record or observe in clinical practice as well as important actions for suicide prevention during the first seven and eight weeks of a care stay, and also to describe appropriate assessment interview techniques and a warm hand-off for any concerns that are revealed in that assessment. To begin with, it's going to be particularly valuable to discuss terms, keeping these terms in mind that we share an understanding.

So, while the definition of suicide, suicidal attempts, and suicidal ideation are well-understood, the clarity around the issue of self-harm is much less so. So, when we speak of direct self-harm, it's those actions such as cutting or ingesting with known harm to oneself, whereas an indirect self-harm is the act of refusing food or hydration but also with a known harm to the self. Keeping those terms in mind, we'll be focusing our discussion on residential communities and long-term care settings because the incidence of suicide in a closed care environment seems to be the most surprising to us. However, any of these prevention strategies are deployable to home health environments or adult day health settings as well, so listen for opportunities to adapt

and modify the recommendations to those settings. I also invite and encourage you to look for opportunities to use and share what you learn here today to persons of all ages and throughout your community. Because there's a lot of misconceptions about suicide, we're going to begin by looking at the data to build an understanding of suicide scope. First, we're going to discuss the incidence of suicide in the older adult. So, let's take a minute and consider this first graph. This is CDC data, and it's cited in references and also available on the CDC website, although in a slightly different form. So, the gray bars here are the year 2000 and the red bars are the most recent compiled year, which was 2016.

We can tell from looking that in all age ranges, there's a higher incidence of suicide in recent years than that of 20 years ago. That is, the red bars are much bigger. And, in fact, the CDC has calculated an age adjusted increase across all ages of women at 50% higher between 2000 and 2016. However, we see that the shape of the curve, the shape here, has stayed the same. So, death by suicide amongst females, as you can see here, is at its highest in mid-life. It drops on either side, with the lowest incidence in adolescence and then in the elderly. But since we're discussing suicide in the elder population, we're going to focus on these last two age ranges, in women 65 to 74 and 75 plus. So, I want you to notice that for women ages 65 to 74 and 75 plus, in 2000, these bars are the same.

So, rates were steady from a point of 65 and beyond a couple of decades ago, whereas more recently we see that there's a slight trend, though, higher. So, incidence was far higher in the young senior before dropping into the elderly, the lowest point. So, a few takeaways here. The mental health crisis point for females occurs in mid-life, age 55 to 64, where it reaches a peak of nearly 10 suicides per 100,000 women. For young seniors, it is declining but remains fairly high before dropping again in the elderly. So, it's outside the scope of this course, but take a moment to consider the many life role changes and transitions that affect women uniquely that may be

impacting these statistics. Here is the chart for males. Now, to start out it's important to realize that the X-axis, here at the red circle, has been adjusted for the data. So, whereas the data for women was fewer than 10 per 100,000, we see the incidence for men sitting much higher at nearly 40 per 100,000. We also see a very different overall shape. For the most part, incidence of suicide is still higher in recent years than two decades ago, though not quite as significantly higher in men, with one exception at age 75 plus. You also see a very slight rise toward mid-life. These numbers are going up, followed by a decline and then a peak in the older senior, 75 and older, in which deaths by suicide is higher than at any other age. In this view, I've pulled off the year 2000 data just to show those trend lines between males and females more clearly as well as the number of suicides, male to female.

So, here you can see in both sexes a rise occurring in mid-life, followed by a decline in young seniors, followed by the substantial spike in elderly males. So, again, let's pause and consider the many role changes and transitions that are clearly affecting men over 75. So, let's stop a moment and consider the possible impact of indirect self-harm, which is a harder figure to gauge because statistics don't necessarily indicate the cause of death as refusal of nutrition and hydration.

Researchers indicate that if we were to include indirect self-harm, again, with, that's refusal of food or hydration with the knowledge that it would cause harm or death to oneself, this number jumps to 94.9 per 100,000. So, if this mark here is 39.2, then 94.9 is somewhere up here. While all suicide attempts need to be addressed in every age group, statistics show that for a variety of reasons younger people are more apt to survive their suicide attempts than the elderly. Average statistics provide that one death occurs for every 200 suicide attempts in younger individuals. However, due to issues of already declining health and frailty, in the elderly, one in four attempts results in death. So, urgency for the issue has certainly been established. While we don't have insight into reasoning for elder suicide, we see in the data that something akin to despair is

occurring in older ages, particularly in older men. So, as we observed in the data, the overall suicide rate has increased 30% since the year 2000. Where does that come from? The CDC reports that the rate of suicide increased by an average of 1% per year from 2000 to 2006 and then 2% per year between 2000 and 2006. Here, we're looking at age adjusted suicide by race and ethnicity, and the highest rate of suicide is amongst those identifying as AI/AN, or American Indian/Alaska Native, the top red bar here. This is just over 22.15 per 100,000, and the line just below is white, non-Hispanic at 17.83. In contrast, the suicide rate amongst those identifying as Asian/Pacific Islander, Black, or Hispanic are all down here. This is each of those three races with individual lines drawn, though nearly on top of one another, and these lines are only within a few hundredths of each other and at a substantially lower rate than either white, non-Hispanic or American Indian/Alaska Native.

Here we've pulled out the data of the identifying American Indian/Alaska Native individually. X-axis is per 100,000 and Y-axis is cohort by age. And this is a very important story as we consider theories of causation. In the American Indian/Alaska Native, suicide rates peak in adolescence and young adulthood and then decline with only a slight increase in later life, reaching its very lowest point in the young senior, age 65 to 74. This is a much different pattern than we saw in the US population, either men or women, where suicide rates are peaking in mid-life and in US remains through the elder years and then rose significantly in the oldest elder. So, while age adjusted rates show AI/AN population to be the highest incidence of suicide overall, the graph of that population shows that most of that disparity occurs in early life. So, young AI/AN individuals are at very high risk and then if they reach mid-life that risk somewhat decreases. And we do that Native American culture reveres the tribal elder in a way that white culture does not. The United States is developing a conversation around healthy aging, but for the most part, it remains persistently behind that of other ethnicities. So, it is hypothesized that this cultural perspective is a considerable factor. We also saw that male elders showed nine times the incidence of suicide between

female elders, and we also see that men are three or more times as likely to die by suicide at any age than women. And those figures are not unique to the United States. A significant study was completed in Australia, published in 2016 and in your references, and that occurred at the peak of the CDC reporting period on our charts. And that study used a substantial sample size of 13,884 Aussie men. Assessment used were the PHQ-9, the same tool we'll be discussing in this course for its inclusion in the Medicare MDS, as well as a standardized measure of traits of, quote, masculinity, which comes from our care partners in the field of psychology. And in this study, researchers compared responses in 11 factor areas, things like relationship to work, themes of power, status, traits of aggression, et cetera, to determine if any of those traits would increase or decrease a man's risk of suicidal ideation and planning. While controlling for all other variables, only one was shown to correlate to increased risk of suicidal ideation.

That of self-reliance. The researchers described that, quote, a man who is normally self-reliant may experience heightened levels of defeat or humiliation if his usual state is threatened in some way. They go on to say that, quote, self-reliance may lead to an acute sense of burdensomeness in circumstances of perceived dependence, a confluence of factors which may reach a peak at the critical transition points of the spike we observed at 75 and older, such as when an individual faces a chronic health diagnosis or a change in level of mobility or living situation. And that tends to be exactly the point at which we are providing care. So, as we go on to discuss these and other warning signs and risk factors, you'll hear the words humiliation and burden repeated as factors which may increase risk. So, Australia's large sample of male population do line up with our understanding of suicidal risk as present in the current literature. So, let's take a moment and discuss the impact of Baby Boomers and a possible cohort effect. So, we see that, that Baby Boomers have an incidence of death by suicide at a 60% rate higher than previous generations. And while economic factors are not the only consideration, we can determine that because this change began a

decade before the recent recession. So, life factors as occurring as Boomers enter these older ages do include economic conditions but also include chronic unemployment or underemployment, out-of-pocket spending for healthcare, as well as the chronic nature of illness that are affecting our elders today, along with what researchers describe as these generational paradigms that affect Baby Boomers individually, such as questioning purpose and meaning of life. So, that creates what's called a suicide cluster or contagion inside of a generation or even a population group, in which suicides or suicide attempts occur in a specific area or social group or population such as Baby Boomers. Some literature report that as few as two or three could comprise a cluster, and another thing to discuss relative to cluster suicides is the effect of celebrity deaths by suicide.

And we can look at particular celebrity deaths in every generation and explore the effect that they've had on suicide rates overall. We think of Marilyn Monroe, who died in 1962 at age 36, with co-occurring diagnoses of depression and mental illness and as well as what we now identify as ACEs, or adverse childhood experiences. And what we saw following her death by suicide was a 12% rise from expected rates nationwide. Looking to the next generation, we can explore the death of Kurt Cobain in 1994 at age 27. Also experiencing clinical depression, as well as drug and alcohol abuse.

However, interestingly to the researchers, suicide rates went down following his death in five, 10, 15-day counts, and this was a generation that was particularly monitored following his death. But what was observed or what was hypothesized about the rates going down is that the cohort actually came together to support each other along with the possible impact of the media blitz that occurred in all platforms around suicide prevention, support, help lines, et cetera. More recently, we look to the death of Robin Williams in 2014, age 63, with diagnoses of depression as well as history of drug and alcohol abuse and what we later discovered was a new diagnosis of Parkinson's. And, in fact, we saw an increase in death by suicide following his death of nearly 10%

across all age groups. So, those things that occur in our society do create some version of suicide cluster or contagion, but this can also occur inside of a residential community or long-term care setting. There's a video that I've provided in references that discusses this in specific, following the story of one resident's death by suicide in a long-term care environment. Staff began to hear on the floor that other residents were now considering suicide by the same method, stating, "I always wondered if that would work, "and now I know that it does." That's a suicide cluster. So, let's discuss suicide prevention strategy. So, we're going to begin with universal strategy and, as we explore universal strategy, that is prevention measures that are applied to a large population or a cohort of all persons.

So, out in the community, that could be a statewide initiative, it could be a regional initiative, and anything that targets a large volume of the population. And in long-term care and residential environments, that may mean that all residents have access to programming that improves emotional health and coping. So, persons at risk are not singled out and identified, but the community takes a proactive stance to address prevention to all people. Selective prevention begins to focus that lens a little bit and hones in on those groups that are at high risk. And in the general population, that may be a community help center, a grief support group, and in long-term care and residential care, we see that selective prevention may be targeting activities in particular that engage men.

Also focusing on those groups that are high risk, chronic pain and disease, persistent sleep disorders, or residents that are showing active warning signs and entering them in a supportive cohort is a form of selective prevention. And then indicated prevention is the same in the community or care setting, and that's targeting those individuals that are at imminent risk or actively showing red flag behaviors. So, let's discuss what some of those are. There is a distinct difference between risk factors and warning signs. Risk factors are those things that increase the likelihood that a person may attempt suicide,

not that they necessarily will. But it increases the likelihood that they may. They are exhibiting a risk factor. Those things can be demographic, historical, documented. You can observe risk factors before an individual comes into your care. Whereas warning signs are the active, observable behaviors that you notice in a person in your care and something you would consider a red flag. They're often intuitive, but they're also informed by your educated awareness. It's been suggested that 80% of individuals that do die by suicide were exhibiting warning signs, but the people closest to them did not recognize those signs. So, let's talk about what risk factors are that what I would call knowable, things that you can know or identify, things that are demographic. Age, veteran status, LGBTQ status, and cultural clusters, these are things that we can identify prior to an individual entering our service, as well as things that we can detect in the medical record, their mental health diagnosis, alcohol abuse, substance use, et cetera. And then there's another aspect of risk factors that may be in the undocumented history but things that I would describe as ask-able, things that we can determine in conversation with somebody.

A history of past attempts or a family history of suicide. Death by suicide has a significant family legacy, considering Ernest Hemingway, for example, who died in 1961. He had a father, a brother, a sister, and a granddaughter all die by suicide. Along with that history of ACEs, those adverse childhood experiences that may not be documented in the medical record. Also, an individual's access to mental health services or the culture of lethal means in that community are factors which significantly influence risk, along with that individual's style of coping. Observable warning signs, again, things that you can observe in an individual's behavior. And as we look over this list, it's important to note here that depression is not a normal part of aging. Again, depression is not a normal part of aging, and so it's not something. It's a mental health condition to be discussed and address and not something to be dismissed because of our own preconceptions about growing older. Also, shame and humiliation, which you see on that list. We saw in our prior slides regarding causative factors that it's cited

here as an observable warning sign. And this has particular impact in our male residents as well as those cultural groups where perceived burden results in feelings of shame and humiliation. Please note that it is not actual burden or the caregiver's perception of burden but the individual's self-perception of burden, which is actually unrelated to their performance. So, we arrive at the four D's of suicide risk, and these are something you can commit to memory and are particularly important for the care team. Depression, disease, deadly means, and disconnectedness. So, let's take a look at particular prevention steps for care communities. And I invite you, as you take this learning forward, to look for opportunities to participate in these conversations in your work environment. Join those teams, lead those teams.

There are resources out there that are available for you to lead this discussion in your workplace. One important aspect is that your program address all staff at every level to identify and respond to those warning signs. Often, we receive education based on those that have client contact versus those that don't, and yet if we reflect on the availability of lethal means, it may be the janitorial staff that first detects that an individual has been medication hoarding.

So, it's important that all staff have an appropriate level of education commensurate with their role in that environment. Any staff education that's deployed needs to practice delivering those suicide screening interviews, to know those warning signs as well as how to activate next steps. So, let's discuss what some of those lethal means are. One thing that the research tells us is that the lethal means change inside of a protected care environment, but they don't disappear. We see that firearms are more likely in men occurring in the community and less likely, of course, in long-term care and residential settings, although the incidence of death by suicide with firearm inside of long-term care is not zero. Medication we see as lethal means of more often in women, and we see with medication that it is equally likely to be the lethal means of death by suicide in the community or in long-term care and residential environments. In

care environments, we see jumps and falls occurring more likely as well as the impact of indirect self-harm. So, looking at risk factors versus protection factors. We've discussed depression. Interestingly, number of medications is a risk factor, with more medications increasing, increasing the risk. Loss of a spouse within one year. Again, we see the perception of burden. Particularly, the diagnosis of chronic disease, especially at the early stages. Alzheimer's disease, Huntington's disease, as we saw with Robin Williams, Parkinson's disease. In later stages of the disease, the disease process may make death by suicide less likely, but particularly as the individual is taking on this chronic disease diagnosis, they're at particularly high risk.

Along with chronic sleep disturbances and alcohol dependence or misuse, as presented in the medical record, which is observed in one study in 35% of elder males. Protective factors being, overall, certainly emotional health programming that's present in the environment, but an overall internal locus of control. Something that would say, "Even though I don't have "a lot of control over my environment, "I can still identify things that I can control here." That is how somebody has a protective factor. They can shift their ability to have control from a community environment to a care environment. So, there's particular elevated risk of new residents, and we see that that is occurring at the highest at the point of transition from home.

So, it's highest at that point, but once they've relocated, the risk remains high for seven to eight months for that individual. 12% of newly relocated residents had suicidal thoughts, and another thing to consider is that transitions are from the perspective of the individual. So, for example, if a resident is transitioning to another wing of the facility, to memory care or long-term care which is attached or adjacent in the parking lot or on the same care campus, the staff doesn't necessarily perceive that as a significant transition. They see how all the pieces fit together, they know all the staff people in those areas, and it seems like they're just changing rooms. Whereas, to the individual, it occurs like an entirely new transition process in which, perhaps, more of

their freedom has been removed, they may have more restrictions in that environment, and a new window of transition risk opens up again. So, it's important to think about those transitions from the resident's perspective, not from the staff perspective, and that a long-term resident of a multi-level community could actually have another window of risk opening once they transition to increasing levels of care. Another thing as you're supporting your facility's policies is that they need to limit lethal means but not be activity restricting. Because other studies show that more intense security is positively associated with suicidal behavior. Again, individual's locus of control becomes more difficult to assert.

So, it's important that watch statuses be evaluated over time. So, programming in our residential environments should focus on the improvement and emotional health of all residents and should include things like physical activity, mindfulness, sleep hygiene, those things that we know impact wellness overall and well-documented, along with those that engage and participate the individual resident and then programs I'm going to describe next called resilience training. How to create resilience in an individual to carry over these transitions.

So, the hypothesis of a resilience program is that having reasons for living, setting goals, meeting goals, are actually protective, possibly protective against suicide. This is an 11-week program design that was present in the literature, focused on resilience and reduction of suicide risk in the long-term resident environment. Week one, the group members came together, discussed their experience of transition, built a foundation of relatedness, and then over successive weeks began to develop an inventory of personal goals that they had along with, importantly, discussing what irrational thoughts we have about our goals. Setting a priority for what those are. Considering, based on your current living situation, what are the resources that we have available? Which ones are possibly attainable? How much effort would be required? What amount of control do I have over meeting that goal? Kind of narrowing

the focus, narrowing in on selecting a goal to meet within the course of this program. Successive weeks then developed a goal, began to plan the actions to meet that goal, things that we do all the time when we're goal-setting, and reintroducing that to this population and establishing that internal locus of control. Really developing the sense that I still have the ability to set, meet, and attain an objective. The instilling in the residential population that goal attainment remains possible in this environment, and without that specific support, it may not be evident to the resident that they can continue to do that. Your therapy team can provide this, your activities group can support it, and your communities and facilities can develop this resilience in your residents. Let's talk about some other steps for transitioning safely. I'm not going to go over these individually, but there's some checklists that are available, and you can take these to your administrators or direct their attention to the resources provided in this course about how to explore some of these issues with family as an individual is transitioning.

Addressing feeling and mood, behaviors, medications, lethal means. We're going to spend most of our time on our direct impact with an individual by perfecting our ability to ask about suicide. Due to the sensitive nature of asking about suicide, you'll wanna make sure that your interview environment is conducive to discussing the topic. Assume you're going to get a yes answer, and where would you want, what environment would you want to be in to have that discussion? And the resident is more apt to feel comfortable discussing private feelings in inherently private spaces versus, say, the dining room, even if it's empty of others. Of course, ensuring hearing. This is something that speech therapists are experts at is establishing the communicate, the foundation of communication, but important in setting up the PHQ-9 interview is assuring that individual that you're asking the same questions of everybody. This is not because of any concern about them in particular. You're asking the same questions of everyone and explaining the purpose of the tool. If you get a refusal, moving on to the next item. In all the PHQ-9 questions, the resident is responding to the exact prompt.

Over the last two weeks, have you been bothered by any of the following problems? The resident responds in two ways, presence of the concern, which is answered as a yes, no, or no response, and frequency of the concern for any yes answer. Choices of never or one day, two to six days, which is several, seven to 11 days, which is half or more, and 12 to 14 days which is nearly every day. Now, item I is at the very bottom of the PHQ-9, the last question, which is worded thoughts that you would be better off dead or hurting yourself in some way. The key to this question is to ask it openly, directly, and without hesitation and to ask it exactly as it's worded. Few people would struggle with the item D, feeling tired or having little energy.

No one seems to have a problem asking about sleep or appetite, and yet many, many providers have trouble delivering that same objectivity to question I because it involves suicidal ideation. Asking about suicide does not put the idea in someone's head. Chances are if they have considered it, you have cracked open the door to safety and healing by starting the conversation. All of the evidence shows that if they haven't considered it prior to your asking, it is just another question, the same as asking about sleep or appetite.

Asking about suicide does not put the idea in someone's head. We have very clear parameters around how to ask this question. 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? It is clear and unambiguous. The question then arises, what happens if you get a yes? It's appropriate to then ask a follow-up. Are you thinking about suicide? Do you have a plan to kill yourself? Asking directly and with compassion. And that's a direct ask. Are you thinking about suicide? Do you have a plan to kill yourself? Versus an avoidant ask. You aren't thinking about killing yourself, are you? The avoidant ask shuts the conversation down. It doesn't leave the individual with an opening. It leaves them with closed door. So, the ask needs to be direct and without any perception of judgment. Are you thinking about suicide? Do you have a plan to kill yourself? If yes,

we wanna thank the individual for their honesty and their courage. Recommend some ways to ask those next questions. Have you thought about how you would end your life? Have you already considered? Do you have access to those means? Are you thinking about when you would end your life? And then the critical step is that warm hand-off to the staff person in charge, as well as following any subsequent steps of your facility policy if your facility has this in place. Again, a direct response, "Who can help you limit your access to," whatever means they've identified. Versus, "Why would you do something like that? "You have so much to live for." That's, again, an avoidant response. It shuts the individual down from sharing. We need to stay objective in this conversation.

Who can help you limit your access? If they answer no, does your intuition agree? There are many reasons why an individual may answer no to that question, even if they have considered death by suicide, so you have to check in. Does your intuition agree? If they answer no, it's not necessarily the end of the conversation. Do you detect any discrepancies between a no answer and any other conversations you've had with the individual or heard from the individual? Is there a mismatch?

Looking at the next steps, the way you would respond to a yes answer is to say, to close with, "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 or her know "to come and talk with you further." We know that though many residents endure symptoms of depression, as of 2010 research, fewer than 25% of depressed residents in long-term care settings had been accurately identified. There are lots of reasons for this finding, which we continue to see play out in facilities across the country today despite the requirement that the PHQ-9 be administered completely with standardized wording and exactly as written, which we just addressed. This may be due to incomplete training, discomfort in asking the question directly, or perhaps uncertainty of the consequences of a yes answer, such as how to complete a hand-off

or taking the next appropriate steps. Or even perceived pressure to under-report. It is critical that ethical and compliant care guide accuracy in reporting of all questions on the PHQ-9. Any variation in this is a very clear practice standard. So, any variation is a compliance issue. The answer to the question is not a provider's judgment call. Regardless of the resident's appearance, apparent mood, personal feelings, how you feel about the question or the interviewee, if the resident responds yes then yes is recorded. Regardless of any possible reasons for the under-reporting of depression and suicidal ideation, inaccurate representation on the PHQ-9 has potentially life-threatening consequences. It is critical that providers and teams get this right. And getting it right doesn't take unique expertise.

It takes practice and compassion. It takes asking the question as exactly as it's worded. Asking openly and directly and then accurately reporting he resident's response. It takes one more essential step to get it right. If you are the provider receiving a yes, in addition to recording it accurately on the MDS, you have an obligation to provide a warm hand-off to the person in charge of their care. "I just completed the PHQ-9 with so-and-so, "and I have a concern about their well-being. "They answered yes, they have thought about hurting themselves."

Then pass on any related dialogue that took place as part of the interaction, such as they thought they would be better off dead or they thought about hurting themselves or they've considered suicide. "I marked the frequency on the PHQ-9 "and told them that speaking with you could help." It is then very important that you as the therapist document that hand-off encounter that you had with the staff member. While the PHQ-9 serves as documentation of the presence of depression and possible risk, it doesn't address next steps and activation of your facility policy. It is your professional responsibility to document that the current concern was brought to the live attention of the individual in charge of patient care as well as any other identified staff selected by the facility. Even if the PHQ-9 does reflect the resident's suicidal ideation accurately,

this is another frequently dropped or inadequately completed step. The person in your care gave you the gift of trust with their honesty and disclosure, and the professional responsibility that comes with that trust is to ensure that it affects a change in the care plan. The possibility exists that suicidal ideation will occur at any point in the care stay, not only when the initial MDS is administered. Recall in our earlier slides that two weeks, two months, and in long-term care residents up to eight months following a transition, they continue to have an elevated risk of suicide. Following up on any comments or observed red flags is an important step in delivering compassionate care. One thing that has been expressed is that there is some normalcy in casual death talk amongst the elderly. One interviewed resident in the television broadcast about suicide in the elderly, which I've linked at the end of the course, said, "Who hasn't thought about it?"

However, the staff member may not be able to distinguish between causal talk and intentional harm, and it isn't their role to do so. So, it is essential that any talk or red flags be communicated to the care team and followed up on. And while this conversation may be occurring inside of a group or with a peer and it may not be an appropriate time to ask the individual at that moment, in the dining room, in the lounge, on the patio surrounded by others, it is important that you, upon overhearing it, you follow-up quickly and directly and within that same shift. And doing so can reveal if there is any suicidal ideation behind the conversation that was overheard. Listen for intention, ask directly and without euphemism. Are you thinking about suicide? Do you have a plan to kill yourself? Asking directly will not put the idea in someone's head. But asking directly and without judgment just may reveal a level of despair that you and your care team is equipped and empowered to address. Online learners are constantly requesting more practical tools and resources to take back to the workplace, so as we are wrapping up today, I wanna bring your attention to what those are on the topic we've discussed today. This is where to spend some additional time after the course is over if you are passionate about impacting this issue. Direct links are provided to each

of these items, and a membership or subscription is not required to access them, so as soon as you enter the web address the resource is yours. Here are two different newscasts that broadcast on TV just last year. In particular, I want to draw your attention to the PBS News Hour. I was not able to include this video today, but it focuses on the issue of suicide specifically in long-term care and residential environments. It aired last year. It's only 10 minutes and 22 seconds long, so I strongly encourage you to go directly to the link and watch it after we conclude today. It will significantly add to the impact of the course material by providing you with the personal family stories that I could not include today for privacy reasons.

It would also be an excellent team activity to watch as a group if you are interested in spearheading this work in your facility. This is a downloadable facility toolkit that SAMHSA has developed to assist senior living communities with policies and practices to aid in suicide prevention and emotional health. SAMHSA is the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services. Yes, it was published in 2011, but I've been lecturing on this topic to facility administrators nationwide, and no one has been familiar with it. So, the discussions are still lagging in senior communities despite available resources, although interest and focus is gaining.

So, this is a wonderful tool to support you in bringing this issue to the forefront in your workplace. If you feel like you need to have something in hand to bring to your administration, this is it. The website, if you're interested, has toolkits as well for senior centers as well as other focus populations such as veterans, LGBTQ, schools, as well as resources in Spanish, et cetera. This is not an emergency number. This is specifically called a lifeline and not a crisis line, and its use is encouraged before the individual is in crisis. For caregivers that are not comfortable doing so, a trained staff will complete a risk assessment with the individual present. This may also be an appropriate resource to provide families as the individuals are transitioning into your

care, perhaps as part of a transition package. Internally, it's appropriate to have your identified staff complete this risk assessment. But, again, having this number programmed into your phone may open conversations. The support person may be able to make the call and provide a warm hand-off to the individual on the phone that can determine level of risk and appropriate next steps. And this is one I think is particularly interesting. The Friendship Line is developed by the Institute on Aging, and it's dedicated in service to adults over 60 or of any age with a disability, making it the only hotline of its kind.

Research shows that older adults do not call crisis lines on their own. They perceive that others are in more crisis than they, so even if they're in crisis and considering suicide, they tend not to call crisis lines or hotlines. So, this is called The Friendship Line, and it's the only program nationwide that reaches out to older adults after they've been contacted. So, volunteers are trained in offering a caring ear and having friendly conversations with older adults, and unlike crisis lines, The Friendship Line then reaches back out on a scheduled interval of calls to monitor emotional change and provide ongoing support over time. All right, several references for you today along with the sources of the data. I'm ready to take any questions you may have.

- [Amy] Okay, great, thank you. Excuse me. One question so far is if you could review what direct self-harm is.

- [Teresa] Pardon me, so direct self-harm is something such as cutting or ingesting with known harm to the self.

- [Amy] Okay, great, thank you very much. And then knowing, oh. Oh, somebody is actually answering. Knowing you are harming yourself, i.e. cutting, great. And then I had a question as well. If you reach out to an individual and ask them those questions about are you thinking about suicide, do you plan on hurting yourself, those questions

and they say no, do you follow-up with them? And if so, when? How long do you wait before you would actually follow-up with that individual?

- [Teresa] I, well, that probably has a different answer if it's an individual in the community. I think any time, again, we think about those risk factors versus warning signs. So, if someone has said no, they aren't, has anything they are presenting with changed? And that can be a little bit subtle, and that's why it's relatively intuitive-driven if you would ask again. And in a care environment, again, it could be that there's a conversation about death and somebody fairly casually brings it up, and that's why I say it's not our role to decide how serious or casual the conversation is. That's an opening to have the conversation again. So, and I think with other people in our lives of all ages, it's if there's no status change, then it may not feel appropriate, but if there's something about the individual that isn't resting with you and red flags are popping up, then it may be appropriate to revisit the issue.

- [Amy] Okay, great, that helps. That makes sense. Rosemary is asking where we can get the PHQ-9.

- [Teresa] The PHQ-9 is part of the Medicare MDS, but it's also a widely available tool. I believe it is published on the internet as well, so it's not proprietary. There's a lot of research on the PHQ-9, and CMS has selected that for the standardized administration to detect for depression and suicidal ideation.

- [Amy] Okay, thank you. And we'll give it just a few more moments to see if there are any additional or last-minute questions, but in the meantime, I do wanna thank you, Teresa, for joining us today, talking on a very, very important topic. I really like the different questions that you shared, the examples of what to ask and how not to ask certain questions. I think that's very helpful. So, thank you for joining us today and sharing your expertise in this area.

- Absolutely.

- And I'd like thank all of our, yeah, yeah, very--

- [Teresa] Another thing I want to close with is that the language around suicide has changed, and we, we're refraining from using the term committed suicide and really focusing on something more objective, which is death by suicide. Committing something criminalizes the act of someone in despair, so we're keeping our language objective and more factual, that someone died by suicide, and also removing the terminology of a successful or unsuccessful suicide attempt. There's no success associated with death by suicide, so we're focusing on that someone either died by suicide or had a non-fatal attempt and focusing on the support that may be required for that individual.

- [Amy] Very good to know, thank you. All right, we will go ahead and wrap it up there for today. Thank you to all of our participants for joining us. We appreciate your time and look forward to seeing everyone again soon. Thanks so much, Teresa.