Suicide in Long-Term Care

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Objectives

- Discuss the demographics of suicide in the elderly in the community and in the nursing home
- Look at risks for self-harm in the nursing home
- Discuss how to evaluate opportunity for suicide in the nursing home
- Identify interventions facilities can use to prevent suicide in the nursing home
- Propose a means of conveying all information to providers to assess a suicidal resident

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Case

- Mrs. Q
  - 81 year old with moderate dementia
    - Placed two months ago after a hospital stay
    - Had been at home before that hospitalization
  - Very angry, especially at her family, for being in the NH
    - "What's the use…they dumped me here!"
    - Noncompliant at times.
    - Seen weeping at times, usually after family visits

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Demographics

- On the rise in the USA since 1950s
  - More people die by suicide than homicide
- 8th leading cause of death in the USA
  - 3rd leading cause of death among those 15-24 years of age
- 30,000 suicides a year in the USA
  - 5800 suicides in those 65 every year in the USA
  - 86 suicides/day
  - 1500 attempted suicides/day
    - Roughly 1 in 20 attempts succeeds

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Demographics

- Suicide in the elderly
  - Highest completed suicide rate
    - 19% of all suicides
      - 13% of the general population
    - Greatest is for those over 85
      - 21/100,000
  - Means
    - Firearms 71%
      - Most widely used means among men (78%) and women (35%)
    - Overdose 11%
    - Suffocation 11%
    - Falls 1.6%
    - Drowning1.4%
    - Fire 0.4%

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Demographics

- Race
  - Over 65 years of age (2006)
    - White 15/100,000
    - African-American 4/100,000
    - Native American 5/100,000
    - Asian-American 8/100,000
- Geography
  - Massachusetts 5.9/100,000
    - Men 9.0
  - Wyoming 31.9/100,000
    - Men 53.0
  - Nebraska 11.1/100,000
    - Men 23.9

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Characteristics

- Fewer warnings of intent
  - More planning, more determined
  - 2/3 had a high intent score
- Less likely to survive
  - More violent means, more immediate
- Ideation less common than in younger people
  - 1-36%
- Smaller ratio of attempts to completed suicides
  - 4:1 in men over 65 years of age
  - 200:1 in young women

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Risks for Suicide

- Depression and other mental disorders
- Substance abuse
- Previous suicide attempt
- Family history of mental health problems
- Family history of suicide
- Firearms in the home
- Exposure to others who have committed suicide
- Male

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Risk Factors for Suicide in the Elderly

- Mood disorders
  - Especially Major Depression
  - Higher prevalence of depressive disorders than in young people
- Previous suicide attempts
- Substance use
  - Alcohol disinhibits and depresses
- Male
  - 85% of the suicides over 65 years of age
- Physical illness or decline in self or spouse
  - 56% had serious illnesses
- Loss of social support
  - More isolated socially

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Case

- She reports she wants to kill herself
  - Endorses her family “doesn’t care”
- Risks
  - No history of depression, suicide attempts
    - No history of such comments
  - No substance abuse
  - Female
  - Recent worsened physical and cognitive health
    - Led to admission to the NH
  - Perceived lack of social support
    - Family emotionally involved

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Evaluation

- Unfortunately
  - 20% had visited their MD within 24 hours
  - 41% had visited their MD within a week
  - 75% had visited their MD within a month
  - 11% had seen a mental health provider within the month
  - 7% had seen a mental health provider within the year

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Suicide in the Nursing Home

- New York City (2008)
  - 1,724 suicides in those over 60 in one year
    - 47 occurred in the NH
  - Main risk factor was age
    - Fewer died by gunshot wound
    - Increase in death by falls 2.5x if in the NH
  - Over 15 years there was a decline in suicide in NYC in those over 65
    - But the rate in NH stayed stable

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Suicide in the Nursing Home

- Northeast Italy (2006)
  - 5 completed, 8 attempted but not completed
    - 18.6/100,000 and 29.7/100,000
  - All but one suicide and one attempted suicide had a history of psychiatric problems
    - 7/13 lived in the facility <1 year
  - No differences in those seeing or not seeing a mental health provider

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Suicide in the Nursing Home

- USA (1999)
  - Aged 60 and above
    - Community 19.2/100,000
    - Nursing home 15.8/100,000
  - Indirect self-destructive behaviors
    - Usually related to dementia
    - Leads to death 79.9/100,000

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Case

- Is there opportunity for suicide?
  - She uses a walker, but is frail
    - Readily fatigued by short walks to the dining room
  - All available means removed
    - Cords tied up high, finger foods, no pills in room
    - No elopement risk
  - She scores 14/30 on the MoCA
    - Cannot plan any daily activity at all

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What to do?

- Assess risk
- Assess opportunity
- Convey information to provider
- Interventions

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Assess Risk

- Do they have a previous suicide attempt?
  - How serious was this attempt?
  - How long ago?
- Do they have a family history of suicide?
  - Ask family or friends
- Do they have repeated suicidal ideations?
  - Ask all shifts if this has occurred
- Is the resident male?
- Is the resident white?

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Assess Risk

- Is the resident less cognitively impaired than most residents?
- Has their physical health worsened recently?
- Do increased social stressors now exist?
- Have they suffered the onset of, or the worsening of, disability?
- Is there a family member or friend overly sympathetic to their suicidal wishes?

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Assess Opportunity

- Are they ambulatory?
  - More physically robust
- Can they readily leave the facility?
  - Elopement risk
- Is a method of suicide available to them?
  - Overdose
  - Hanging/suffocation
  - Fall
  - Cut wrists

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Assess Opportunity

- Have you eliminated available methods?
  - Cords
  - Belts
  - Shoestrings
  - Plastic utensils
  - Plastic bags
  - Razors
  - Checked for pill hoarding

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Assess Opportunity

- Cognitive evaluation
  - Do they have the cognitive capacity to formulate a plan?
    - Are they too demented to even employ an available means?
  - Do they rapidly change emotions when redirected?
  - Would they forget the suicidal ideation within an hour?

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Case

- All her comments, behaviors documented
  - No matter how serious it appears
    - Said this repeatedly for 20 minutes, then redirection helpful
  - Reviewers always like a clear paper trail
- All risks documented for her
  - May be helpful to have an existing form
- Evaluation of her opportunity documented
  - Helps assess how realistic the threat
    - There appears to be little opportunity in this case
- All information conveyed to the primary provider
  - Patient has no history of psychiatric illness, therefore no mental health provider

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Convey the Information

- When the suicidal ideation begin?
  - Early in the morning
    - Anxiety, mood often worse in the AM
  - Afternoon
    - Sundowning, fatigued
  - Nighttime
    - Frustrated by efforts to get then to return to bed
  - Yesterday
    - Why did you wait?
  - Five minutes ago
    - May require a bit more observation

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Convey the Information

- What were the circumstances when this began?
  - Out of the blue
    - May quickly go away
  - After a family visit or phone call
    - Cued into thinking about going home
  - After an altercation with a staff or peer
    - Heightened anxiety, anger
  - Asking the resident to do something they did not want to do
    - Fight about a bath
  - New onset physical symptoms
    - “I feel so bad I could…”

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Convey the Information

- What did they actually say?
  - “I could just kill myself.”
    - Frustration?
    - Figure of speech?
    - Real intent?
  - “Why am I alive?”
    - Not all references are pathologic
  - I’ll show you…I will end my life and you’ll be in trouble.”
    - Anger towards someone who gets in their way
  - Nothing
    - This may be the most concerning

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Convey the Information

- What did actually do?
  - Tried to push through staff to get out the door
    - Not suicidal, want to go to work
  - Wrapped a cord around their neck
    - Trying to move the radio
  - Found hiding pills
    - But not hoarding
  - Cutting on their wrists with a plastic knife
    - Impulsive or history of anxious cutting
  - Refuse to eat, take medications
    - Real wishes to die versus manipulation
  - Nothing
    - Just said they want to kill themselves

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Convey the Information

- How long did the talk or behavior last?
  - Seconds
    - Possibly a figure of speech
  - Minutes
    - Then readily redirected
  - Several hours
    - May be the real thing…
  - Until they took a nap
    - Frustrated but redirected
  - Stopped after the offending party left
    - Angry at someone, e.g. daughter

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Convey the Information

- Are they angry or frustrated about something?
  - Certain individuals
  - Being in the nursing home
  - Being ill
  - Recognizing their cognition is declining
  - Pain
  - Feeling abandoned

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Convey the Information

- Have they made such claims before in the facility?
  - Came and went quickly
    - Appears less serious
    - Cry wolf
  - Led to an ER visit
    - What happened there?
    - $5,000 car ride and snack
  - Led to an inpatient stay
    - Made an attempt
    - Made a serious attempt

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Case

- Physician called
  - Relay all the information collected on Mrs. Q
    - Does she have other symptoms of depression?
- Convey facility interventions
  - Will follow 1:1 for the next hour
    - Mrs. Q without serious risk or opportunity
      - No further talk, behavior after 20 mins.
  - Then every 15 minutes for the rest of the day
    - Repeat question every hour or so
      - Document she denied after that for the rest of the day
    - Reevaluated the next morning
      - No suicidal thoughts endorsed
      - Physician discontinued every 15 minute checks

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Interventions

- Gain assessment from the provider
  - Use their psychiatrist first
    - The primary provider will thank you
  - Convey all the information
    - Especially about opportunity and risk
    - Convey any concerns about depression
      - May require treatment intervention
- Facility interventions
  - One to one
    - Next hour until done or gone to ER
  - Every 15 minute checks if no further ideation or low risk
    - Discontinue the next day
  - Continue to question the resident about suicide, thoughts of death
  - Remove all means
  - Persistent symptoms, numerous risks
    - Now transfer to the ER may be appropriate

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