Suicide Prevention in Senior Living Communities

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Disclosure

The presenter DOES NOT have an interest in selling a technology, program, product, and/or service to CME/CE professionals.

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Therefore, there are no relevant financial relationships to disclose

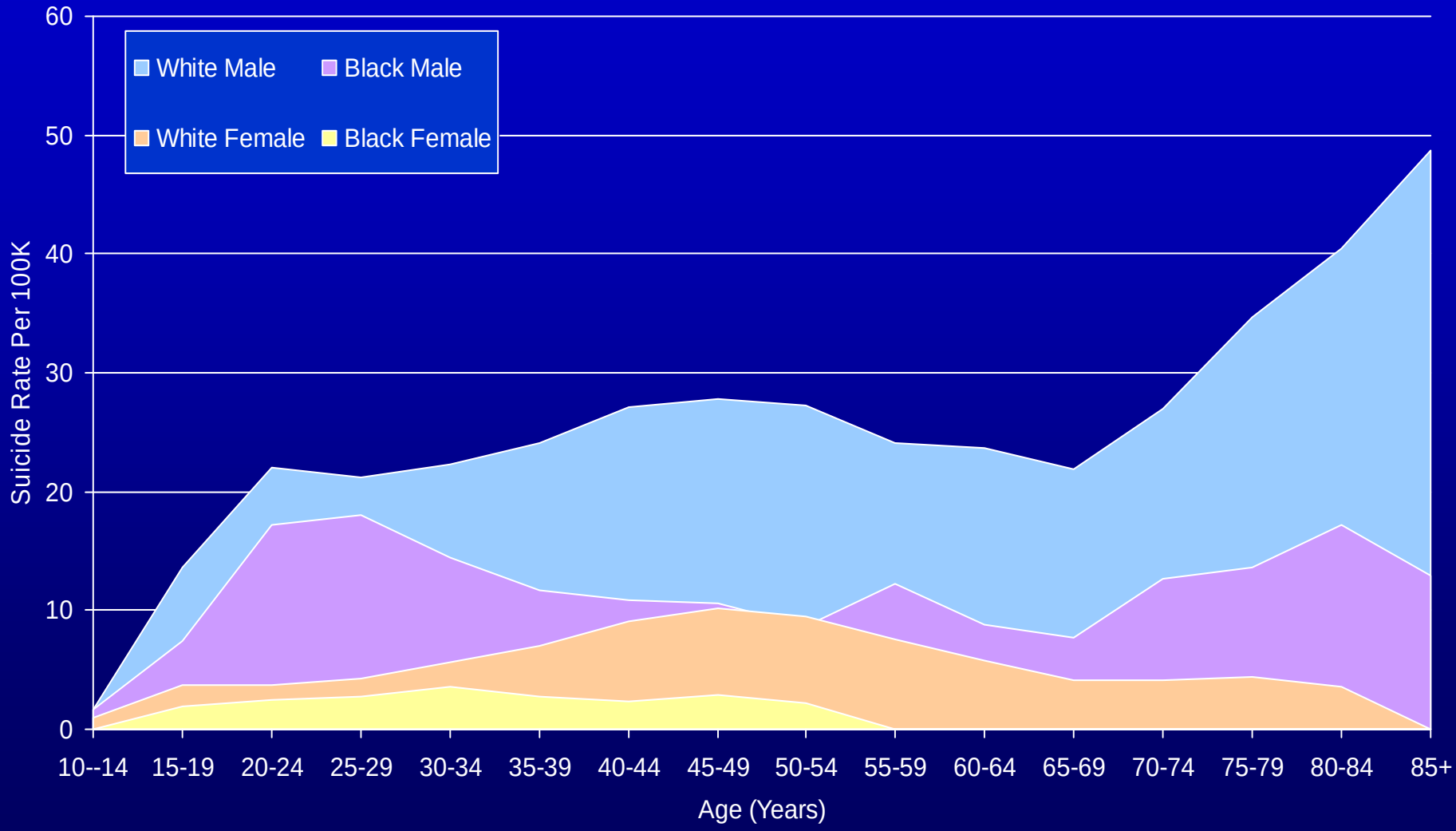
Objectives

- Provide an overview of the epidemiology of suicide and suicidal behaviors in congregate living settings
- Introduce tools that providers and facilities can use to promote healthy populations while reducing risk factors that contribute to suicide
- Present a case study of a suicide attempt in a senior living community to illustrate
  - Individual, interpersonal and ecological factors that contribute to suicidal behaviors
  - Opportunities for intervention/prevention

"My work is done. Why wait?"

George Eastman
March 14, 1932
Age 77

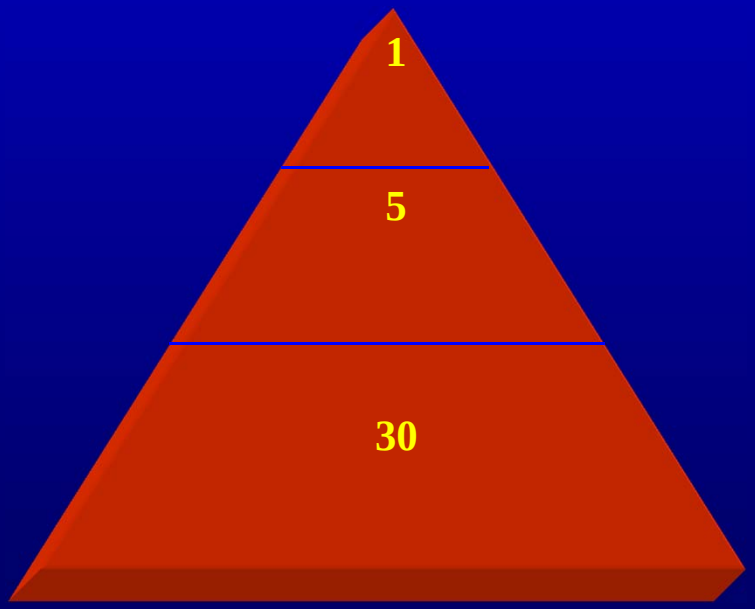
Suicide Rates by Age, Race, and Gender U.S. -- 2004



Source: National Center for Health Statistics

ATTEMPTED:COMPLETED SUICIDE

General population



Deaths

Hospitalizations

Emergency Dept visits

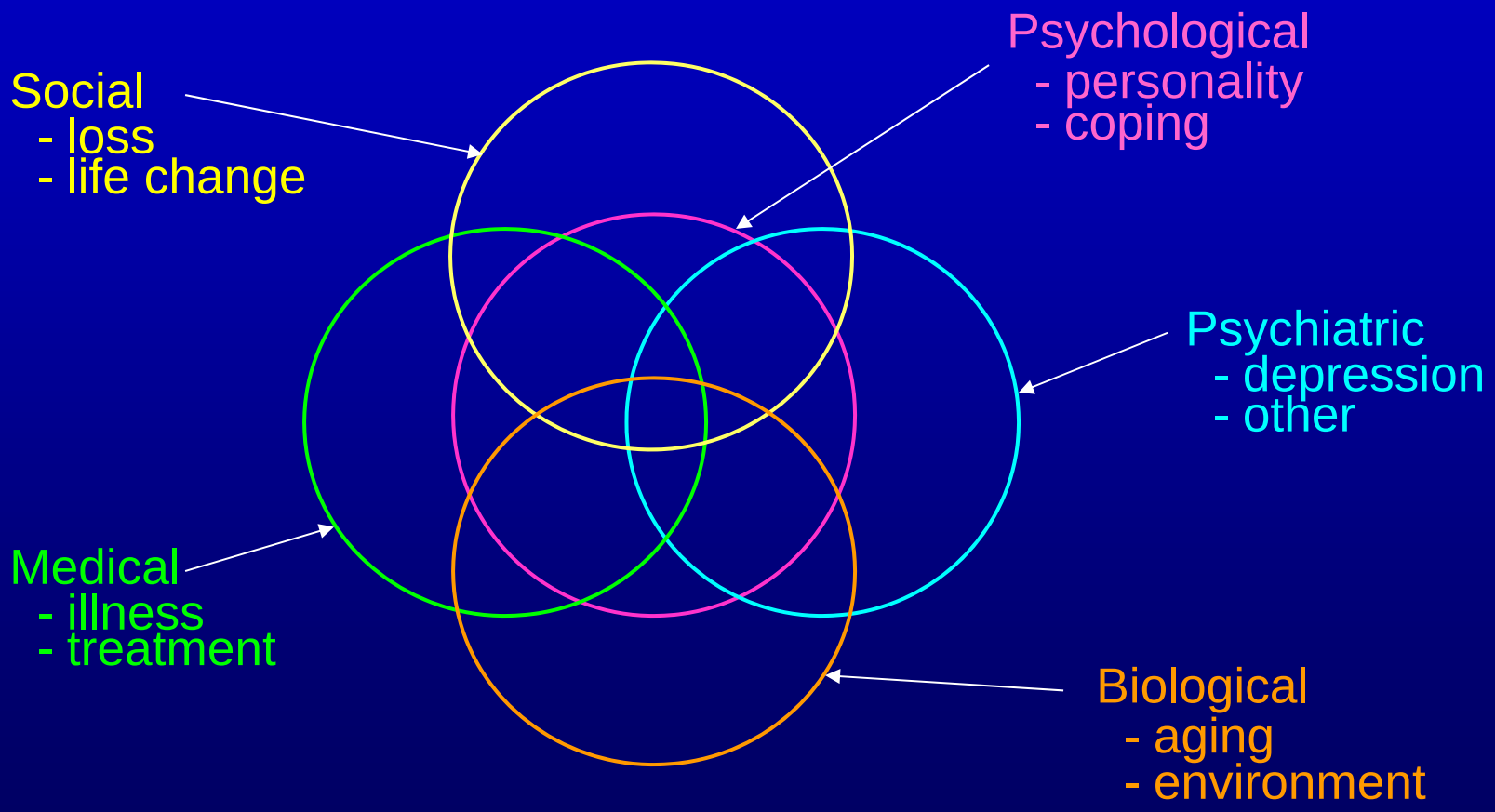
Older adults

LETHALITY OF LATE LIFE SUICIDE

- Older people are
  - more frail (more likely to die)
  - more isolated (less likely to be rescued)
  - more planful and determined

- **Implying**
  - **interventions must be aggressive**
  - **primary and secondary prevention are key**

DOMAINS OF SUICIDE RISK IN LATER LIFE

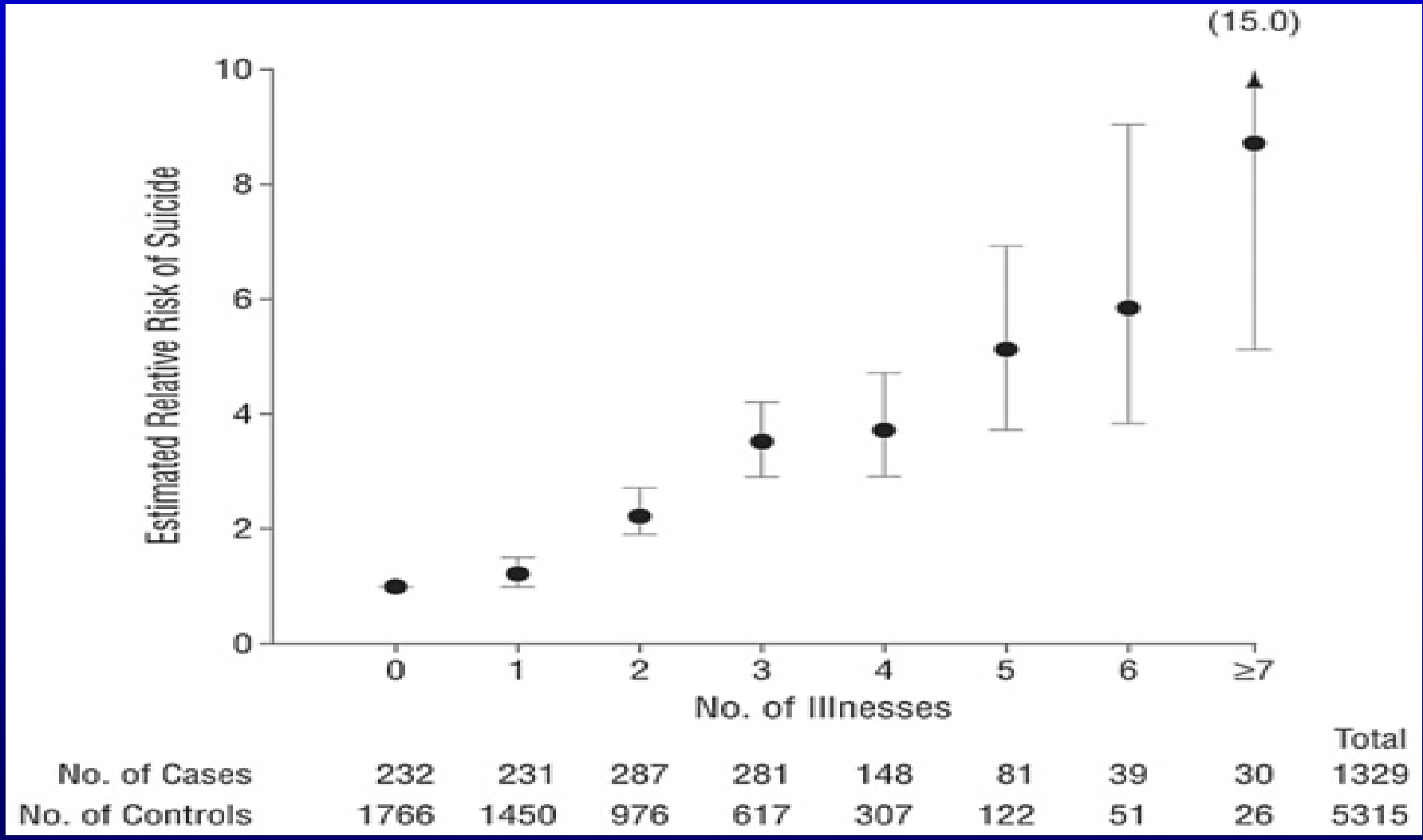


Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986

RISK FACTORS FOR SUICIDE AMONG ELDERS

- Depression – major depression, other
- Prior suicide attempts
- Co-morbid general medical conditions
- Often with pain and role function decline
- Social dependency or isolation
- Family discord, losses
- Personality inflexibility, rigid coping
- Access to lethal means

Comorbidity and Suicide Risk



									Total
No. of Cases	232	231	287	281	148	81	39	30	1329
No. of Controls	1766	1450	976	617	307	122	51	26	5315

Juurlink et al., *Arch Intern Med 2004;164:1179-1184*

Loss and Bereavement

- Bereavement greatly increases the risk of depressive episodes (Bruce et al., 1990).
- Complicated grief and depression in bereaved older adults increases suicidal ideation (Szanto, Prigerson, Houck, et al., 1997).
- The oldest old men experience the highest increase in suicide risk immediately after the loss of a partner (15 fold) (Erlangsen, Jeune, Bille-Brahe, Vaupel, 2004).
- Older adults who experience stressful losses are significantly more likely to drink excessively than those who have not (Jennison, 1992), and to use ISDB in LTC (Nelson & Farberow, 1980).
- Suicide rate in elderly is highest for divorced/widowed (CDC).

Senior Living Communities (SLCs)

- For purposes of this presentation, SLCs include:
  - Independent senior living communities
  - Assisted living facilities
  - Long term care facilities
  - Continuing Care Retirement Communities

Independent Living Communities

- Units are designed for healthy, active seniors
- Types of units include:
  - Studio apartments
  - 1-, 2-, or 3-bedroom apartments
  - Cottages
  - Townhouses
  - Duplexes
  - Single-family homes

Assisted Living Facilities

- 267,000 to 417,000 (1992-1998)
- Average age: 85
- 79% female
- 99% white
- Require assist with average of 2.3 ADLs
- 52% have some cognitive impairment
- (AARP, 2000)

Long Term Care Facilities

- For those who require skilled nursing care
- Population is:
  - 70% female
  - 75% ≥ 75 years old; median age is 83.2;
  - 84% white; 13% African American; Hispanic/Latino underrepresented at 4%
  - Require assist with average 3.8 ADLs

Population 65 Years and Over in Nursing Homes by Age, 1990 and 2000:
Percent of U.S. population age ≥65 that live in nursing homes

Age	Percent of age group		2000
	1990	2000	
65 years and over	5.1%	4.5%	1,557,800
65 to 74 years	1.4	1.1	210,159
75 to 84 years	6.1	4.7	574,908
85 years and over	24.5	18.2	772,733

Source: U.S. Census Bureau, Census 2000 special tabulation;
1990 Census of Population, *Nursing Home Population: 1990* (CPH-L-137).

Common Factors

- Congregate/Communal living settings
- Loss
- Homogeneity (age, SES, experience)
- TRANSITIONS!!!

washingtonpost.com

Man Fatally Shoots Wife, Self at Retirement Home

Ex-Diplomat's Spouse Was Infirm, Police Say

Friday, May 16, 2008

Risk Factors for Suicide in LTC Residents

- Major Losses
  - Function -- ADLs/IADLs
  - Cognitive loss
  - Self-esteem
  - Purpose

(Rosowsky, 1993)

- Situational Cues
  - Death of someone close
  - Diagnosis of major illness
  - An unwanted move or change

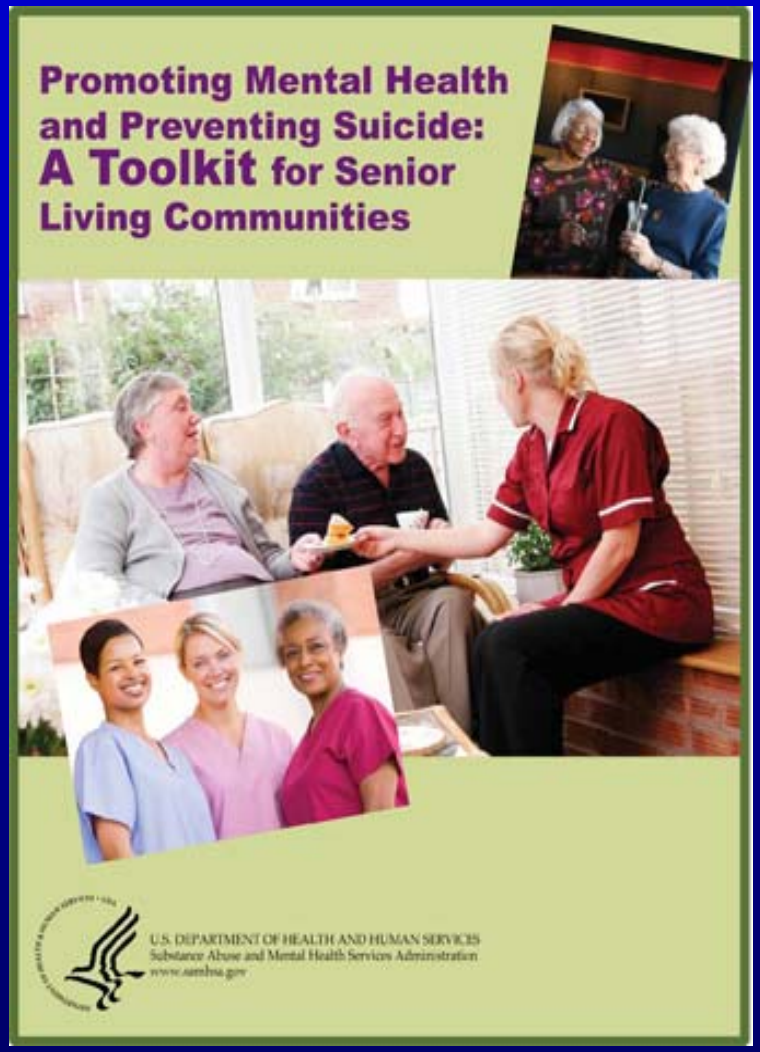
Means of Self-Harm in LTC

- Old-old are more likely to employ indirect Intentional Life Threatening Behaviors (ILTBs)—refusing to eat or drink (43%) and taking medications (40%) (Rosowsky, 1993)
- Wrist slashing (49%), shooting (18%), asphyxiation (13%) (Rosowsky, 1993)
- Food refusal (26.8%) (Draper et al., 2002)

Method of suicide among NYC residents age 60+ by location: 1990 – 2005

	All	Long-term care	Community-dwelling	p-value
	N (%)	N (%)	N (%)	
Total N	**1770**	**47**	**1723**	
Overdose	224 (7.0)	4 (8.5)	220 (12.8)	0.387
Hanging	503 (28.4)	17 (36.2)	486 (28.2)	0.231
Long fall	**533 (30.1)**	**24 (51.1)**	**509 (29.5)**	**0.002**
Cutting	81 (4.6)	2 (4.3)	79 (4.6)	1.000††
Firearms	**286 (16.1)**	**0 (0.0)**	**286 (16.6)**	**0.002**
Other	143 (8.1)	0 (0.0)	143 (8.3)	1.000††

(Mezuk, B, Prescott, M, Tardiff, K, 2008)



http://store.samhsa.gov/product/SMA10-4515

Everyone in a senior living community has a role to play in promoting emotional health and preventing suicide

What is in the Toolkit?

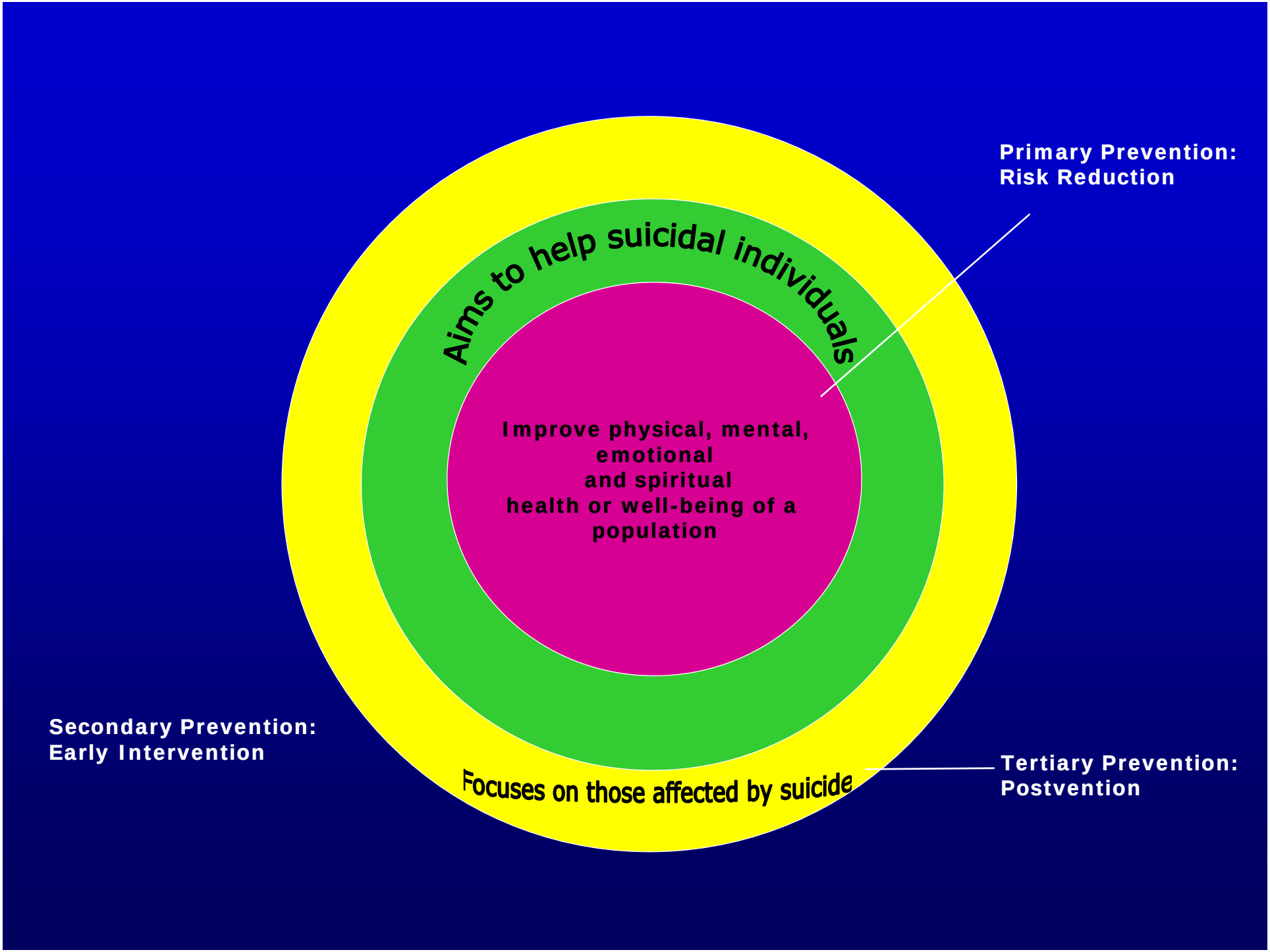
- Resources to help staff in SLCs promote emotional health and prevent suicide among residents
  - Executive director, administrator, department managers, supervisors
  - Nursing, medical, mental health, social work, clergy, activities staff
  - Dietary, housekeeping, transportation, maintenance, grounds, security
- Provides resources and information to engage residents

Toolkit Components

- Overview
- Guide to Promoting Emotional Health and Preventing Suicide in SLCs
- Trainer's Manual
- Fact Sheets for Residents

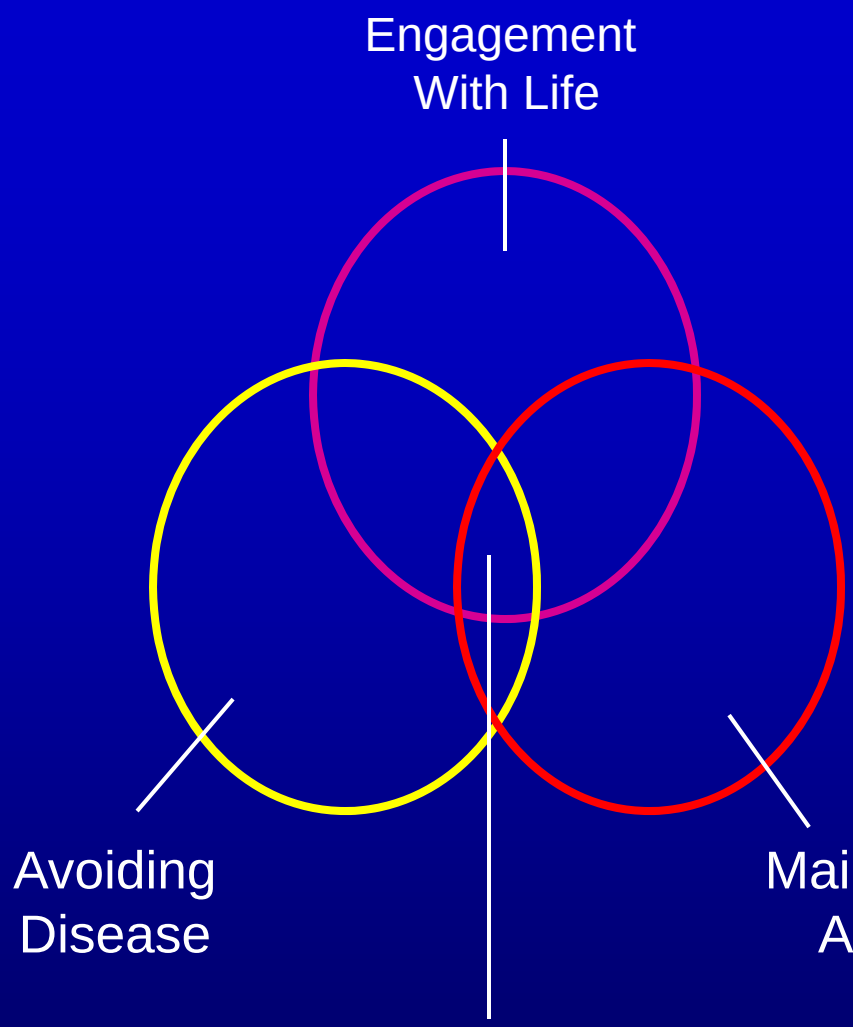
The Toolkit Framework

- Comprised of three approaches
  - Whole population
  - At-risk
  - Crisis response


Primary Prevention:
Risk Reduction
Aims to help suicidal individuals
Improve physical, mental, emotional and spiritual health or well-being of a population
Secondary Prevention:
Early Intervention
Focuses on those affected by suicide
Tertiary Prevention:
Postvention

How can whole population approaches help to reduce suicide in SLCs?

- Reduce risk factors
- Increase protective factors
- Create health-promoting environments



SUCCESSFUL AGING

Rowe & Kahn, Successful Aging, 1998

Whole Population Approach: Goals

Goal 1.1: Activities	Residents have access to activities that promote emotional health and well-being
Goal 1.2: Social networks	Social networks are established among residents
Goal 1.3: Environment	Physical and social environment promotes emotional health and well-being
Goal 1.4: Lethal means	Residents' access to methods of self-harm is limited
Goal 1.5: Staff training	Staff receive training and support for their roles in promoting emotional health of residents

Goal 1.1:
Activities

Residents have access to activities that promote their emotional health and well-being

Examples of Health-Promoting Activities

- Health/wellness activities
- Disease and injury prevention and chronic disease management classes
- Intellectual activities
- Art – creativity, imagination, self-expression
- Skill-building
- Coping support programs
- Spiritual activities
- Volunteer/mentoring

Active Engagement with Life

- Maintaining relationships with other people
  - Balance between providing and receiving support
- Performing activities that are productive
  (Rowe and Kahn, 1998)

Function and Suicide

- Lower level of functioning predicts mortality in NH residents (Draper, et al., 2003).
- Functional disability together with depression predicts suicidal ideation.
- Self-neglect in basic ADLs and higher levels of functional disability have been correlated with suicidal behavior/ideation. (Nelson & Farberow, 1980; Zautra, Maxwell, Reih, 1989)

Move over, bingo!

Nursing home residents use Wii for therapy, fun

By Stacy Forster of the Journal Sentinel

Multiple leisure activities on a regular basis

38% less risk of dementia

Each additional leisure activity

8% less risk of dementia

FEAR affects function

FEAR of Alzheimer's Disease

The New York Times

November 11, 2002
More Than Death, Fearing a Muddled Mind
By N. R. KLEINFIELD

- 1/3 of well-educated older adults have this fear – "the most dreaded" (Dark-Freudeman, et al., 2006)
- Prevents active living
- Influences use of resources and choices
- Leads to isolation

Fear of Alzheimer's Disease is modifiable!
(e.g., understanding memory; "Maintain Your Brain")

Fear of Falling

- 1 in 3 adults >65 experience a fall; 30% require treatment (Friedland,2008)
- Reduces physical activity
- Reduces function and increases frailty
- Decreases pleasure and participation in activities previously enjoyed
- Increases isolation

- **Fear of falling is modifiable!**
- **Environmental safety features, medications, assistive devices, exercises, learning how to fall, tai chi**

Fear of Losing Sensory Function

- Hearing loss
  - 45.9%: prevalence between ages 48-92
  - 30% over 60; 50% over 85
    - Cruickshanks KJ,Wiley TL, Tweed TS, et al. The Epidemiology of Hearing Loss Study, 1995
- Vision loss
  - 21% >age 65 have some visual impairment
  - Vision loss leads to social isolation and depression (14-20%), higher among women
  - Estimates for NH population: 21%-52%
    - www.lighthouse.org

- **Most Americans could benefit from available services but don't use them!**

Goal 1.2
Social Networks

Social networks are established among residents

Establishing Social Networks

- Welcoming activities, buddy systems, friendship tables
- Caring neighbor activities
- Programs where staff and residents partner
- Programs that involve residents in decision-making

What is social support?

- Information leading one to believe that he or she is cared for, loved, esteemed, and a member of a network of mutual obligations (Rowe & Kahn, 1998)

- Socio-emotional
  - Expressions of affection, respect and esteem
  - Assure a person that s/he is valued

- Instrumental
  - Acts of direct assistance such as giving physical help, helping with chores, transportation, financial assistance, meals.

Social Connections and Health

- Resistance to colds (*JAMA*, 1997)
- Prolongs life in illness (GWUMC, 2001)
  - Breast cancer
- Combats depression (*Circulation*, 2000)
- Isolation and heart disease (*UC-Irvine*, 2002)
- Delays AIDS in people HIV+ (*Psychosomatics*, 2000)

Social Connections and Health

- Potential Mechanisms
  - Social relationships increase motivation to take better care of oneself because these networks promote feelings of self-worth, responsibility, control and meaning in life.
  - May alter our moods and cause changes in levels of hormones that regulate our immune systems
  - Offers comfort and protection; serves as the litmus for one's own pain, alienation, and invalidism

Why Loneliness Is Hazardous to Your Health

Science *14 January 2011:*
Vol. 331 no. 6014 *pp. 138-140*

John Cacioppo, PhD

Social Connections and Memory

- Socialization helps memory by keeping many regions of the brain stimulated.

- Swedish Longitudinal Studies (1987-1996)
  - Studied types of activities (productive, mental, social, physical, and recreational)
  - Rich social networks → ½ AD risk
  - Avoided social contact → 2X AD risk

A Caveat …

- “Silent collusion” refers to the assistance from others for the achievement of death – e.g., “not looking”.
- It is more prevalent in LTC.
- Understanding and accepting “rational” components of another's decision to die may make others in the context silent “colluders”
- The cultural system of the institution, its goals, attitudes, values and beliefs affect risk in LTC.

(Rosowsky, 1993)

Goal 1.3:
Environment

The physical and social environment promotes emotional health and well-being

Key Environmental Factors

- Welcoming and inclusive
- Homelike
- Accessible
- Aesthetically pleasing
- Presence of gathering areas

Goal 1.4:
Lethal Means

Residents' access to methods of self-harm is limited

Strategies to Restrict Means

- Policies and procedures
- Physical barriers

Goal 1.5:
Staff Training

Staff receive training and support for their roles in promoting the emotional health of residents

Examples of Staff Training

- Train ALL staff on the aging process, risk and protective factors for suicide emotional health issues
- Importance of consistent, high quality care
- Interpersonal skills; attitudes toward depression, substance abuse, suicide
- Value of consistent assignment to the same residents

At-Risk Approach: Goals

Goal 2.1 Warning signs	All staff are able to identify and respond to warning signs for suicide.
Goal 2.2 Risk factors	All staff are able to identify risk and protective factors for suicide.
Goal 2.3 Depression	All staff are able to recognize symptoms of depression.
Goal 2.4 Substance abuse	All staff are able to recognize symptoms of alcohol abuse and medication misuse
Goal 2.5 Community connections	Appropriately designated staff establish effective connections in community to support emotional health of residents
Goal 2.6 Help seeking	Residents are knowledgeable about and comfortable seeking help for emotional health problems (SI, depression, substance abuse)

Goal 2.1:
Warning Signs

All staff are able to identify and respond to warning signs for suicide. Designated staff are able to screen individual residents for suicide risk and ensure that the appropriate action is taken when a resident may be at risk

The Warning Signs

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless; engaging is risky activities
- Feeling trapped
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep, sleeping all the time
- Dramatic mood changes
- No reason for living; no purpose in life

Goal 2.2:
Risk Factors

All staff are able to identify risk and protective factors for suicide

Goal 2.3:
Depression

All staff are able to recognize symptoms of depression. Appropriately designated staff are able to screen individual residents for depression and ensure that residents who are depressed receive treatment.

Goal 2.4:
Substance Abuse

All staff are able to recognize symptoms of alcohol abuse and medication misuse. Appropriately designated staff are able to screen individual residents for these conditions and ensure that residents with substance abuse problems receive treatment.

Goal 2.5:
Community Connections

Appropriately designated staff establish effective connections in the community to support emotional health of residents.

Establishing Community Connections

- Compile a directory of mental health care providers
- Establish a personal connection
- Disseminate the information to appropriate professional staff

Goal 2.6:
Help Seeking

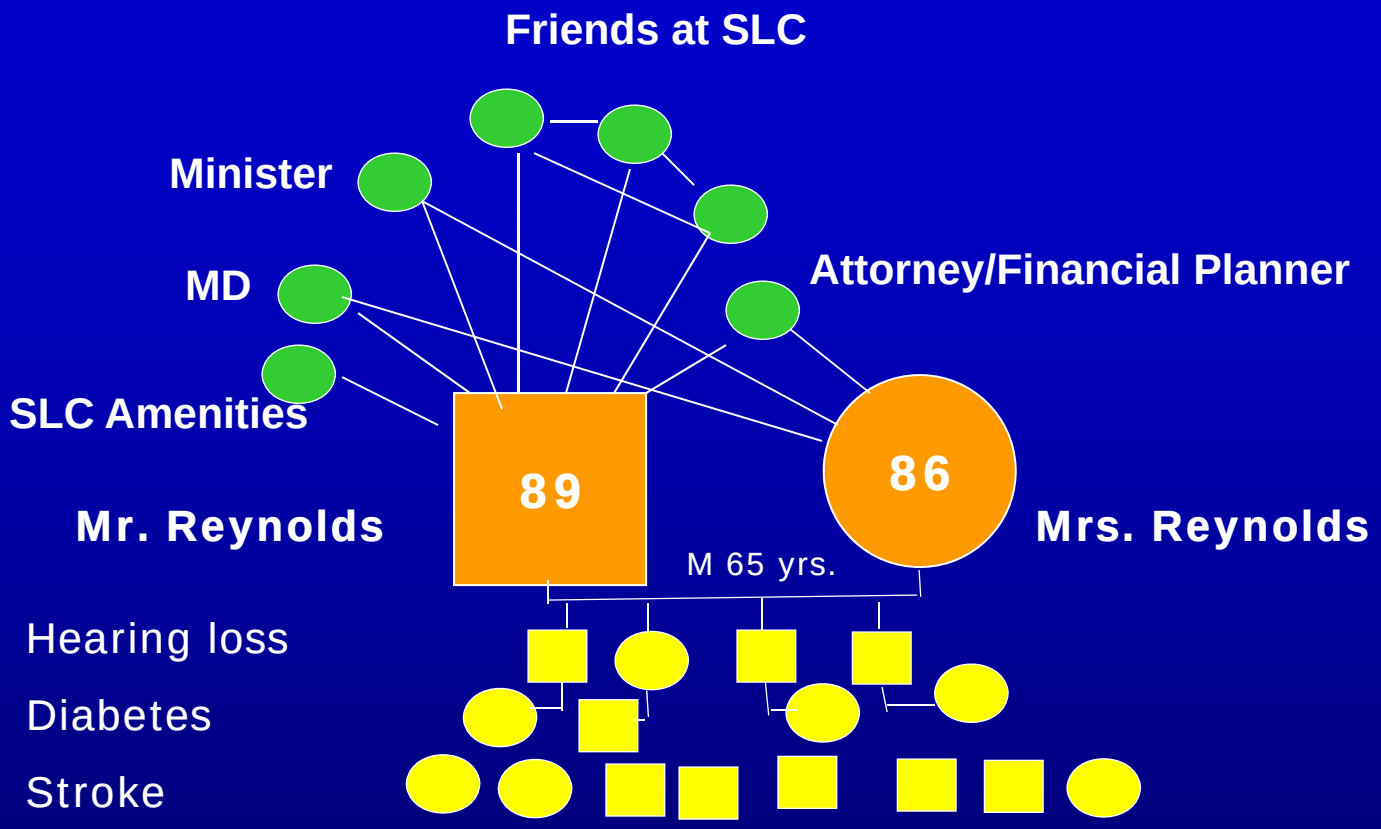
Residents are knowledgeable about and comfortable seeking help for emotional health problems, including suicidal ideation, depression, and substance abuse

Promote Help Seeking Behavior

- Decrease barriers to seeking treatment
- Cultural stigma
- Personal embarrassment about mental illness
- Normalize help-seeking
- Involve family members and caregivers

Problem Solving Skills

- Difficulties with interpersonal problem solving have been associated with hopelessness and suicidal behavior (Arie, 2008; Roskar, 2007; Jeglic, 2005)
- Suicide attempters were poorer, more passive problem solvers even when mood improved (Pollock & Williams, 2004)
- Promising interventions
  - Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) (Ciechanowski, Wagner, Schmaling, et al., 2004)
  - Problem solving therapy (Arean, Hegal, Vannoy, et al, 2008)



Hearing loss

Diabetes

Stroke

Early AD

Mobility