Suicide and Self-Harm in the Elderly

Recorded March 3, 2020

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OccupationalTherapy.com Course #4637

- [Fawn] Today's course, is Suicide and Self-Harm in the Elderly. Our presenter today is Dr. Teresa Fair-Field. She graduated from Pacific University in Forest Grove, Oregon, with a Bachelor of Science in 1993, and from Chatham University with a Post-Professional Doctorate in Occupational Therapy, in 2016. She has worked through the lifespan including early intervention and pediatrics, adult neuro, elder health and end of life care. She works full time in academic and clinical education. Her primary role is on the Select Rehabilitation Education team. Welcome to Dr. Fair-Field. So happy to have you back.

- [Teresa] Thank you. I am delighted to be presenting our topic today on suicide and self-harm in the elderly and let's get started by reviewing our learning outcomes. So we are covering a lot of ground today. As participants, you will be able to describe the scope of suicide in older adults and the elderly as well as identifying risk factors and warning signs, as the difference between those two and important actions that you can take as a provider during the first seven to eight weeks of care. The appropriate assessment interview technique as well as how to make a warm hand-off if you have concerns about an individual that you are working with.

So to begin, it's important that we share an understanding of what these terms are. And while the definition of suicide and suicidal attempts and suicidal ideation for that matter, are well understood, the clarity around the issue of self-harm is much less so. Direct self-harm are those actions such as cutting or ingesting where the individual has a known harm to themselves. While indirect self-harm is the act of refusing food or hydration, for example, also with a known harm to themself. So in this course we'll be focusing our discussion on residential communities and longterm care settings because the incidence of suicide in a closed care environment seems to be the most surprising amongst individuals that I talk with. However, any of these prevention strategies are deployable to home health environments or adult day health settings as well. So please listen for opportunities to adapt and modify the recommendations that

I'll be discussing for those settings as well. Also I 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 are a lot of misconceptions about suicide.

We're going to begin by looking at the data to build an understanding of suicides. First, we're going to discuss the incidence of suicide in the older adults. So let's take a minute to consider this first graph. This is CDC data cited in references and also available on the CDC website. The gray bars 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 is a higher incidence of suicide in recent years than that of about 20 years ago. The red bars are much bigger. And in fact the CDC has calculated an age adjusted increase across all ages of women to be 50% higher between 2000 and 2016. However, we also see that the shape of the curve here has stayed the same. Death by suicide amongst females is at its highest in midlife. It drops on either side with the lowest incidence in adolescents and in the elderly. But since we're discussing suicide in the elder population, we're gonna focus on these last two age ranges. I want you to notice that for women, age 65 to 74 in both 2000 and 2016, death by suicide in women was higher than it was at adolescence. But since we're discussing suicide in the elder population here in the 75 plus female, the gray bar and the red bar are relatively steady here between age 65, 74 and 75 plus, the gray bars haven't moved except with this higher incidence in early aging. In the recent data, the incidence was far higher in the young senior compared with that of the older senior. This is at its lowest point here in the elderly. A few takeaways here, the mental health crisis point for females is occurring in midlife, age 45 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 while it's outside the scope of this course, we can 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, this red circle here, has been adjusted for the data. So whereas the data for women is 10 per 100,000, this one for males is sitting at 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, though not as dramatically higher, except here at midlife. You also see a very slight rise toward midlife followed by a small decline and then a peak in the older senior, 75 and up, in which death by suicide is higher than at any other age. In this view, we pulled off the year 2000 data just to show these trend lines between males and females, males here on the top and females here below so you can compare the rate of suicide male to female. You can clearly see this trend towards rise in midlife, followed by a slight decline and continued decline in the female with a sharp rise in elderly males. So again, let's pause and consider the many role changes and transitions that are clearly affecting men over 75 and we'll take a moment to discuss those. 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, one in four attempts in the elderly results in death. So urgency for the issue is certainly been established. And while we don't have insight into the reasoning for elder suicide, we see in the data that something akin to despair is occurring in the 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 between 2000 and 2006 and then grew to 2% per year between 2006 and 2016. Let's look at some of the possible causes of those increases. Here we're looking at age adjusted suicide by race and ethnicity. And the highest rate of suicide is this top red line which is individuals identifying as AIAN or American Indian Alaska Native, the top red bar shown here. This is just over 22.15 per

100,000 and the line just below is White non-Hispanic at 17.83. This is both genders together. In contrast, the suicide rate amongst those identifying as Asian Pacific Islander, Black or Hispanic are all down here. These are three bars together, three races with individual lines drawn though nearly on top of one another within only a few hundreds of each other and at a substantially lower rate than either White non-Hispanic or American Indian Alaska Native. Here we are viewing the non-Hispanic, American Indian Alaska Native cohort by itself. The Y axis is per 100,000 and the X axis is cohort by age. And this tells a very important story as we consider theories of causation. In the American Indian Alaska Native suicide rates peak during adolescents and young adulthood and then decline with only a very 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 general US population, either men or women, where suicide rates are peaking in midlife. And in US, males remain high through those elder years and then rising significantly in the oldest elder. So while the age adjusted rates show the AIAN population to be the highest incidence of suicide overall, which we saw on the previous line graph, this shows that most of that disparity is occurring in early life. Young AIAN individuals are at very high risk and if they reach midlife, that risk decreases. We do know 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 elderly showed nine times the incidence of suicide than female elders. And we also see that men are three or more times as likely to die by suicide at any age than women. Those figures are not unique to the United States. A significant study was completed in Australia, which was published in 2016, recall that that was the peak of the CDC reporting period on our charts. And this study used a substantial sample size of almost 14,000 Aussie men. Assessment tools used where 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 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 see 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 describe that, "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, "Self-reliance may lead to an acute sense of burdensomeness in circumstances of perceived dependence." Consider for a moment that that is exactly the point at which we provide care, when the usual state has been threatened. Those critical points occur when an individual faces a chronic health diagnosis or a change in mobility or a transition in their living situation. And as we go on to discuss these and other warning signs and risk factors, you will hear the words humiliation and burden repeated as factors which increase risk. So Australia's large sample of men does line up with our understanding of suicide risk as presented in the current literature.

So let's talk for a moment about Baby Boomers and so-called cohort effect. We saw from the data that there is a 60% higher incidence of suicide in the Baby Boomer generation than that of previous generations. The silent generation which is what is sometimes called. And this began a decade before the economic recession. Though economic conditions are certainly one factor affecting an individual's condition, but there are other life factors that Boomers endures, as they enter older ages. They experience more chronic unemployment or underemployment than the silent generation. They have increased out of pocket spending for the healthcare that they are receiving along with an increase in chronic illness from the silent generation. Along with pairing that with those generational paradigms that the Baby Boomers have grown up with, what was called in the evidence, questioning purpose and meaning. And that

creates a cohort in which suicide is seen differently, seen different culturally, than previous generations.

And we also need to discuss the impact of celebrity suicide. And I've pulled from each generation of celebrity here, we can look back to in the 1960s to Marilyn Monroe who committed suicide at age 36. We now know that she had diagnoses of depression as well as mental illness and what we now call ACEs, which was not identified in those years. The adverse childhood experiences that goes towards resilience as well as many, many other factors which are now being researched. And following her death by suicide, there was an increase 12% nationwide in suicide across both genders, all ages. But this isn't necessarily consistent. There are some outliers that we can examine and study. For example, Kurt Cobain suicide in 1994 at age 27 also with the diagnosis of depression, drug and alcohol abuse. But following his suicide, researchers were incredibly tuned in to what would happen in this generation, in this grunge population. And they actually saw a decrease in suicide rates below the consistent average in all of their counts. And this was discussed as possibly due to an increase in media and the presentation of hotlines and support lines to those that were grieving this loss during that time. But it was also discussed to have a very cohort creating effect. It actually brought people together in a way that other suicides tend to spread people apart. So peers actually reached out to each other to process their grief and feeling less alone following his suicide actually brought down the suicide rate following his death. That did not have the same impact at Robin Williams death recently in 2014, when at age 63, he died by suicide. We saw following his death, a conglomeration of factors including also clinical depression and a history of drug and alcohol abuse. Along with what later was revealed as a new diagnosis of Parkinson's disease And following his death by suicide, we saw an increase of near 10% across all age groups. But this is the Baby Boomer that we've all had our eyes on. And what that creates is what's called a suicide cluster or contagion. Several suicides occur within a region or a social group or a generation greater than would be expected by chance.

So the CDC has their counts and anything that occurs that is outside of that could be related to this idea of a suicide cluster or contagion. And literature reports that can be as few as two or three individuals comprising a cluster in a community, for example, or a small cohort. And what that means is that if this occurs in a longterm care facility or a care facility of some kind, if the community has one suicide, it automatically increases the risk of having another. There's a video in course resources that describes this impact following one resident's death by suicide, where staff of that facility 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.

As we discuss suicide prevention strategy, we're going to go from larger groups to smaller groups, so here's your visual. Universal prevention, is prevention which is deployed to the largest population. And in the community, we see this going out locally, regionally, nationally, in reducing new cases in a large population overall by increased education and awareness along with targeting skills training across groups of a population. Whereas, in longterm care, it's the widest possible lens of that residential group, in which, for example, all residents would have access to programming that increases emotional health and coping. And we're starting to see universal prevention methods applied to entire communities of elders to address this. Everybody is supported. Building social networks that are healthy between residents of all walks of life, restricting access to lethal means and all staff receives suicide prevention training that is appropriate to their level. And we'll be discussing that in a little more detail. Selective prevention is focusing that lens somewhat. In a general community, this might be targeting high risk groups, those that are more vulnerable to demonstrating risk flags and have increased vulnerability. And in the longterm a residential community, we see that selective prevention being applied when we see an improvement in activities that in particular engage men. And that's something that our

communities are not necessarily strong at. And yet the suicide rates indicate that that's our highest risk group for dying by suicide inside of residential care, along with those with chronic pain and disease, those with persistent sleep disorders and any resident showing warning signs. So that is developing programming, that's targeting residents that are at particularly high risk based on their profile. And then narrowing the focus even further an indicated prevention is the same between the general community and a care setting. And that is to target those that are at imminent risk, individuals that are demonstrating red flag behaviors and have indicators of mental illness or substance use.

So what are explicitly the risk factors versus the warning signs? They are very different things. Risk factors are those things that increase the likelihood that a person may attempt suicide. Not that they necessarily will. They can be demographic, historical, things that are detected in the medical record. Those are risk factors. They increase someone's risk, but not necessarily their likelihood. Whereas, warning signs are those observable behavior changes that indicate an individual's possible decision to die by suicide. Their red flag behaviors. And studies of these warning signs along with interviews with family members and staff, up to 80% of people were showing warning signs, but the individuals close to them did not know to detect them. Again, they're observable, things we can watch for, a noticeable behavior change. Things that are outside of an individual's particular typical expression. And they're intuitive. They're largely intuitive. People say, well, I thought like something was... I couldn't put my finger on it. But the individual was detecting warning signs. So we'll be talking about those more explicitly.

Knowable risk factors are those things you can know and identify. Again, may increase an individual's likelihood and we think back on our celebrity suicides, all of whom exhibited risk factors that were knowable. Robin Williams demonstrated by age, by drug and alcohol addiction history, by clinical depression and then upon our later

discovery, the recent chronic health diagnosis. Each of these was a knowable risk factor. Along with as you see veteran status, LGBTQ status, cultural clusters. Other risk factors may not be present in a medical record, but they are ask-able. Things that are undocumented, like perhaps a past attempt or a family history that may not be present in someone's medical record, but his ask-able. Along with that possible history of adverse childhood experiences. Other things like the individual's access to mental health services or access to lethal means are also risk factors. Along with that, individual's overall coping style, their ability and willingness to access mental health supports, stressors over time. Those critical transitions and loss. It's important to note here as we look at these observable warning signs that depression is not a normal part of aging. Again, depression is not a normal part of aging. It is a mental health condition to be discussed and addressed, not something to be dismissed because of our own preconceptions about growing older. We see shame and humiliation on this list. What we saw in our prior slides regarding causative factors here is an observable warning sign. And this has particular impact in our male residents as well as in cultural groups where perceived burden, results and feelings of shame and humiliation. Please note that it is not actual burden or the caregiver's perception of burden, but the individuals self-perception of burden, which is unrelated to their actual performance. Irritability, hopelessness, helplessness, behaviors including new med seeking or new med storing, self isolating, giving things away more than you would expect beyond an individual transitioning into a new living situation, including sudden joy that's atypical for the individual, escalating self-harm, which we can observe in residential settings. Bringing us to the four D's of suicide risk, which is depression, the presence of disease, the presence of deadly means, combined with disconnectedness.

So let's discuss some prevention steps for our care communities. Designated staff education is the most critical component. Practicing our suicide screening interviews until we are comfortable delivering them, knowing those warning signs of elevated risk versus imminent danger, which is a risk factor, which is a warning sign. Activating

those appropriate actions within our facilities when we detect risk, do we know whom to discuss this with and what the process is? Do we know what our facility policies are? And reviewing that training at appropriate intervals. And this is something that our profession can spearhead or lead within the communities where we work. But it's important to identify that all staff at every level receive some level of education to identify and respond to these warning signs. Can every individual throughout the facility identify what to do if risk is detected? For example, it may be the housekeeping staff that is the one that detects an individual that's medication hoarding. It may not be therapy staff, it may not be nursing, it may be the housekeeping staff that has that insight but doesn't know to detect it or what to do following its detection. So it's important that all staff receive information and education appropriate to their level.

So what are the lethal means that we see in use in longterm care? In the community, we see that fire arms are more likely and more likely amongst men, with medication being more likely amongst women. Whereas, in longterm care and residential sites, we see that firearms are less likely. So our facilities are doing for the most part a good job in preventing that lethal means, but jumps and falls are more likely. Medication appears equally likely both in the community and in longterm care settings, along with the possible impact of indirect self-harm, which we see as a factor in longterm care and residential environments. So let's discuss those risk factors versus protective factors that have been documented in the elderly. So again, risk factors include depression, which we've discussed. The number of medications increases an individual's risk. Again, they have access to more medication and they have access to more harmful medication. Loss of a spouse within one year seems to be a critical tipping point. Again, the perception of burden, chronic disease, including new diagnoses of Alzheimer's and Huntington's disease. Again, the newer the diagnosis, the higher the risk. The individual has ideas and concerns about that chronic diagnosis. By the time an individual has progressed in their disease, they may not have the ability to deploy an action plan for suicide. So we see that early in that transition period is the highest risk.

Chronic sleep disturbances along with a history of alcohol dependence or misuse, which we see co-occurring research wise in 35% of elderly males. And the protective factors that we see are a general outlook of optimism along with internal locus of control, belonging, satisfaction with life, et cetera. But what we know about that internal locus of control is that for an individual that has that sense, it persists beyond their transition to longterm care or residential communities. That individual with a internal locus of control can say, I may not have control over the environment that I'm in, but I still have control over some factors of my care. So they look for places they still have control, even if they don't in their residents. So that internal locus of control causes that individual to look for places in their life where it can be sustained. That is a protective factor. So our facility policies need to target those at risk. Of course, by limiting lethal means, but not be activity limiting. And that's a fairly delicate balance. But research has shown that more intense security was positively associated with depression symptoms and suicidal behavior because more intense security reduce that individual's locus of control. So it's a delicate balance between being able to control certain aspects of your life and care.

And so we as therapists, can support the individual in having locus of control over their treatment plan, over their care activities, for example. Our activity and the therapy we deliver may be somebodies source of control in that environment, which they cannot. But it's important that our facilities kind of balance this risk versus level of support and to elevate watch status over time. So if an individual is on watch status that they have the ability to demonstrate over time that they're safe and we can adjust as a facility based on what we know about risk factors and warning signs in suicide to increase or decrease the level of scrutiny that an individual experiences. Programming in residential environment should focus on the emotional health for all residents. Again, gathering the entire community in that wide lens of support. We know that wellness programs and physical activity, things like mindfulness and addressing sleep hygiene are critical for elder wellness and cultivating those issues, addressing those issues in

our communities cultivate emotional health overall along with activity programs that support engagement and participation. But we know from our prior slides that it is particularly urgent that we address emotional health programming for men, which is our highest risk group. And most of our environments inadequately address the needs of this market.

I'm going to be talking now about resilience training, what it is and how to implement it. It's present in the literature with the hypothesis that 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. So the researchers designing this resilience program, which is deployable in your community, have identified targeting that locus of control, that ability to continue to build and meet personal goals inside of a clinical care environment. What does that look like? So over 11 weeks, this program has been designed with a different theme each week, meeting group members, discussing experiences including the transition to the care environment that you're currently in. Talking about goals overall, what are our preconceived ideas about goals? What has been our experience about setting and meeting goals that we come into the group with? And how might that impact our relationship with goals in elder life? And then towards the end of that first month, selecting goals that have a high priority to the individual along with realistically what can we accomplish in the environment that we're in? What resources do we have? What level of control do we have over completing that goal, achieving that goal in this new environment? And that's a critical part of developing a realistic goal inside of a care community. And successive weeks, five through 11, go into more in depth. That might be adjusting the goal over time or looking for ways to modify that goal, supporting others in reaching their goal. All critical, critical steps to building cohesiveness within the group.

Let's talk for a moment about transitioning and our perspective on the critical point of transition. So we know that transitioning into a facility and the elevated risk of suicide is at its highest at the point of transition from home. But we also know that it doesn't decline very quickly. Another critical thing to realize is that when we say transitions appear to be the tipping point of suicidal risk, it's important that we think about those transitions from the resident's perspective, not from our own. So while it might be highest at the point of transition from home, researchers gained insight following the suicide attempt of an elder that was moved out of her usual residence on the floor, her usual unit, to an attached memory care suite. She'd been a longterm resident of the same community. So while that initial window of risk had already passed since she first arrived from home, the transition to an adjacent longterm care complex or memory care complex, even co-located or even attached to the same building is a new window of transitional risk. The person is removed from their familiar environment and care team and it might be just down the hall or across the parking lot, but from the view of the resident, it is entirely new transition and that may increase that window of risk again. You and I might know intimately the staff on that floor or that wing or that unit, but to the individual that's relocating to that unit, it is a brand new transition. So it's important that we keep the resident's perspective in mind when we talk about transitional risk. So once the individual relocates the risk of suicide is at its highest within the first seven to eight months following that transition. Up to 12% of interviewed newly relocated longterm care residents endorsed suicidal thoughts. And even at two weeks, two months, there continues to be a persistent group up to that full window of seven or eight months. That's a significant amount of time when we as practitioners feel as though that window has closed. For the individual, it apparently has not. So I'm presenting some transition checklists feel free to take these back to your community. Things like feelings and mood, any change in feelings and mood, any observed behavior changes, relationship to medications. Lethal means as an individual is transitioning into the environment. Again, that may not be valuable once the individual has relocated, but if as a therapist you are spearheading suicidal prevention

efforts in your community, that could be a critical resource to provide the family as the individual is transitioning into your care.

Now we're going to spend some time practicing asking about suicide. Obviously, we want a private setting, but due to the sensitive nature of asking about suicide, you'll wanna make sure that your interview environment is conducive to discussing the topic. The resident is more apt to feel comfortable discussing private feelings in private spaces versus say the dining room, even if it is empty of others. So again, from the resident's perspective, is this a private space conducive to discussing a significant topic? Of course, we want to ensure that they can hear, that they can adequately see us. When we set up the PHQ-9 interview, we are giving an introduction that standard work for the interview, assure them, that you are asking the same questions of everyone. It is nothing about them that indicates these questions. You're asking each individual the same questions. You're explaining the purpose of delivering the PHQ-9 which is to help you develop a customized care plan. If they refuse, you're moving on to the next item. In all of 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 yes, no or no response and frequency of the concern for any yes answer. With response choices of never, or one day, two to six days, which is several, seven to 11 days, which is half or more, or 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 worded. Few people would struggle with item D feeling tired or having little energy. No one seems to have a problem asking about sleep or appetite and yet 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. This

is entirely built upon a myth. 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 this 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. How to ask. We have very specific guidance here. The text we are provided is this, "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. Of course, they're going to give you an answer and it could be yes. So preparing yourself with a follow up to that yes answer, you're not gonna mark your box and leave the room. You are engaged at that point in this conversation.

So how do you ask the next question? "Are you thinking about suicide?" "Do you have a plan to kill yourself? "Have you thought how you might kill yourself or harm yourself?" That next question needs to be explored. What is the level of their plan? "Do you have a plan?" "Have you thought about the means?" Discussing that openly and without judgment. Objective, and we're going for a direct ask. "Are you thinking about suicide? "Do you have a plan to kill yourself? "Have you thought about how you might hurt yourself?" Versus an avoidant ask, which is based on our discomfort. "You aren't thinking about killing yourself, are you?" Because that introduces personal judgment and shuts down the conversation. That individual now knows that you are not a safe person to talk about their concerns with. "You aren't thinking about killing yourself, are you?" Versus, "Have you thought "about how you might hurt yourself?" We're asking directly without hesitation using plain language. If they do answer yes, our first move should be to thank them for their honesty and courage. "Have you thought about how you would end your life? "Have you already considered "how you would access those means? "Are you thinking of when you might end your life?" Followed by our warm hand-off to the staff person in charge and we should be following our facility policy when we do so. Who can help you limit your access to that means? Versus an avoidant

response again, "Why would you do something like that? "You have so much to live for." We're staying objective. We're keeping our feelings to the side. We're asking and answering directly. We're leaning in to the topic. If they say no, there's a lot of reasons that they may say no even if they have considered suicide. Does your intuition agree with their no answer? Do you detect any discrepancies between this interview and other things you've heard or seen? Is their no answer a match? Now, if they've answered no, you may mark on your PHQ-9 that they've indicated a no answer, but then you may document that you have concerns and recommend a followup interview. So a no answer doesn't mean the topic is complete.

And what are those next steps in communication within your facility? We know that though many residents endorse symptoms of depression, a study was done in 2010 indicating that fewer than 25% of depressed residents in longterm care settings have been accurately identified. And there's a lot of reasons for these findings, which we continue to see played out in facilities across the country despite the requirement that the PHQ-9 be administered as part of the Medicare MDS completely with standardized wording and exactly as written, which we just addressed. And 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 the accuracy in reporting of all questions of the PHQ-9 and any variation in this very clear practice standard 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 about the person, how you feel conducting the interview, the issue or the question itself or how you feel about the resident. 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 of these PHQ-9 questions 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 exactly as it's worded on the MDS, asking openly and directly and then accurately reporting the resident's response and activating a change in the care plan if necessary.

"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 talk with you further." And that's your pivot to the next steps. The warm hand-off, 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 wellbeing. They answered yes, they have thought about hurting themselves and then pass on any related dialogue that took place as part of that interaction. They thought they would be better off dead. They thought about harming themselves, they've considered suicide, et cetera. What other details came up in the conversation. It is then very important that you as the therapist document your hand-off encounter with that appropriate staff member because while the PHQ-9 serves as documentation of the presence of depression and possible risk, it doesn't address next steps in activation of your facility policy.

It is your professional responsibility to document that the 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. So even if that PHQ-9 does reflect the residents 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 that initial MDS is administered. Recall in our

earlier slides that two weeks, two months, and in some longterm residents, up to eight months following a transition, they continue to have an elevated risk. 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 are some normalcy in casual death talk amongst the elderly. One interviewed resident in a television broadcast about suicide, which I've linked the end of the course, said, "Who hasn't thought about it?" However, the staff member may not be able to distinguish between casual talk and intentional harm and it isn't their job to do so. So it's essential that any talk or red flags be communicated to the care team and followed up. And while this conversation might be occurring in a group or with a peer and it may not be effective to ask an individual at that moment in the dining room or in the lounge, or on the patio when they're surrounded by others, it is important that upon overhearing it you follow up both quickly and directly within that same shift. Doing so can reveal if there's any suicidal ideation behind the conversation that was overheard. Listen for intention, ask directly and without judgment or euphemism, "Are you thinking about suicide? "Do you have a plan to kill yourself?" Asking directly will not put an 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.

I wanna bring your attention to some of the current language around suicide. We are using the term died by suicide versus successful or unsuccessful. There's nothing about suicide that is successful. So we are using the very objective terms died by suicide or a non-fatal attempt. Committed suicide is no longer in use because it criminalizes the act of someone who's in despair. We are steering away from media hyped terms such as the suicide epidemic. Instead we're discussing higher rates or increasing rates because individuals are behind this issue and we're refraining from out of context use of suicide as well.

I want to bring your attention to the resources for your own review. Online learners are constantly requesting more practical tools and resources to take back to the workplace. So as we close, I want to bring your attention to what those are on the topic we've discussed today. This is where to spend some additional time after this course is over if you're passionate about making an impact on 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 just broadcast on TV last year. In particular, I want to draw your attention to the PBS news report on the issue of suicide specifically in longterm care and residential communities. It aired last year and I strongly encourage you to go directly to that link provided and watch it after we conclude today. It will significantly add impact to the course material by providing you with the personal and family stories that I wasn't able to include today for privacy reasons. It would also be an excellent team activity to watch as a group if you're interested in spearheading this work in your facility. This is a downloadable toolkit that SAMHSA, the Substance Abuse and Mental Health Services Administration developed to assist senior living communities with developing policies and practices. 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 discussions are still lagging in senior communities despite available resources. So this is a wonderful tool to support you in bringing the issue to the forefront in your workplace. And if you feel like you need something in hand to bring to your administration, this is it. The website if you're interested, has other toolkits for senior centers as well as other focus populations such as LGBTQ and schools, along with resources in Spanish, et cetera.

And then finally, I want to draw your attention to the Friendship Line for those of you involved in home health, for example. This is a dedicated call line and service to adults over 60 or those with a disability making it the only hotline of its kind. Research shows that people do not call crisis lines on their own. So the Institute of Aging developed this

program, which is the only one that reaches back out to older adults. So unlike other crisis lines, the Friendship Line initiates a call out or call back service and schedules a regular interval of outgoing calls to monitor the individual's emotional changes over time and provide ongoing support. I thank you for your time and attention today on addressing this very important issue.

- [Fawn] Thank you so much Dr Fair-Field. We have a few... Actually a question came in, but it's a pretty lengthy one here. I wanna read it out loud. I'm very glad of this presentation since I have seen so much of this problem across settings, acute care, home health. I would welcome guidance on addressing denial in fellow staff or patient families. I would also welcome guidance on differentiating dementia from depression as well as whether there are ways to promote a larger awareness or a message of the reality of multiple losses as a very typical experience aspect of aging.

- [Teresa] This is a very complicated but very valuable question and I would encourage any of you, again, to spearhead the work inside of your facilities. It's a great place for occupational therapy to be positioned and there's number of tools on the websites that I provided at the end of the course, including staff training tools, a staff training manual and a lot of resources specifically around memory care. This wasn't addressing Alzheimer's or memory care, dementia in particular, although that is a great pivot point for some additional research. And there's a lot of study happening in this area. It seems to be reaching a critical point. So you're welcome to reach out to the email address shown, but again, investigate each of the resources that you see. And I think in terms of guidance on addressing denial in staff and family it takes somebody that's passionate about the issue to move it forward and move the training and the discussion. And I think, again, the more we can openly talk about it amongst ourselves and our teams it can make a significant and life changing impact.

- [Fawn] Thanks for this very important topic. So I hope everyone, if you have more questions, please feel free to reach out. I hope everyone has a great rest of the day. You join us again on continuedandoccupationaltherapy.com. Thanks everyone.