

**ALBANY COUNTY
LONG TERM CARE SYMPOSIUM SERIES**

**Suicide Prevention
Identifying and helping those at risk of suicide
among the long-term care population**

Wednesday, June 23, 2004
William K. Sanford Colonie Town Library

Symposium Minutes

Introduction to Symposium:

Vincent Colonna, Commissioner of the Albany County Office of the Aging:

Vince welcomed participants to the first Symposium in the Albany Long Term Care Consortium (ALTCC) Series and stated that the key to a successful series is an exchange of information between all participants. This Series will be held quarterly in different venues. The first half of the program will feature a speaker and a Question & Answer period. The second half will focus on interaction between a panel of experts and the audience about the presentation topic. The information from each presentation will be available on the Office for the Aging Website.

Participants were asked to fill out an Evaluation Form and turn it in before leaving. This feedback will be used to plan future events.

Michael Breslin, Albany County Executive:

The purpose of the ALTCC is to gather people with expertise [in their respective fields] and have open communication so as to provide the best services for the older residents of Albany County. Needs include money for transportation and improvements in homes for people living on the edge (for safety reasons). In the past there has been a lack of communication about simple items such as making houses safer.

Rosemary Bailey (Albany Law School), Lillian Moy (Legal Aid), Chris Cary (Colonie), Nora Baratto (St. Peter's Hospital), and Edie Sennett (Red Cross) planned this event. We all need to learn more about how we can help residents in the Long-Term Care System

Guest Speaker:

William Dickson, CSW-R, Associate Director of Clinical Operations,
Albany County Department of Mental Health

Suicide is the 11th leading cause of death nationally. For men, it is the 8th leading cause of death and men complete acts of suicide at a higher rate than women (4:1). Men use more violent means especially if they have access to firearms. Women make more suicidal gestures but don't succeed as often, generally understood to be a function of the less lethal methods used, such as self mutilation and non-lethal drugs.

Cohort Data:

- risk factor for suicide increases with age
- over 65 age group fastest growing cohort
- white males over 85 fastest rate - 13% of population, 18% of completed suicides
- 71% of completed via firearms
- risk of depression and alcohol dependence rise in later age

Other Relative Facts:

Reasons for risk:

- Social barriers (more reluctant to ask for help)
- Inappropriate use of medications, esp. use of concurrent medications (may impair them), -- psychological or emotional mood changes; forgetfulness; could just be polypharmacological therapy gone "haywire"
- Alcohol abuse which causes emotional and mental struggles
- Nutrition (poor nutrition impacts the way the brain functions)
- Anemia (blood disorder)
- Clinical depression (non-regulated)
- Diabetes (non-regulated) erratic blood sugar level
- Stigma of mental illness
- Lack of access to medical services (insurance restrictions, transportation issues)
- Mental illness misperceived as "normal" function of aging (by the person); aren't "supposed to" feel good
- Diseases: lung (COPD, asthma, CHF) oxygen deprivation – alters brain functioning
- Dementia & Alzheimer's Disease (the 4th leading cause of death in America; 1 in 100 adults will be diagnosed each year):
 - Cognitive impact
 - Emotional / behavioral impact

- “LOSS” - of spouse, independence, functional capacity, friends, home, health, self-esteem, intimacy, role in society, freedoms (*i.e.*, institutionalization, home-bound, DWI, handicapped accessibility), sense of identity

Clinical Diagnosis of Depression:

- ✓ Lethargy
- ✓ Eye contact (lack of)
- ✓ Disturbances in sleep / appetite
- ✓ Loss of interest in pleasurable activities (*i.e.*, isolaters → no longer go to bridge games, social outings, etc.)
- ✓ Agitation (feeling miserable)
- ✓ Anger (justifiable due to losses)
- ✓ Apathy
- ✓ Limited resources:
 - ❖ lack of social support
 - ❖ financial
 - ❖ personal (level of energy, coping strategies [Ask how have they historically done things on their own? Do they seek help when needed?])
 - ❖ lifestyle (historically) → physically aggressive, high-risk taker, impulsive, alcohol use
- ✓ past history of suicide gestures—much more likely to complete act of suicide
- ✓ hopelessness & helplessness—“things just can’t get better ever”, individual doesn’t see anyone (anything) as potentially helpful

How do we assess for suicide?

- Develop rapport and credibility (clients need to trust you)
- Need to find out the person’s perception of seeking help (historically how have they dealt with similar situations)
- Use open-ended, non-judgmental questioning & statements
- Be honest about your concerns for the person—“I’m concerned. I want you to be safe.”
- Don’t stress pulling through for others—“can be seen as another burden to person contemplating suicide”
- Trust intuition—“trust your gut”
- Don’t go it alone, work as a team—get help, supervision, case conferencing

Typical Evaluations of suicide & suicide risk:

Look at:

- 1.) Ideation
 - a. How frequently do they think about suicide?
 - b. How specific are suicide *ideas and plans*?
- 2.) Intent
 - a. Is suicide frightening to them?
 - b. Is the thought of suicide comforting? Are they “okay with dying”?
 - c. Does it conflict with their internalized belief system?
- 3.) Plan
 - a. Do they have a specific plan?
 - b. Is there access to the plan?
 - c. How detailed is the plan?

Resources:

Very limited for the elderly who are depressed & at risk of suicide.

- Albany County Department of Mental Health’s Mobile Crisis Team housed at CDPC—available 24/7:
 - Mobile response, emergent mental health assessment, risk assessment, consultation and recommendations
 - Crisis ER nursing, crisis assessment
 - Look at psychiatric need, risk & diagnosis
- Albany County - CDPC Crisis Service & Albany Med – Hospital-based assessment of acute psychiatric distress; many elders end up here since distress may be exacerbated by medications, illnesses, etc.; acute medical issues can’t be addressed at CDPC; Medical rule-outs important for those 65 years of age & older; evaluations take a number of hours to complete if they end up in ER and subsequently CDPC Crisis Service (4-6 hours average)
- Rensselaer County—Samaritan Hospital
- Schenectady County—Ellis Hospital
- Saratoga County—Saratoga Hospital
- Albany County Department of Health—does geropsychiatric assessments for people 65 & over (4 hours of psychiatry committed to this each week); last resource seek other available resources first for assessment
 - Up-to-date medical assessment, including blood work
 - Primary care physician
 - 447-9650=>Mobile Crisis Team
 - 447- 9611=>CDPC
 - 447-4537=>County MH Department Administration (Bill Dickson)
- CDPC—outpatient service has geriatric specialty (highlighted by Melissa Vliek and qualified psychiatrists),

- Rehabilitation Support Services (RSS) has a Continuing Day Treatment track and a geriatric social club that serves the 65 + population
- Samaritan Hospital Geropsych Unit
- Four Winds (inpatient for adults)
 - Partial hospital a possible option, but may not serve 65 + population (day treatment)
 - Consultation to primary care physicians (may want to advocate for this. Four Winds does this for children)
 - Create specialized service
- Medical provider is a resource
- VNSA
- Adult Protective Services
- Nurse practitioners
- Samaritans Hotline—24 hour suicide prevention hotline (throughout the Capital Region)
- Haven—suicide support group (for those who have lost a loved one through suicide)

Questions & Answers:

“Wish I was dead.”—common statement→How do we know when it is much more than drama? (3rd leading cause of death injury stats NYS for people 65 & over)

689-4673 Samaritan Hotline

Clearview→contract mental health provider→(not much for people over 65)

Community Hospice & St. Peter’s Hospital→(Choices program)→evaluates for depression in elderly

- ✚ University at Albany→Graduate Schools of Social Welfare and Public Health are good resources; committed to partnering with the community
 - When people start treatment & begin to feel better they may be “energized to follow through”.
 - 1st 6 weeks of anti-depressants at highest risk of following through with suicide

BREAK

Panel Discussion:

Case Study Presentation:

Facilitator: Chris Cary, Case Manager, Town of Colonie Resource Department

Panelists: Kurt Ottendorf, Albany County PSS, Adult Services
 Anne Malak, Legal Aid Society of NEWY
 William Dickson, Albany County Department of Mental Health
 Tianna Pettinger, Senior Services of Albany
 Lanette Marciniac, Visiting Nurses Association of Albany
 Sue Weisz, New Scotland Senior Services
 Melissa Vlieg, CDPC, geriatric outpatient

Case Summary:

Immediate concern: suicide (57 yr. old male)
 Over time: LTC services

Family unit: patient, wife, elderly mother

Case from downstate

57 yr. old man; family moving from Brooklyn to rural area of Albany County (20 miles from CDPC)

was an outpatient downstate
 depression since 1996

1995—local hospital; serious suicide attempt (cut wrists; needed surgery);
 inpatient care, then outpatient

→for 10 yrs. but depressed & told no one

→family didn't notice changes

outpatient treatment

- continuing day treatment
- anti-depressants
- therapists bi-weekly
- psychiatrist 1 X / monthly
- group treatment

thought CDPC could provide upstate

- continual symptoms of depression
- diminished interest
- recurrent thought of suicide
- psychotic symptoms
- disinterest
- dysphoria (sadness)

hospitalization in 1997, 2000, 2001

exacerbation of suicide ideation

- anti-psychotic; anti-depressant medications
- mood stabilizer and still symptomatic

married, 3 children / divorced, estranged from all when 1st attempt at suicide

remarried w/3 step-children

HS / 2 yrs. College / supervisor for many people

Performance on job changing—performance evaluations bad—keep changing / working then suicide attempt

1997 SSDI + Medicare; no Medicaid

decided to leave city

89 yr. old Mother-in-law lives with them

obese / COPD / hypothyroidism / HDL / 2 hip replacements / painful knees—chronic pain / disabilities / hypertension (patient)

has a pulmonary care physician

Major depression, recurrent, partial omission

Compliant with medications but wife administers with verbal reminders

Many medical medications

Spouse supportive; he wants to feel better

+ treatment at CDPC:

- ✓ meals
- ✓ psychiatrist 1 X monthly
- ✓ therapist bi-weekly
- ✓ refer to continue day & outlined or health treatment
- ✓ group, but not a good match→attended despite “bad fit”
- ✓ transportation a big problem

designing a treatment plan is a problem

89 yr. old mother-in-law: multiple medical problems & her medical status is changing (*i.e.*, anemia, blood transfusions, Procrit injections)

4 falls (one fall hit her head & had 68 sutures—1 hospital stay), dislocated shoulder uses a walker & wheelchair; VNA is coming into the home for dressing changes (short term)

urinary incontinence—uses commode

memory impairment (since her fall when she hit her head)

wife is handling all the caregiving → she supervises spouse & her mother
 end up in hospital; surgery on wrist needed / who will do care when she can't
 pain medications for her wrist impair her caregiving abilities so she doesn't take them
 patient doesn't supervise mother-in-law; can't leave either person alone

when wife shops for food, spouse won't leave car; if he is at home he calls her constantly
 on her cellphone because he is panicked about being at home

neat, well-kept home → only 1 neighbor across street; no one else close by

Barriers to treatment:

1. individual Medicaid (ineligible):
 - a. under 60
 - b. not homebound
2. lack of social supports, stimulation (rural area)
3. lack of supports for caregiver
4. coordination of releases through family CHIPAA requirements
5. lack of transportation
6. balancing medical & psychiatric needs
7. Is this what the client wants (care plan) and are these the best alternatives?
8. mother-in-law (Medicaid eligible)
9. financial & legal concerns for long-term care

income: \$1,300 a month

needs assessment of mother-in-law
 a lot of unknowns

try to prevent institutionalization
 solutions / problem-solving

day-care for mother-in-law

find out spouse's income (spousal impoverishment)

maybe he can get Medicaid (need patient & spouse income)

is wife eligible for income – SSDI, survivors benefits (1st husband deceased)

→ wife wanted to get a job; was a bus driver

income issues must be addressed first for all people → basic needs

- Town of New Scotland Resource guide
- Transportation—no access

Evaluate each person for Medicaid separately

- patient→qualifies for Medicaid if spend down medical
 - does not qualify for LTC program (Medicaid)
 - VNA—1 time weekly for mental health because he is unstable
 - If taxing to get out of house qualify for Medicare short-term (needs to be qualified as homebound)
- Look at nutrition / home health aide / patient sliding fee is available at VNA for people with limited incomes

Rural home setting is a HUGE problem

Can social workers do an assessment for family? Yes-- organizing everything is difficult

When involved with one patient, became aware of needs of other family members & set them up with care

SSA – Tianna Pettinger Caregiver Connection Telephone support groups

Wife (eligible because caring for mother)

Support groups

- a) Focus on how important it is to care for self
- b) Coping skills, identify barriers to her getting the help she needs
- c) Benefit from knowing she is not alone, there are other caregivers dealing w/ similar issues

Caregiver Connection→respite services

Meals-On-Wheels may be possible for mother-in-law for several days a week (while look at eligibility for long term)

Social model adult day program in Albany→need to assess if social model is appropriate

Caregivers at risk for suicide→need to do assessment

- Personal responsibility for keeping these people alive

Legal Aid Program:

- He is not eligible (not 60)
- Mother-in-law is & could do phone intake if homebound
- a lot of medical needs for care
- Are there financial services & what can be done to maximize them?
- wife's health beginning to fail—may be eligible for SSDI or SSI
- employed for 29 years—Is he getting pension & full benefits?
- Is mother getting full benefits? SSI? Medicaid?

Look at all benefits to maximize what they can get – even \$20

\$1,300→qualify individual 1 (not entitlement program→1st come, 1st serve, run out of money) pays for Medicare Part B premiums \$ over 1,000 a month for two people

need to be creative in financial issues – look at all benefits

emergency HEAP tier 1→no resource limit

tier 2→ for either tier

weatherization money if qualified for HEAP

some employers pick up premiums for Part B Medicare

mother-in-law→look at EPIC Program

make chart of all benefits for each person

patient→Medicare HMO

CMS.gov

Compare Medicare HMO programs

- Lifetime limit on hospital days for psychiatric care
- 140 lifetime days for psychiatric care
- What are HMO benefits for hospital stays?
- Compare by Zip Code

What is the best Medicare plan for him & his needs?

Nursing home without walls

Community spouse limit over \$2,200

Medicaid household \$970 (significant spend down)

Special needs trust→is patient eligible?

Need to look at whole financial picture

Need help caring for house→need to keep them in home

Needs Durable Power of Attorney & Health Care Proxy – other than his wife who would be an appropriate alternate→his opportunity to make choices regarding care

can't take care of self without wife guardianship

Adult Protection Services:

- Family doesn't meet criteria but if something happens with caregiver—could be
- Potential for neglect which is APS—however, could make an assessment & refer for case management if eligible for services.

Elderly mother-in-law first priority

- Several falls

- Possible TB1 or hitting head accelerated a very mild dementia

Does spouse have health insurance & access to care?

Consumer directed personal care

(consumer appoints someone—caregiver can get benefits→relieve some financial burdens)

paid for with Medicaid dollars—need to be eligible to get this
dealing with lay person who may not be able to diagnosis

patient hospital choice—Albany Med (psychiatric) intensive care management?

Who can provide?

E2/E3 – need to be ambulatory, etc.

If physically dependent, where will he go for inpatient psychiatric care?

“lucky” that he is getting outpatient psychiatric care

If this piece wasn't in place, who would these people turn to?

Mental health for the patient

Mental health provider arrange for health services→case manager / person triaged

Considered for a range of services

Case manager make some referrals for patient

Mental health for him / get other services

Single point of entry for Mental Health Services

State agency→can bill all insurers / never pay out-of-pocket so CDPC never talks about this

Model of advocacy team to use with clients

Catholic Charities has a respite program [(518) 449-2001]

\$500 grant→can't be on Medicaid

S counties

Next ACLTC Symposium Series Presentation

**September 22st – 9:00 AM; American Red Cross Building, 33 Everett Road,
Colonie, NY**