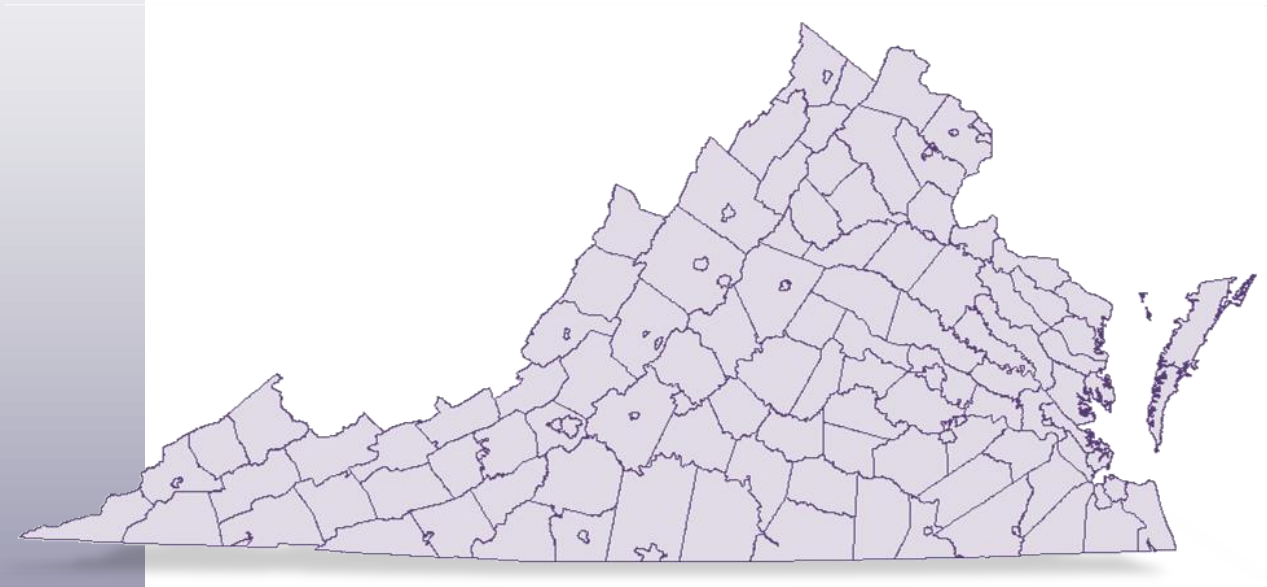
Suicide and Placement for Nursing Home or Hospice Care in Virginia



VDH VIRGINIA DEPARTMENT OF HEALTH
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A report from the Virginia Violent Death Reporting System

Commonwealth of Virginia
Virginia Department of Health
Office of the Chief Medical Examiner

February, 2014

Suicide and Placement for Nursing Home or Hospice Care in Virginia

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This report was created to provide information that can be used to prevent violent death in the future. Please notify Marc Leslie (see contact information above) if you distribute or use any portion of this report for training, education, policy decisions, or other uses.

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Other Reports Available from the VVDRS at http://www.vdh.virginia.gov/medExam/NVDRS.htm

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INTRODUCTION

The elderly population in Virginia is growing. Estimates suggest that by the year 2030, the 65 and older population in Virginia will double in size to 19% of the overall population.[1] As the population ages and people continue to live longer, likely with chronic diseases and other health conditions that limit mobility and independence, the need for hospice and nursing home care will also increase. As of 2011, just over 28,000 Virginia residents were in a nursing home;[2] this number will surely grow as the population ages.

This paper examines suicides related to nursing home admission and hospice care, including persons whose suicides are, in part, a reaction to a loved one's admission to nursing home or hospice care.

DATA SOURCES

Violent death data used in this report come from the Virginia Violent Death Reporting System (VVDRS). The VVDRS is part of the National Violent Death Reporting System (NVDRS). The NVDRS documents violent deaths that originate within a state's borders.[3] It compiles information from sources used in violent death investigation, and links decedents to circumstances to explain such issues as the role of substance abuse and mental health in suicide, and the connection between physical health problems and suicide. The VVDRS is the operation and reporting system of the NVDRS within Virginia, and uses the same methodology, definitions, coding schema, and database as the NVDRS.

The VVDRS abstracts death investigation information from several sources, primarily the Office of the Chief Medical Examiner, law enforcement, the Virginia Division of Health Statistics, Vital Records, and the Virginia Department of Forensic Science. Deaths entered into the VVDRS are reconciled with deaths reported by the Virginia Division of Health Statistics and the Virginia Office of the Chief Medical Examiner for the purpose of comprehensive case identification.

TERMINOLOGY

The term "nursing home" is used here to encompass a range of facilities that provide housing and medical care for persons who are no longer able to care for themselves. The essential component of a nursing home is that the persons who reside there cannot live independently and must depend on someone else for assistance with activities of daily living. Excluded from this definition are persons who live independently in their own homes or apartments in senior-only communities.

The phrase "physical health problem" will be used in this report to discuss a problem that is causally related to a suicide. A suicide is related to physical health problems when one of two specific criteria is met. One, the person who dies from suicide explicitly communicated that their suicide was due to a physical health problem. This could be done in a suicide note or by telling someone prior to the suicide. Two, there are no known reasons for why the person would choose suicide, but he or she had a physical health issue that was either terminal or debilitating to the point where he or she could no longer

[1] Cai, Qian. (April, 2009). "Virginia's Diverse and Growing Older Population." *The Virginia NEWS LETTER, 85.*
[2] National Center for Health Statistics. (May, 2013). *Health, United States, 2012: With Special Feature on Emergency Care.* Retrieved from http://www.cdc.gov/nchs/data/hus/hus12.pdf
[3] Persons who die in Virginia, but were residents of another state, are excluded.

function independently without some form of assistance, either from another person or from a medical device (e.g., reliance on an oxygen tank for breathing).

SCOPE OF THIS REPORT

Four groups of suicide decedents are discussed in this paper. They are:

1. Persons who have a loved one in hospice care or in a nursing home (*n* = 17). This loved one is typically a family member. These persons are stressed over their loved one's illness and facing the potential death of their loved one in the near future.
2. Persons for whom hospice care will soon be needed or who are in hospice care (*n* = 22). These are persons who are dying.
3. Persons whose suicide was motivated, at least in part, to avoid entering a nursing home (*n* = 36). In many cases these persons would have been placed in a nursing home in the near future. This group also includes persons who explicitly link their suicides to fear of going into a nursing home, whether or not that placement is imminent.
4. Persons who die by suicide while they are nursing home residents (*n* = 45). This group is comprised of people who, in all likelihood, would remain in nursing home care for the rest of their lives.

Combined, these four groups comprise 1.5% of all suicide decedents, 6% of suicide decedents ages 60 and over, 10% of those ages 70 and over, and 14% of those ages 80 and over.

These persons are typically male (83%), White (98%), and older (median age of 79) when compared with other suicide decedents. Most of these persons used a firearm to complete the fatal injury (62%), followed by hanging/suffocation (11%), poisoning (9%), and a fall from a high place (9%).

Table 1 presents highlighted summary information about these four groups.

Table 1. Suicide and Nursing Home or Hospice Placements: Selected Characteristics Among Four Groups (Number and Percentage)

	Loved One in Hospice/Nursing Home (*n* = 17)	In Hospice Care (*n* = 22)	Possible Nursing Home Admission (*n* = 36)	Current Nursing Home Resident (*n* = 45)	Total (*N* = 120)
Gender	Male (15, 88%)	Male (21, 96%)	Male (31, 86%)	Male (32, 71%)	**Male (99, 83%)**
Race	White (17, 100%)	White (22, 100%)	White (35, 94%)	White (44, 98%)	**White (117, 98%)**
Age Groups	Ages 75-84 (6, 35%) Ages 85 and older (4, 24%)	Ages 65-74 (9, 41%) Ages 75-84 (8, 36%)	Ages 75-84 (19, 53%) Ages 85 and older (10, 28%)	Ages 85 and older (18, 40%) Ages 75-84 (15, 33%)	**Ages 75-84 (48, 40%) Ages 85 and older (33, 28%)**
Median age	75	72	81	83	**79**
Marital Status	Married (14, 82%)	Married (10, 46%)	Widowed (17, 47%)	Widowed (19, 42%)	**Married (50, 42%)**
Method of Fatal Injury	Firearm (14, 82%)	Firearm (19, 86%)	Firearm (29, 81%)	Firearm (12, 27%)	**Firearm (74, 62%)**
Place of Fatal Injury	House or Apartment (15, 88%)	House or Apartment (22, 100%)	House or Apartment (34, 94%)	Nursing Home (37, 82%)	**House or Apartment (74, 62%)**
Two Most Common Circumstances	Mental Health Problem (11, 65%) Crisis in Past Two Weeks (5, 29%)	Physical Health Problem (21, 96%) Crisis in Past Two Weeks (6, 27%)	Physical Health Problem (27, 79%) Mental Health Problem (18, 53%)	Mental Health Problem (26, 63%) Physical Health Problem (17, 42%)	**Physical Health Problem (68, 60%) Mental Health Problem (60, 53%)**
Toxicology – Positive Results	Alcohol (4, 27%)	Alcohol (2, 10%)	Alcohol (1, 3%)	Opiates (1, 14%)	**Alcohol (8, 7%)**

PERSONS WITH LOVED ONES IN HOSPICE/NURSING HOMES

These decedents are overwhelmingly male (88%) and White (100%) with a median age of 75. Most of these persons were married at the time of the suicide (82%). A firearm was the most common method of fatal injury (82%). Most of these persons (88%) committed suicide at home.

Nearly two-thirds (65%) of these persons had a noted mental health problem and 71% were noted to have a depressed mood prior to the suicide. Among those with a mental health problem the most common diagnosis was depression (91%).

Nearly one-third (35%) sent out clear warning signs of self-harm by disclosing intent to commit suicide and/or having prior non-fatal suicide attempts. More than one-fourth (29%) had a crisis in the past two weeks that contributed to the suicide; for 60% that crisis was having a loved one placed in hospice care.

Even though these persons were, at least in part, reacting to a loved one being placed for nursing home or hospice care, 18% also had a physical health problem of their own that was related to the decision to carry out the suicide. Of these persons, 100% were dealing with chronic and severe pain, 33% had heart problems, and 33% had cancer.

Nearly one-fourth (24%) of these persons were known to consume alcohol prior to the suicide with 12% having a Blood Alcohol Concentration (BAC) of .08 or greater.[4]

PERSONS IN HOSPICE OR NEARING HOSPICE CARE

This second group is made up of persons who were either currently in hospice or whose illnesses had progressed to the point where hospice care would have occurred in the near future. This group is also typically male (96%) and White (100%) with a median age of 72. Many of these persons were married (46%) with a sizeable proportion being widowed (27%). Most of these persons used a firearm in the fatal suicide (86%). All (100%) committed suicide at home.

The most common trait for these persons was a known physical health problem that led to the suicide (96%). For those with such physical health problems, nearly half (47%) had cancer. The most common cancer sites were the testicles (40%), the pancreas (10%), and the colon (10%).

Mental health problems were relatively uncommon (23%). Among those with a mental health problem the most common diagnosis was depression (80%).

More than one-third (36%) of these decedents signaled their suicide risk by disclosing intent to commit suicide and/or having prior non-fatal suicide attempts. More than one-fourth (27%) had a crisis in the past two weeks that contributed to the suicide; most of these crises (83%) were related to the diagnosis or the worsening of the physical health problem.

Ten percent had alcohol in their system at death.

[4] A BAC of .08 or greater is the legal standard for driving while intoxicated in Virginia. Although individual tolerance varies, the level of .08 is used as an indicator of possible intoxication.

PERSONS FACING NURSING HOME ADMISSION

These suicide decedents were persons with suicides explicitly or implicitly related to fear of having to go into a nursing home, including persons who had already been in a nursing home and may have had to return. Persons in this group either told someone prior to the suicide that they would never go into nursing home care, or their suicide was clearly related to the timing of a possible nursing home admission. Most (94%) committed suicide at home.

These decedents are mostly males (86%) and White (94%) with a median age of 81. They were largely widowed (47%) or married (33%). Most persons used a firearm in the fatal suicide (81%).

Nearly four-fifths (79%) of these persons had a physical health problem that led to the suicide. Most of these health problems were chronic diseases or disabling conditions such as heart problems (29%), diabetes (21%), mobility/paralysis issues (21%), lung or breathing problems (14%), or sepsis (14%).

Additionally, 53% had a known mental health problem. Among those with a mental health problem, 72% had been diagnosed with depression.

Half of these persons disclosed intent to commit suicide to someone else prior to the fatal attempt and with time for intervention. Nearly half (47%) had a crisis in the past two weeks that led to the suicide. For 75% of those with a crisis, the crisis was either an impending move into a nursing home or the issue of nursing home care being discussed as a possibility.

Three percent of these persons had alcohol in their system at the time of their death.

PERSONS IN NURSING HOMES

The fourth group is persons who were already in nursing home care at the time of the suicide. These persons are mostly male (71%) and White (98%) with a median age of 83. The percentage of decedents who are male is disproportionate; nationwide, males constitute 33% of nursing home residents.[5] These persons were primarily widowed (42%) or married (31%). Most of these persons (82%) committed suicide in the nursing home.

Like the other groups, firearms were the most common method of fatal injury (27%); the other groups, however, had a notably higher frequency of firearm usage (average of 81%). Other common methods for this group included hanging or suffocation (22%), a fall from a high place (22%), poisoning (13%), and sharp instruments (11%). This higher prevalence of other methods suggests that lack of access to firearms in long-term care facilities increases use of other suicide methods. The other markers for firearm usage (male, White, older) are in place for this group, so a large percentage using a firearm would be expected.

Physical health problems were known to contribute to the suicide of 42% of these persons. Some of the more common health problems were hypertension (23%) and generalized health problems due to aging (15%). While 15% of these persons had health problems that were terminal, 54% had health problems

[5] Center for Medicare and Medicaid Services. (n.d.) *Nursing Home Data Compendium. 2012 Edition.* Retrieved from http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/nursinghomedatacompendium_508.pdf

that limited their independence and 39% expressed hopelessness that their health problem could be resolved.

Mental health problems were a known factor for 63%. Most of these persons with a mental health problem (96%) had a diagnosis of depression; other common diagnoses included anxiety disorder (15%), bipolar disorder (8%), and dementia (8%).

Nearly half (49%) sent out clear warning signs by disclosing intent to commit suicide and/or having prior non-fatal suicide attempts. The proportion with a crisis in the past two weeks is the lowest of the four groups (17%). Most of those persons with a crisis were reacting to being admitted to a nursing home (43%), but an additional 29% were reacting to intimate partner problems.

Three percent had alcohol in their system at death. Fourteen percent had opiates in their system, which were most likely prescribed opiates.

CONCLUSION

The suicides described in this report were related to an issue – nursing home or hospice placement for care - that is difficult to resolve. Persons typically enter hospice care and nursing homes as an act of last resort related to health problems, an inability to live on their own, or the need for end of life care. This creates unique challenges in applying suicide prevention techniques that could alleviate these problems.

The period of time prior to entering a nursing home is a period of high suicide risk, particularly for elder White males. While there are some recent efforts to prevent suicide among persons who are already in nursing homes and other senior living facilities[6] the issue of preventing suicide among those who may have to enter such a facility is a topic that should be addressed.

This report suggests two critical types of persons in these decedents' lives. The first, of course, are spouses, friends, and family to whom a person discloses their intent to end their lives. These persons should assist their friend or family member in finding help in adjusting to a nursing home placement or finding alternatives to a placement. The second are health care providers, those providing mental and physical health care to their patients. The data presented here suggest that pain and chronic illnesses significantly eroded an elder's ability to live independently. Responding to suicide risk will require that physicians and other health care providers be aware of these risks among their elder patients and work with their mental health colleagues in assessing for and addressing suicide intent. And, as these data suggest, outreach must also include spouses and other family members who are at risk for suicide when their family members face a placement in nursing home or hospice care.

A theme in these suicides is fear of going into a nursing home, a fear that seems to eclipse the fear of dying. While this fear is undoubtedly tied to the loss of independence or the loss of home, there is also a clear link to the unpleasantness of living in a congregate setting such as a nursing home. One possible avenue for reducing suicide would be to introduce congregate care options that soften the medical model characterizing so many of these institutions. Hospice programs take that step by emphasizing

[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2011). *A Guide to Promoting Emotional Health and Preventing Suicide in Senior Living Communities*. Retrieved from http://store.samhsa.gov/shin/content/SMA10-4515/Guide.GettingStarted.pdf

care for the whole person: medical, emotional, and spiritual support. Other features of congregate care for nursing home patients could include emphases on communities of care that encourage friendships and shared responsibilities between residents.

These types of suicides make up a relatively small proportion of the overall suicide problem. However, as the population ages and continues to live for longer periods, it is likely that the need for congregate care and hospice care of some sort will increase, and these types of suicides will also increase if no workable alternatives are identified.