Suicide in Long-term Care settings
What to know, what to do, how to help

Screen for depression. If PHQ-9 is normal, still keep watch for objective signs:
- Change from baseline
- Disinterest in eating, poor sleep
- Distinguish apathy from resignation

Understand risk factors for suicidal thinking (even in the absence of depression)
- Just moved in!
- Spouse died
- Loss of function
- New cancer dx.
- Hx. Depression
- Hx. Attempt
- Access to means
- Intent
- Hopelessness
- Older white males highest risk – guns and hanging
- **4 D's: depression, debility, deadly means, disconnectedness**
- **Not everyone who is suicidal is depressed!**

Aggressively treat depression with talk therapy and medications; consider ECT

*Know when meds **aren't** going to help and stop them – they can make things worse*

Sending someone to the hospital reflexively may cause more harm than benefit – 15 minute checks can be done in house

Dementia is the elephant in the room – must be measured and considered in context

Plan more supervision, engagement during transitions

Reduce number of changes and losses

Assign consistent staff and identify staff "buddy"

Allowing death to occur is not causing death to happen – understand "rational SI"

What mitigates risk? MEANING AND PURPOSE