Mental health in later life – who is giving up?

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Key contexts

• Ageism
• Transition to long-term care
• National suicide strategy
The ONS in England and Wales, define suicide as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent (ONS, 2017).

‘Care home’ includes a variety of NHS, local authority and private nursing/care/residential homes. Also included are homes for the chronic sick; homes for people with mental health problems and non-NHS multi function sites. Figures are for people who died in a care home, and so do not include, for example, care home residents who were transferred to hospital shortly before their death’.

ONS data provides the number of suicides by place of death, sex and age-group, England and Wales, registered between 2011 and 2016.

<table>
<thead>
<tr>
<th>Date</th>
<th>Males 65+</th>
<th>Females 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>2012</td>
<td>4</td>
<td>7</td>
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<td>2015</td>
<td>8</td>
<td>4</td>
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<td>2016</td>
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The majority of studies (n=8) focused on identifying risk factors associated with the individual. The most common individual risk factors included:

- Depression (documented or diagnosed in 67% of NH residents who suicided)
- Duration of residence in the nursing home (<12 months)
- Decline in physical health

Other individual risk factors examined included:

- Prior suicidal behaviour
- Cognitive function
- Personal loss

Only one study (Osgood, 1990) examined any organisational risk factors associated with the nature of the nursing homes in which suicides occurred.

No broader structural risk factors such as policy factors or those relating to the broader community were considered among eight the studies.

None of the studies formally examined interventions nor discussed recommendations for organisational or structural change to reduce suicide risk in nursing homes.

Lack of consensus in literature in regards to:

- Distinguishing between some suicidal behaviours;
- the relationship between suicide attempts and suicide completion, particularly among older people; and
- in classifying indirect or passive forms of life-threatening behaviour as suicide, particularly in the nursing home setting.

Mezuk, 2014 highlighted difficulties in understanding suicide risk in these settings because of inconsistent terminology for suicidal behaviours and the use of broad outcome measures.

Important to examine each type of suicidal behaviour independently to better understand and predict the risk of these behaviours (Nock & Kessler, 2006), and to appropriately utilize prevention resources (Moscicki, 2001)
Systematic reviews (2)

25 studies (1990-2016) – 5 in the UK

Most commonly used is the Geriatric Depression Scale

• 15 item screening tool, used in variety of settings and countries
  • Are you in good spirits most of the time? Yes/No
  • Do you often feel helpless? Yes/No
  • Do you think it is wonderful to be alive now? Yes/No
  • Do you feel pretty worthless the way you are now? Yes/No

1. How prevalent is depression, self-harm & suicidal behaviour in residential care?

2. How are these measured, and how effective are these measures?

3. What interventions have been used to prevent, identify or address these issues?
Interventions (18 studies addressed this)

Staff training

- Primarily in recognising or screening for depression
- Positively received by staff
- Few actually measured the impact or outcomes of this training on levels of depression in residents
- Therapeutic interventions show decreases in depression
- Care-planning (2) shows positive outcomes
‘Giving up’ /‘Turning to the Wall’

• ‘Everyone knows someone’

• Passive ideation and behaviour

• Discourse of silence

• Significant role of the care home workforce

• Organisational factors and professional expertise
Study design

Research questions

1. What is meant by the term ‘giving up’ from the perspective of care staff working in care homes and how is this described, conceptualised and understood by those who are involved?

2. What happens in care homes when an older person is identified as ‘giving up’ and what can we learn from care staff experiences about their needs and the needs of care staff looking after them within these situations?

3. What factors are commonly identified by care staff in relation to prevention, early intervention and support for older people ‘giving up’ and their loved ones?

- Co-produced with stakeholders
- 3 peer researchers
- Focus groups using a vignette
- Inductive approach to data analysis

### Table 3: Characteristics of Focus Group Sample

<table>
<thead>
<tr>
<th>Home</th>
<th>Focus group participants</th>
<th>Care Quality Commission rating</th>
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</table>
| 1 Private   | 8 carers                 | Overall ‘good’
| 2 Private   | 8 carers                 | Accommodation for persons who require nursing or personal care, Dementia, Caring for adults over 65 yrs |
| 3 Charity   | 1 manager, 6 carers      | Overall ‘good’
| 4 Charity   | 1 deputy manager, 9 carers | Accommodation for persons who require nursing or personal care, Dementia, Caring for adults over 65 yrs |
| 5 Total     | Total 33                 |                                                                                                                                 |
Key findings

The meaning of ‘giving up’

Staff are well aware of residents’ emotional states and observed:

- not eating, talking, slowly withdrawing
- statements :“ ready to go “, “what’s the point of living?”
- “he really went down”, “it was his time and that was it”
- anger & aggression over their circumstances
- trying to assert their power & identity

“he was determined, he wouldn’t get out the bed, the family were brought in here, and I thought it might help. He was really charming, you’d sit with him and he just made you feel warm inside you know. But he thought that his wife should have looked after him though and she shouldn’t have given up on him. Then he went to hospital and that was it … The son used to get mad and cross with him, because he’d got the grandkids, but that wasn’t, it was his time he’d decided, and that was it.”
(Care worker, focus group 2)
Responding to a ‘giving up’ situation

“I had my friends and now I’m here with strangers, I don’t know who they are. I’m here with people who have to look after me yes. When I was in my own home it would take me two and a half hours to get myself washed and dressed but I did it myself. Here somebody is washing me. It could be somebody who could be my granddaughter’s age ... It’s a lot to take on board when you go into a residential home”.

(Care worker, focus group 1)

Recognition that residents were coping with multiple losses:

- Independence
- Health
- Partners
- Family
- Network of friends, neighbours etc
- Resources e.g. homes, financial
Prevention, intervention and support

• In the discussion groups staff described some of the strategies, both practical and psychological, they used to try to alleviate the sadness and emotional pain that residents displayed:
  
  • Talking 1-1 and spending time with individual residents
  • Building special relationships
  • Distraction e.g. with other activities
  • Giving space, & showing respect
  • Encouraging families to visit in order to maintain a sense of connection
  • Recording changes in mood and behaviour
  • Referring on to senior staff, managers or other specialised services

“Most time what staff does is to try to prompt him, divert his attention from there. We will never accept that fact, oh you want to die, okay oh go on with it – no we will try to get him out of it, if there is a football or TV show going on, how to catch their focus and get them out of their … or do you want a cup of tea, to make them happy. But this strategy we always use”.

(Care home deputy manager, focus group 3)
Other challenges:

- Preferred familiarity of care setting against the need for hospital care
- Tension between relatives and residents’ perspectives on wishes about dying
- Need for meaningful relationship as well as practical care
- Respecting and acknowledging residents’ feelings
- Importance of developing personal relationships with residents
- Meeting spiritual/religious needs

“You never get used to it, I said you find ways of dealing with it, but I said I never think of this job that this is their last stop before they go on to heaven or wherever, you don’t think of the job like that.”
(Care worker, focus group 2)

“But what we feel, I think all of us together, we feel that if just someone would listen to us, instead of all this, there’s a medical thing, there’s a psychiatric thing, and they’d come together and work together, because this gentleman needs help and help now and things need to be put in place which would stabilise him.”
(Care Worker”, focus group 2)
Summary

Our findings paint a complex picture, highlighting tensions in providing the right support and creating spaces to respond to such challenging situations. ‘Giving up’ requires skilled detailed assessment, better conversations, to respond to risks alongside improved training and support for paid carers, to achieve a more holistic strategy which capitalises on significant relationships within a wider context.
Some reflections and recommendations

We need to **maintain and review** research and **knowledge** about depression, self-harm, and suicide ideation and behaviours impacting on older people living in care homes to **understand** and predict risk better and to **understand mental health** in the context of the **institutional environment** in which it occurs in order to develop appropriate and applicable **prevention** strategies.

Increased **standardisation** of recording **suicide behaviour** in care homes is needed to be able to understand fully the extent of ‘giving up’ in residents and to plan and understand ways to respond to it.

Know more about **what works** and how to promote and sustain interventions.

Wider involvement of **older people themselves** and those involved (Paid carers/family carers/ community based professionals) in both talking about the issues and developing community based interventions.
Thanks for listening

If you are interested in following our next project steps or want to be involved, please contact:

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