Self-harm in late life

How can the GP help?

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In late life, self-harm and suicide are closely associated. Thus, good assessment and management of self-harm may prevent suicide. GPs, with their knowledge of the medical, social and psychological issues of their patients, are well placed to intervene and co-ordinate care with relatives and with healthcare and community services. Moreover, GPs are often the first port of call for the older distressed person, and the next port of call after discharge from hospital.

KEY POINTS

- Self-harm is any act of self-injury or self-poisoning, regardless of motivation. This includes indirect self-harm, such as refusing to eat or drink or to take essential medications.
- Self-harm in an older patient should be a red flag for GPs (and all clinicians) to consider suicide risk.
- Understanding what is driving an individual to self-harm may direct intervention.
- The acuity and intent of an individual's self-harm thoughts or actions, access to means and the resources available to him or her will help determine the setting of care and an appropriate response.
- Problems underlying self-harm may be broken down into areas for action by healthcare professionals and other service providers, with the GP in a co-ordinating role.
- Carers are an integral part of effective patient care and are individuals who require support in their own right.
- GPs of older patients who have self-harmed may experience feelings of helplessness. Peer support and resources that promote self-care for medical practitioners are important.

Self-harm occurs predominantly in younger people, often as a way to cope with intense stress or emotional pain rather than with intent to die.[1] However, older people self-harm too, and when they do it is more likely to be with suicidal intent. In fact, suicide rates globally peak in older men. In Australia in 2017, the death rate from suicide was 32.8 per 100,000 men aged 85 years or more – the highest rate of any age group.[2] Suicide rates progressively increase across five-year age bands from 60-64 to 90-94 years for men and become higher at the age band 85-89 years for women.[3] Overall, the most common means of suicide in older people is hanging, followed by firearms/explosives, drug poisoning and nondrug poisoning (e.g. motor vehicle carbon monoxide).[4]

When older people self-harm it should be a red flag for GPs (and all clinicians) to consider suicide risk. Older people who self-harm and those who die by suicide share common risk

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1. FACTORS ASSOCIATED WITH SELF-HARM IN LATE LIFE[6,12-14]

- Living alone, limited social support
- Previous suicide attempts or self-harm
- Psychiatric illness or symptoms: mood disorders (especially depression, but also bipolar disorder), anxiety (including health anxiety), schizophrenia
- Alcohol misuse
- Cognitive impairment (early cognitive decline)
- Physical illness (e.g. chronic worsening disability, chronic pain, delirium, malignancy, neurological disorders, liver disease, male genital disorders)
- Life events (e.g. childhood adversity, physical and sexual abuse, recent bereavement)
- History of limited coping skills in adversity

factors.[5] Self-harm in older people is associated with greater intent to die, higher lethality attempts and subsequent death by suicide.[5,6] A large Australian community study of adults aged 60 years or more found that the two-week prevalence of suicidal ideation was 4.8%.[7] By comparison, a Canadian study of people aged 55 years or more found a one-year prevalence of suicidal ideation of 2.2%; the prevalence of a suicide attempt over the same period was 0.13%.[8] The estimate of lifetime suicidal thoughts was 8.7% and of suicide attempts was 1.8%.[8]

This article focuses on how to assess and manage self-harm in older people in primary care. A previous article, published in the August 2018 issue of *Medicine Today*, dealt with repetitive self-harm in younger people.[1]

What is self-harm?

Self-harm is any act of self-injury or self-poisoning carried out by individuals, regardless of their motivation.[9] Obvious to most clinicians is direct self-harm, namely acts such as taking an overdose, self-cutting or hanging. Ingestion of drugs is by far the most common method of self-harm in older adults, followed by self-cutting and other methods.[10] What is often not thought of, but still considered self-harm, is indirect self-harm – that is, an act of omission or commission that indirectly causes self-harm over time leading to death (e.g. refusing to eat or drink or to take essential medications). Indirect self-harm in nursing homes is more likely in older people with dementia, greater functional impairment and more behavioural and psychiatric disturbance.[11]

Why do older people self-harm?

In epidemiological studies, various demographic, psychiatric, medical and psychosocial risk factors have been associated with self-harm in late life (Box 1).[6,12-14] Although men and women are equally likely to self-harm in late life, men are more likely to die by suicide, one reason being that the means chosen tend to be more lethal.[13]

Many of the risk factors for self-harm identified through quantitative approaches, however, are common to most older people. The relationship between these factors is poorly understood and their meaning may vary between individuals, so it is difficult to know where to focus clinical interventions. Qualitative studies have helped answer these questions. When older people themselves have been asked why they have self-harmed, important themes have emerged (Box 2).[15-19] There is a myriad of personal reasons underlying self-harm in older people, and understanding what is driving an individual may directly inform points of intervention.

Interestingly, carers and GPs of older people who have self-harmed identify similar reasons to patients for the self-harm, but carers may not communicate their concerns to GPs.[20,21] Carers may, often erroneously, assume their relative has disclosed depression or suicidal ideation to their GP.[21] This is especially telling because psychological autopsy studies have similarly revealed that although carers can identify suicide risk factors in their older relative – and more so than the patient's GP – this knowledge was not communicated, suggesting that strategies for strengthening communication represent a key opportunity for change in practice.[22] Even one year after self-harm these 'secrets' may persist, with patients and carers not disclosing repeat self-harm to GPs and mental health professionals.[23]

2. WHY DO OLDER PEOPLE SELF-HARM? THEMES FROM QUALITATIVE STUDIES[15-19]

- Feeling disconnected from others; loneliness
- 'Enough is enough' – a long life has been lived
- 'My ageing body is letting me down', 'I'm falling apart'
- Feeling like a burden
- Cumulative adversity (e.g. migration, early trauma, death of adult children)
- Hopelessness and endless suffering
- Helplessness, with rejection or invalidation from relatives and/or clinicians
- Untenable situations (e.g. elder abuse, family conflict, need for nursing home placement)
- Loss of and regaining control

Clinical assessment and management

Preventing self-harm in older patients

Older people may have physical health comorbidities that bring them to their GP regularly, often resulting in long-lasting therapeutic relationships. Given the myriad of reasons for self-harm in late life, this clinical encounter represents an opportunity for GPs to deal with distressing symptoms and to screen for psychiatric illness, social stressors, and cognitive and functional impairment, especially as patients may not present with self-harm or suicidal ideation. It is important to understand the meaning of the problem to the older person in light of the themes outlined above (Box 2), as this may guide management.

Older people who have self-harmed have described invalidation of their concerns, lack of privacy to disclose abuse or an untenable situation, perceived rejection or non-responsiveness by clinicians and family, and hopelessness as barriers to receiving assistance before self-harm occurs.[18] Thus the

responses of the GP (and other healthcare professionals) to an older person's issues can serve to reinforce or diminish the distress. Comprehensive multidisciplinary and palliative management of distressing physical and psychological symptoms in older people may prevent despair and a sense of abandonment by healthcare professionals. Practical tips for clinical assessment are presented in Box 3.

Responding to disclosures of self-harm thoughts or action

If an older person reveals thoughts of being 'better off dead', self-harming or suicide then a more detailed assessment is needed. This includes exploring when and why these thoughts or plans have arisen. Patients should be asked what they have considered doing and if there has been any action on these thoughts. Careful questioning might determine if they have a means of self-harm or suicide, if they have decided when they would act or if they have made any arrangements in anticipation of their death (e.g. completing a will, giving away possessions). If a patient has means for self-harm then plans should be made urgently to remove access, including by enlisting carer assistance.[24]

It is important to know if a patient has a history of self-harm or suicide attempts, as there is a high risk of repetition.[25,26] The interpersonal supports and personal strategies that a person has to cope with his or her situation and distress should be explored. Unhelpful coping strategies such as substance misuse (especially depressant drugs such as opioids, alcohol or benzodiazepines), which may exacerbate distress or lead to impulsive self-harm, should be highlighted and discussed with the patient. Plans should be made to reduce access (e.g. by removing or limiting the supply of such medication or alcohol in the home) and encourage alternative coping mechanisms. Beware sudden calm in a previously distressed person because this may indicate his or her decision to die by suicide. If there is acuity of risk and intent to self-harm then an immediate plan should be made to address safety (Box 4).

Involving carers

Patients should be encouraged to permit the GP to communicate with their carer, but if they do not and there are disclosures suggesting risk of self-harm or suicide, a breach of confidentiality may be justified.[27,28] This should be explained sensitively to the patient and time should be allocated to speak to the carer separately about their concerns and the GP's regarding self-harm. Carers may be a good source of corroborative history about the patient (and often know much about suicide risk factors), and generally want to be involved and informed about clinician plans.[21,22] They can also be allies in treatment, informing the management plan, knowing what is realistic and possible, assisting in reducing access to means of self-harm, helping monitor symptoms and co-ordinating services for the older person. An open approach helps address the secrecy and poor communication known to occur in self-harm in older people.[23]

Carers of older people who have self-harmed describe intense emotional responses to the self-harm including anger, difficulty empathising, guilt and self-blame that the self-harm occurred, and their own emotional distress (shock, exhaustion, depression and helplessness).[21] They may also experience additional carer burden after self-harm in their relative, through concerns about repetition of self-harm leading to greater supervision or need for practical assistance. Carers of older people who attempted suicide may have difficulty caring for the patient, become distressed, have difficulty coping and feel unable to support the older person, so increasing the older person's risk.[21,29] This suggests that GPs should routinely be asking about the emotional responses of carers and their feelings of burden and offering appropriate avenues of support.

New nursing home residents

Older people may be placed in a residential aged care facility following self-harm. Placement is a major life event often with negative associations and psychosocial losses.[30-33]

3. TIPS FOR CLINICAL ASSESSMENT OF SELF-HARM IN OLDER PEOPLE

- See the older person on his or her own
- Review the impact of the older person's symptoms on quality of life, mood and function
- Acknowledge distress associated with even 'the small things', such as pain or loss of vision
- Identify areas of suffering – physical, psychological, social or spiritual
- Ask directly about thoughts of or actual self-harm – a positive response should elicit more detailed assessment
- Screen for comorbidities – such as depression, substance misuse (alcohol, benzodiazepines and opioids in particular) or cognitive impairment – and flag the importance of managing comorbidities
- Convey optimism that the problem can be managed; be wary of reinforcing hopelessness
- Be wary of ageism: 'What do you expect at your age?'
- Involve specialist services where needed to assist with management
- Encourage the older person to allow his or her carer to be contacted for sharing of information and involvement in management
- Agree on a plan for treatment that focuses on alleviation of suffering
- Schedule another appointment to review progress

This outcome may be due to perceived or actual inability to manage the factors underlying self-harm in the home environment, a healthcare or family response intended to reduce recurrent self-harm (through greater supervision and reduced access to means), or recognition of functional impairment and high-care needs.

Some older people who have self-harmed and subsequently move into nursing homes describe feelings of defeat, misery, demoralisation, 'waiting to die' and difficulties accessing care.[23] The helplessness and invalidation experienced by some older people before self-harming may be reinforced by placement for 'containment of risk', in turn increasing their distress

4. RESPONDING TO SELF-HARM/SUICIDAL IDEATION, PLANS OR ACTION

Acute risk

- Consider the most appropriate setting of care. Does the older person need to be assessed by a mental health clinician in a hospital emergency department or by an acute care team* with a view to admission or can the risks be managed at home with existing support (family, community services) and additional acute outpatient support?
- Assess the patient's level of insight, judgement and willingness to address their issues. If there is ongoing intent to self-harm and symptoms of mental illness combined with unwillingness to accept treatment, consider whether involuntary mental health assessment and treatment are needed (e.g. use of the Mental Health Act).
- Consider whether there is a need to break confidentiality in the interest of patient safety. Speak to carers about the disclosures of suicidal/self-harm ideation and gauge their willingness and/or ability to support the patient (e.g. closer supervision, removal of means of self-harm, assisting to meet the patient's unmet needs).†

Subacute risk (after resolution of self-harm/suicidal ideation or after self-harm)

- Match the underlying factors for self-harm identified in the patient's initial assessment to specific components of a plan to address them.
- Engage specialist medical help to address each of the contributing factors – e.g. geriatric services for medical problems; older persons mental health services; community aged care services for home support.
- Consider whether a psychologist may help with anxiety or depression, ongoing interpersonal difficulties and poor coping through a Mental Health Care Plan. Family therapy may also be indicated to help address ongoing conflict or interpersonal dynamics contributing to patient distress.
- Consider whether there is a need for more domiciliary support or services to meet the patient's needs. Is a My Aged Care referral needed?
- Remember that advance care directives may empower a patient who perceives that they have no control over poor health and chronic symptoms.
- Perform ongoing review of symptoms and enquiry about self-harm/suicidal ideation because there is a high risk of repetition.

* The mental health crisis phone numbers differ between states and territories (www.healthdirect.gov.au/crisis-management).
† For a more detailed discussion regarding the issues of confidentiality and consent in mental health care, see the editorial *Communication, confidentiality and consent in mental health care* (2014).[27]

and potentially driving further self-harm.[18] In fact, people who enter residential care are at greatest risk of self-harm in the year before and after placement.[33,34] Paradoxically, placement of an older person who has self-harmed may be considered by mental health services as solving the problem and specialist care be withdrawn, at the very time they are most at risk and need more support.[23] In addition, the patient's (often long-term) GP may change when they move into care, reinforcing the person's sense of abandonment. Nursing home residents who have self-harmed are therefore a key group for active social and emotional support and follow up from general practice and mental health services.[35]

GP care

For GPs, understanding their own responses to self-harm in their patients is important. GPs of older patients who have self-harmed often feel helpless in supporting their patients and preventing further self-harm.[20] Loss of hope, often engendered by other clinicians, makes this worse (e.g. 'Nothing can be done for your pain, or blindness, or walking difficulty, or ...'), as does a sense of abandonment by mental health services experienced by some GPs.[20] The GP's response needs to be understood, acknowledged and contained before it is conveyed to the patient. We strongly endorse peer support and other self-care initiatives for GPs, such as the RACGP's *Keeping the doctor alive: a self-care guidebook for medical practitioners* (www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20resources/Keeping-the-doctor-alive.pdf).[36]

Conclusion

Self-harm in older people is often multifactorial and complex and may communicate needs that the individual otherwise cannot express. Key to management is listening to the patient and understanding the underlying issues. The acuity of self-harm thoughts or actions and resources available to the older person will help determine the setting of care. Carers are an integral part of effective patient care, in sharing information and providing a corroborative history, as allies in management and as people requiring support in their own right. There should be a low threshold to involve specialist mental health services in the care of older people who have self-harmed. Problems underlying the self-harm may be broken down into areas for action and community, specialist and domiciliary services engaged to assist, with the GP in a co-ordinating role. MT

References

A list of references is included in the online version of this article (www.medicinetoday.com.au).

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