

Decreasing Suicide in Community Elderly: Recognizing Depression and Obtaining Treatment

Fuqua Center for Late-Life Depression

and

gahsa

Part IV: Assessing Suicide Risk

Depression Symptoms

- Depression and/or loss of pleasure
 - Loss of appetite or overeating
 - Insomnia (early morning waking) or hypersomnia
 - Psychomotor agitation/retardation
 - Fatigue
 - Feelings of worthlessness or guilt
 - Difficulty thinking or making decisions
 - **Recurrent thoughts of death or suicide**

Depression in Older Adults

- Additional criteria
 - Anxiety (“Sadless depression”)
 - Somatic problems/ physical complaints
 - Cognitive problems

Facts

- 85 -100 people a day
- “If all were on one aircraft that went down every other day, America would do something about it.”
- Cost of suicide related to depression: \$8 billion / year to the American economy
- 4 ½ days on average in hospital for suicide attempts
 - Up to 16 million a year in one county alone
 - Medical unit, rehab, PT, etc. (increase premiums)

Source: Paul Quinnet, PhD (DVD: Epidemiology of Suicide)

Prevalence

- 65+: highest rates of suicide of any age group (50% higher than the rate for 15 – 24 year olds)
- Older adults make up approximately 13% of the population and 20% of the completed suicides – this number is decreasing
- Even if the suicide rate remains the same the number of lives lost will skyrocket because of the growing number of older adults
- Older adults act with more serious intent
 - Completion
 - Younger: 100: 1
 - Older: 4:1 (not much ambivalence)

(Turvey, CL; Conwell, Y; Jones, MP; et al, Am J Geriatr Psychiatry, 2002)

(Paul Quinnett, PhD, Epidemiology of Suicide)

Suicide in Georgia

- 9th ranking cause of death in Georgia
 - Conservative: up to 50% of “accidents” may be suicides (i.e., one car accidents, jumping in front of a train)
- 70+ years: highest suicide rate (13% of suicides; rate nearly 3 times greater than rate for 15 to 19 years)

Video

Prevention begins by
recognizing depression,
risk factors for suicide and
the ability to alter those
risk factors

Long Term Risk Factors

- Depressive symptoms
- Patient's perceived health status
- Poor sleep quality
- Absence of a relative or friend to confide in

(Turvey, CL; Conwell, Y; Jones, MP; et al, Am J Geriatr Psychiatry, 2002)

Additional Risk Factors

- Personality trait or state
 - Anxiety
 - Timid
 - Restricted interests
 - Shy
 - Hypochondriasis – psychological pain physical terms
 - Hopelessness
 - Past attempts

Additional Risk Factors

- Neurobiologic and Genetic Risk
 - Family history of suicide, substance abuse
 - Less likely genetic predisposition
 - Possible change in brain chemical, perhaps age related

Additional Risk Factors

- Social milieu
 - Social isolation
 - Loneliness
 - Losses
- Psychiatric Illness
 - Single episode, unipolar major depression
 - Psychosis
 - Current substance abuse

Depression, poor sleep,
and limited social support
also contribute or predict
mortality by natural
causes as well as suicide.

Protective Factors

- Social Support
- Religion
- Varied roles in family, community, and religious organization

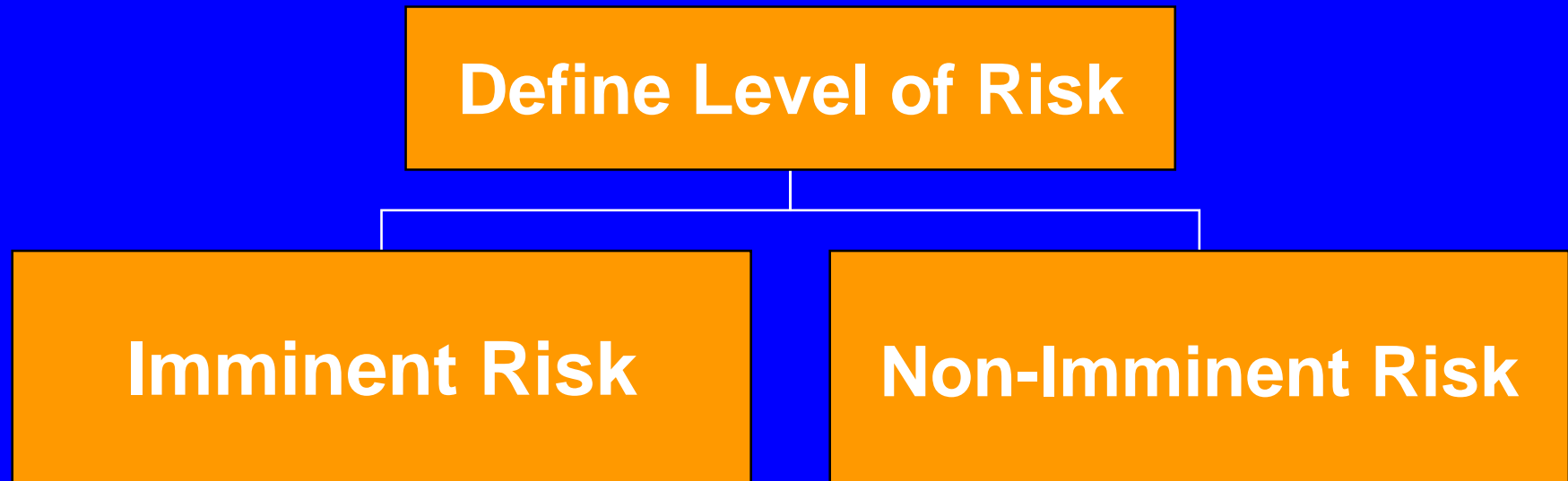
Recognition and Treatment

- 97 suicide victims - 51 been to see primary doctor in last 30 days and were older than those who had not been to doctor
 - 90% had psychiatric illness (45 patients)
 - 29 of those with psychiatric symptoms were recognized (Those not recognized were older, male and had greater # of illnesses)
 - 2/3 offered treatment: 4 refused, 13 inadequate doses, others given antianxiety medication instead of antidepressant
 - 1/3 of the 29 did not receive treatment, perhaps thought symptoms related to other illness or too frail for treatment

Involuntary Commitment

- Is the patient so ill that the situation requires involuntary inpatient treatment
- In your opinion, is the patient TODAY:
 - a substantial risk of imminent harm to self or others or
 - so unable to care for own physical health and safety as to create an imminently life-endangering crisis
- Is outpatient treatment an option?

Mental Health Risk Protocol



What Determines Imminent Risk ?

- **Psychosis (Uncontrolled Symptoms) - delusions or hallucinations**
- **Suicidal or Homicidal Threats**
- **Poor Hygiene**
- **Suspicion of System**

Appropriate Mental Health Services when Imminent Risk Present

- Mental Health Hotlines
- Suicide Hotlines
- Mental Health Inpatient Facility
 - If patient unwilling to admit self refer to facility that does Involuntary Commitment
- Closest Emergency Room - 911

**Suicide Can Not Always
Be Prevented**

SAMPLE DIAGRAM

The Role of Gatekeepers in Preventing Late Life Suicide in an Older Woman

Brief text describing why an older female at risk for suicide does not call for help...

Reasons for resistance to help seeking in older persons...

- Pervasive feelings of shame (I can't take care of myself).
- Suspicion of do-gooders (who put you in nursing homes).
- Fear of hospitalization and loss of personal control of one's life.
- Failing memory or failing mobility
- Fear of becoming a burden on others
- Onset of clinical depression

Who is in contact with at-risk elders and can be a gatekeeper for home-dwelling elders?

Consider training: Property appraisers, apartment and mobile home managers, telephone company personnel, police and sheriff's officers, ambulance companies, fire fighters, utilities personnel, postal carriers, pharmacists, trust and bank officers, meter readers, power company billing staff, fuel oil dealers, ministers, farm equipment dealers, telephone company staff – anyone with frequent contact with at-risk elders can be a gatekeeper!

What can gatekeepers observe?

- *Problems with personal appearance* (unshaven, dirty clothes, body odors, unkempt hair, etc.)
- *Conditions of the home* (poor repair, calendar on wrong month, little or no food, strong odors, too many cats, garbage, walks covered with snow, etc.)
- *Mental and emotional* - confusion, disorientation, inappropriate responses, forgetfulness, repetitiveness, distrust, fear of strangers

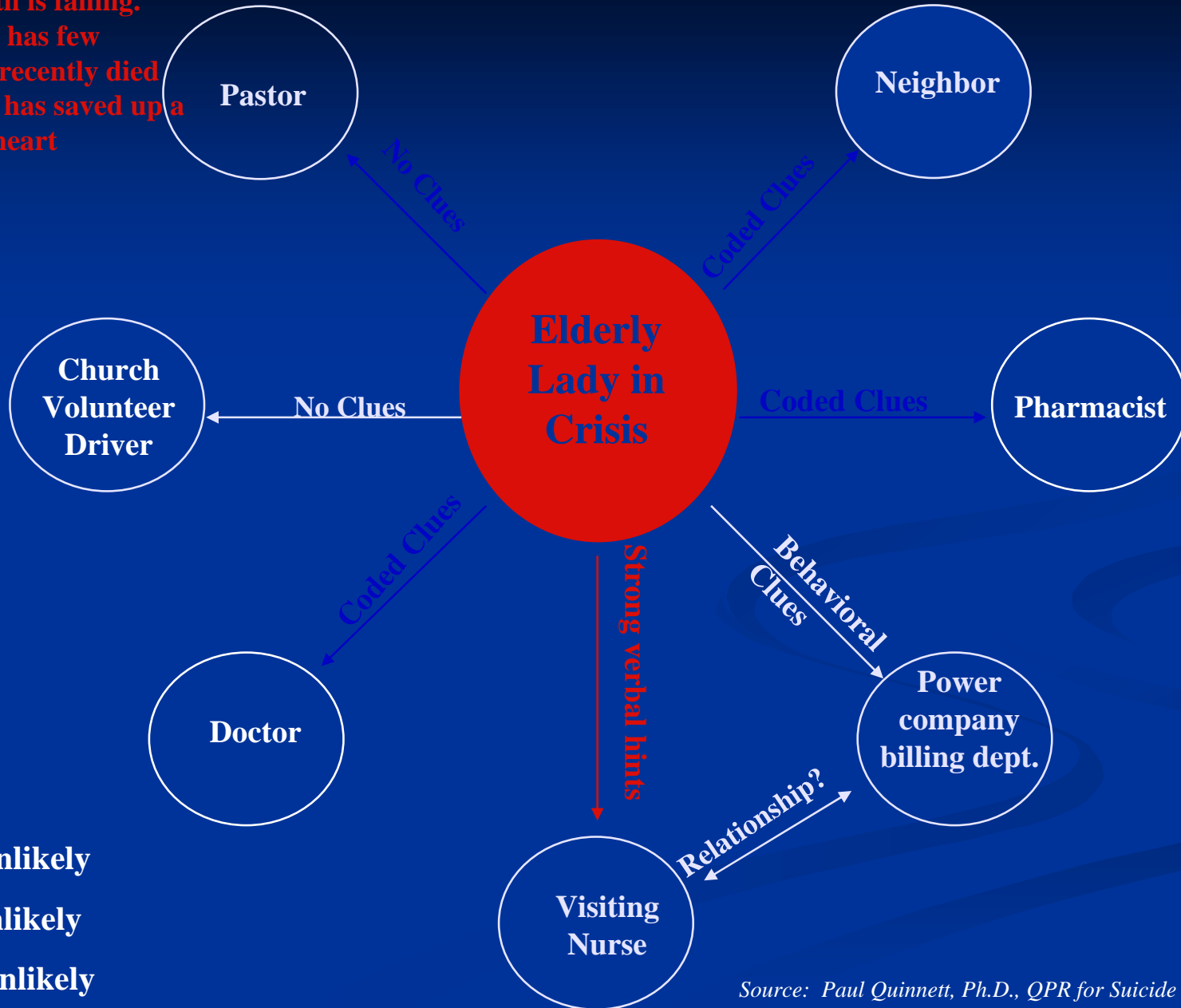
What more can gatekeepers observe and look for?

- Complaints of not eating
- Problems in sleeping
- Evidence of alcohol use (bottles piling up)
- Anger, irritability, hostility
- Appears sad or blue, talking of loss
- Physical losses? Compliant of hearing loss?
- Mobility losses? Now homebound?

Other things for gatekeepers to look for...

- Personality changes? Isolated, withdrawn, suspicions, angry? Is this different from earlier contact?
- Economic problems? Can't pay bills? Overpays or tries to?
- The warning signs of suicide.... Multiple losses? Suicidal communications (e.g., giving away personal possessions?)

Traditional Detection Network

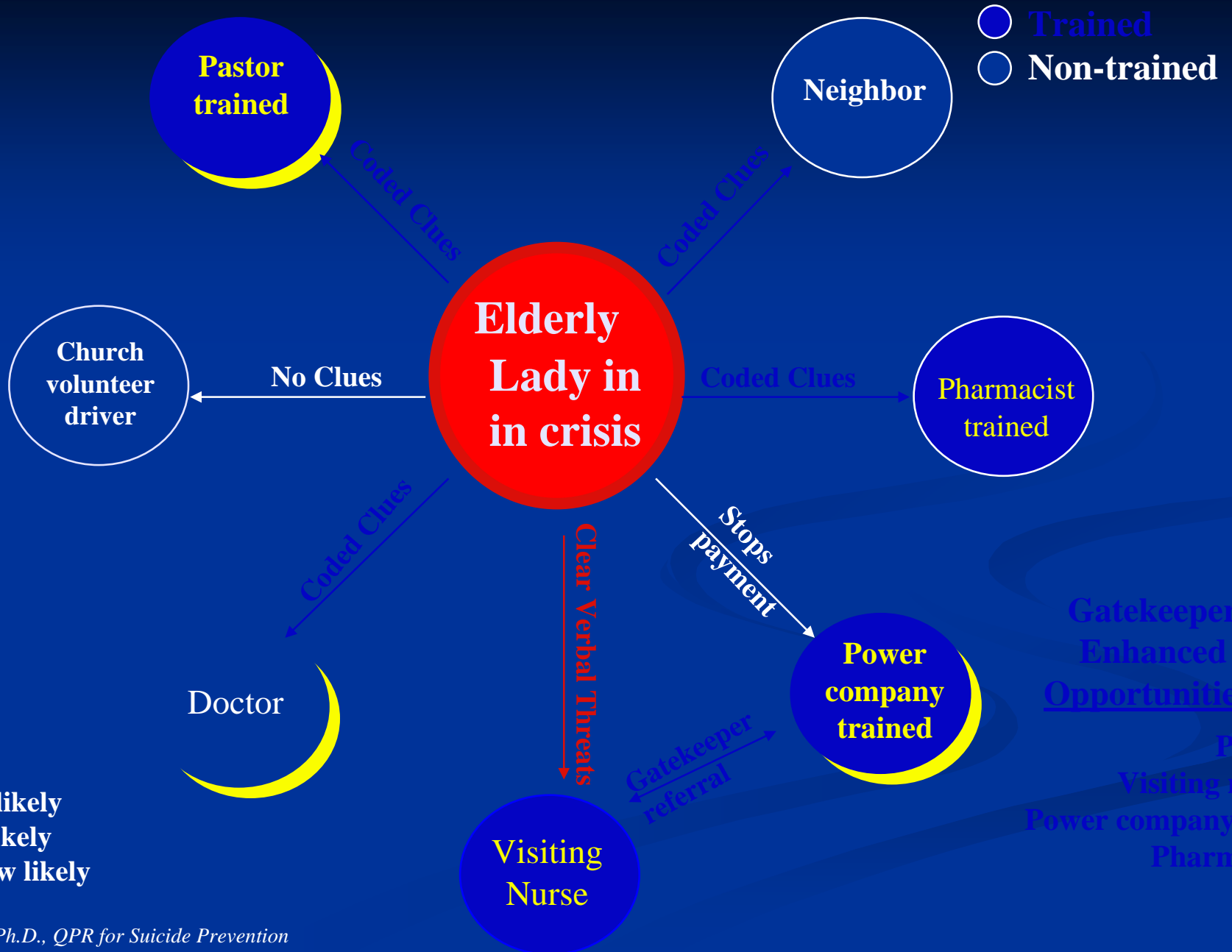


Scenario: clinically depressed, 73- year-old widowed female, living alone. Health is failing. She is isolated and has few friends. Only son recently died by suicide and she has saved up a lethal dose of her heart medication.

- **Self-referral unlikely**
- **Hotline call unlikely**
- **Intervention unlikely**

Gatekeeper Detection Network

Diagram 2



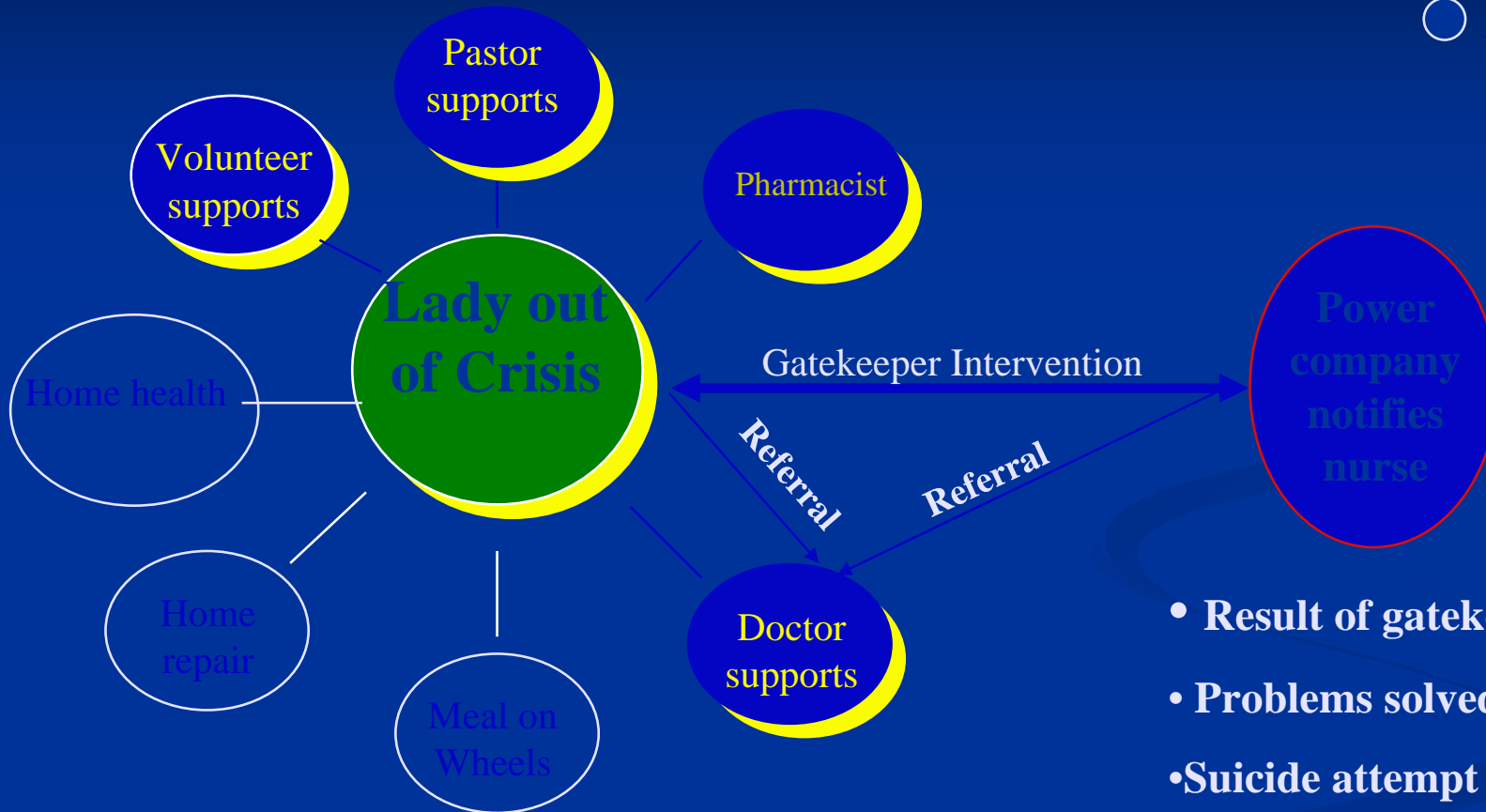
- Self-referral unlikely
- Hotline call unlikely
- Intervention now likely

Source: Paul Quinnett, Ph.D., QPR for Suicide Prevention

QPR Gatekeeper Network

Diagram 3

- Gatekeeper trained
- Additional Resources



- Result of gatekeeper action?
- Problems solved
- Suicide attempt averted
- Social, emotional, medical and spiritual supports now in place

In summary, effective gatekeepers:

- Know that suicide is preventable
- Understand means restriction
- Know how to ask about suicide
- Know how to listen, persuade and refer
- Know community resources
- Are supported by provider agencies
- Know something about the involuntary treatment laws and understand the link between mental illness, substance abuse and suicide

Changing individuals is not enough,
we must change cultures, and we
change them one community at a
time...

QPR

Ask A Question, Save A Life

QPR

Question, Persuade, Refer

QPR

- QPR is not intended to be a form of counseling or treatment.
- QPR is intended to offer hope through positive action.

QPR

Suicide Myths and Facts

- **Myth** No one can stop a suicide, it is inevitable.
- **Fact** If people in a crisis get the help they need, they will probably never be suicidal again.
- **Myth** Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact** Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.
- **Myth** Only experts can prevent suicide.
- **Fact** Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide

QPR

Myths And Facts About Suicide

- **Myth** Suicidal people keep their plans to themselves.
- **Fact** Most suicidal people communicate their intent sometime during the week preceding their attempt.
- **Myth** Those who talk about suicide don't do it.
- **Fact** People who talk about suicide may try, or even complete, an act of self-destruction.
- **Myth** Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact** Suicide is the most preventable kind of death, and almost any positive action may save a life.

How can I help? Ask the Question...

QPR

Suicide Clues And Warning Signs

The more clues and signs observed, the greater the risk. Take all signs seriously!

QPR

Direct Verbal Clues:

- “I’ve decided to kill myself.”
- “I wish I were dead.”
- “I’m going to commit suicide.”
- “I’m going to end it all.”
- “If (such and such) doesn’t happen, I’ll kill myself.”

QPR

Indirect Verbal Clues:

- “I’m tired of life, I just can’t go on.”
- “My family would be better off without me.”
- “Who cares if I’m dead anyway.”
- “I just want out.”
- “I won’t be around much longer.”
- “Pretty soon you won’t have to worry about me.”

QPR

Behavioral Clues:

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability

QPR

Situational Clues:

- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a spouse, child, or best friend, especially if by suicide
- Diagnosis of a serious or terminal illness
- Sudden unexpected loss of freedom/fear of punishment
- Anticipated loss of financial security
- Loss of a cherished therapist, counselor or teacher
- Fear of becoming a burden to others

QPR

Tips for Asking the Suicide Question

- If in doubt, don't wait, ask the question
- If the person is reluctant, be persistent
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; QPR Card, phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important than that you ask it



QUESTION

Less Direct Approach:

- “Have you been unhappy lately?
Have you been very unhappy lately?
Have you been so very unhappy lately that you’ve been thinking about ending your life?”
- “Do you ever wish you could go to sleep and never wake up?”



QUESTION

Direct Approach:

- “You know, when people are as upset as you seem to be, they sometimes wish they were dead. I’m wondering if you’re feeling that way, too?”
- “You look pretty miserable, I wonder if you’re thinking about suicide?”
- “Are you thinking about killing yourself?”

NOTE: If you cannot ask the question, find someone who can.

- **Interview patient in a genuinely concerned manner and observe body language**

- Have you felt like life is not worth living?
- Have you thought of suicide?
- If so, what have you considered doing?
- Do they have access to that means?
- (What have they done to prepare for death?)
- Are you telling me how you really feel or are you trying to cover up how you feel?

How *Not* to Ask the Suicide Question

“You’re not suicidal, are you?”

P *PERSUADE*

HOW TO PERSUADE SOMEONE TO STAY ALIVE

- Listen to the problem and give them your full attention
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

P

PERSUADE

Then Ask:

- “Will you go with me to get help?”
- “Will you let me help you get help?”
- “Will you promise me not to kill yourself until we’ve found some help?”

YOUR WILLINGNESS TO LISTEN AND TO HELP
CAN REKINDLE HOPE, AND MAKE ALL THE
DIFFERENCE.

R

REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help.
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to complete or attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

REMEMBER

Since almost all efforts to persuade someone to live instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.

For Effective QPR

- Say: “I want you to live,” or “I’m on your side...we’ll get through this.”
- Get Others Involved. Ask the person who else might help. Family? Friends? Brothers? Sisters? Pastors? Priest? Rabbi? Bishop? Physician?

YOU MUST INTERVENE WITH SOMEONE'S HELP!!

If the following present:

- Suicidal thoughts
- Intent and Plan
- Means to carry out plan

Assemble a team:

- Communicate your recognition of suicidal/ depressive symptoms with family
- Notify supervisor
- Communicate with primary care provider/ health care provider
- Consider involving someone else that the client can confide in (ie. clergy)
- Decrease isolation/ needs consistent supervision
- Restrict access to guns/ limit potentially lethal drugs

For Effective QPR

- Join a Team. Offer to work with clergy, therapists, psychiatrists or whomever is going to provide the counseling or treatment.
- Follow up with a visit, a phone call or a card, and in whatever way feels comfortable to you, let the person know you care about what happens to them. Caring may save a life.

REMEMBER

WHEN YOU APPLY QPR,
YOU PLANT THE SEEDS OF
HOPE. HOPE HELPS
PREVENT SUICIDE.

Resources

- 911
- Emergency room
- Psychiatric hospitalization/ Involuntary Commitment
- Hotlines: Area Agency on Aging Database
 - (404-463-3333 or 800-676-2433)
- 1-800-273-TALK
- GA Crisis and Access Line: 800-715-4225