Suicide Prevention in Older Adults; Breaking Isolation with Men

Maine Suicide Prevention Program

In Partnership with NAMI Maine and Maine Medical Association

Education, Resources and Support—It's Up to All of Us.

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

Paul R. LePage, Governor — Ricker Hamilton, Commissioner

Maine Suicide Prevention Program

A program of the Maine Center for Disease Control and Prevention since 1998

Statewide Activities Include:

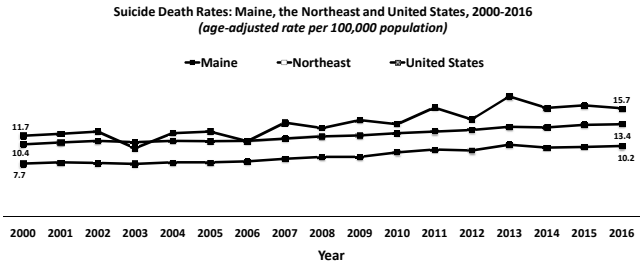
- **Data** collection, analysis & dissemination of **information**
- **Training** on suicide prevention and management to a wide range of partners statewide.
- **Technical Assistance** for schools, healthcare providers and others in protocol implementation and postvention support.
- Annual *Beyond the Basics* **Conference** April 12, 2018

Suicide in the United States, 2016

- **44,965** Americans died by suicide in 2016; about 1 person every 12 minutes[1]
- Suicide deaths are **2.3 times** the number of homicides (homicides=19,362) [1]
- **10th** leading cause of death across the lifespan[1]
  - **2nd** leading cause of death for **15-34** year olds
- Males account for **77%** of suicide deaths[1]
- Veterans account for approximately **17%** of all suicides[3]
- Since 2009, suicides have **exceeded** motor vehicle crash related deaths[1]

1. U.S. CDC WISQARS Fatal Injury Data, 2016 update. Accessed January 2018; https://www.cdc.gov/injury/wisqars/index.html
2. Maine Hospital Inpatient Database, Maine Health Data Organization, 2013-2014. Hospital discharge data for intentional self-inflicted injury related hospital discharges defined as hospital discharges in which any listed external cause of injury was coded as ICD-9CM E950-E959 . 3. 'Suicide Among Veterans and Other Americans 2001–2014' report, updated 3 August 2016, U.S. Department of Veteran Affairs.

Maine consistently has higher suicide death rates than both the U.S. and the Northeast.



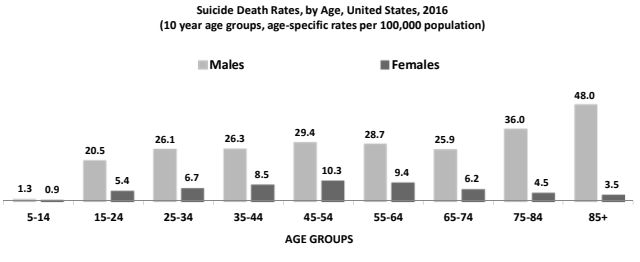
Data source: U.S. CDC WISQARS Fatal Injury Data, National Vital Statistics System (NVSS)

Suicide in Maine, 2014-2016

- **9th** leading cause of death among all ages (previously 10th, 2012-2014)
- **4th** leading cause of death ages 35-54
- Suicide deaths **9x** homicide deaths
- Every **1.6 days** someone dies by suicide
- **3** female attempts per every **2** male attempts[2]
- **227** suicide deaths per year on average
- **Firearms** most prevalent method of suicide (**52%**)

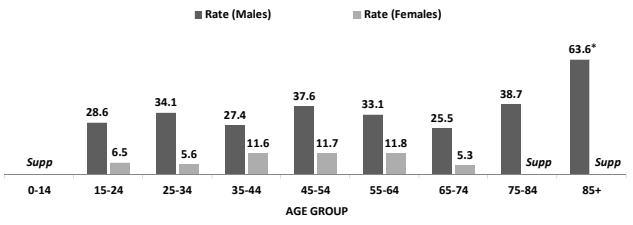
1. U.S. CDC WISQARS Fatal Injury Data, 2016 update. Accessed January 2018; https://www.cdc.gov/injury/wisqars/index.html
2. Maine Hospital Inpatient Database, Maine Health Data Organization, 2013-2014.

In the U.S., suicide death rates among men are higher than women in all age groups.



Data source: U.Ss CDC WISQARS Fatal Injury Data, 2016 update.

Age-specific Death Rates, by Age & Sex, Maine, 2014-2016 *(3 years combined)*



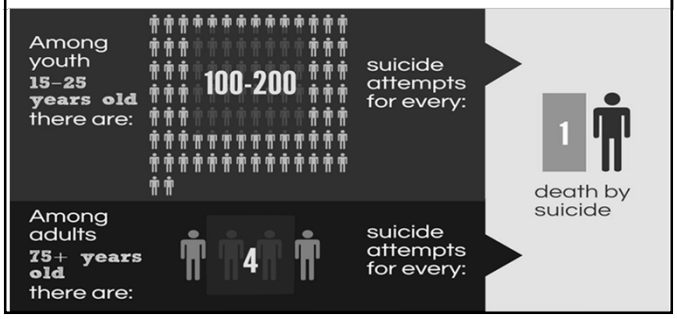
Data source: US CDC WISQARS Fatal Injury Data, Rates for both males and females ages 0-14 and for females ages 75-84 and 85+ are suppressed due to small numbers (fewer than 10 deaths).

Suicide Among Older Adults

- Highest rate of any age group (for men)
- 87.5% of elder suicides in Maine are male (2013-15)
- 2013-15 Rates in Maine (17 per 100K)
  - -women 4.00 per 100,000
  - - men 34.01 per 100,000
- After age 60 rate declines for women
- Firearms most common means
- 66%-90% have diagnosable mental illness
- 2-4% completed suicides are terminally ill

Number of deaths due to intentional self-harm nationwide

Attempted Suicides- A Call For Help!



Characteristics of Elderly Suicide Attempts

Ask about a history of attempts!

- *More secretive:* Fewer warnings of intent
- *More planful:* Attempts are more planned, determined
  2/3 have high suicide intent scores
- *More lethal*
  - Less likely to survive a suicide attempt due to use of more violent and immediate methods
  - Also more frail

Conwell Y, Duberstein PR, Cox C, Herrmann J, Forbes N, & Caine ED. Age differences in behaviors leading to completed suicide. *American Journal of Geriatric Psychiatry*, 1998 6(2), 122-6.

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Discussion

Overall, suicide rates among older adults have fallen since 1930. What changes in policy, supports, cultural attitudes and healthcare practices have supported this trend?

What do you see as priorities that would support reduction of suicide rates among older men?

Suicide in Older Adults

Clarification of Attitudes

Examining Our Own Attitudes

- What associations do we have to the word “suicide”?
- What do we “know” about suicide?
- How has suicide impacted your life?
- What do we “know” about people who are suicidal?

Values Clarification

- Is there a difference between an adolescent suicide and an older adult suicide?
- For someone diagnosed with a terminal illness is it still a suicide?
- What is the difference between “death with dignity” and suicide?
- Is there such a thing as “rational suicide?

Warning Signs
Risk Factors
Protective Factors

Risk Factors among Older Adults

- **Male**, white and old (esp. after losses)
- **Depression** (esp. untreated),
- Prior suicide attempts,
- Marked feelings of **hopelessness**,
- Co-morbid medical conditions limiting functioning,
- Pain and **declining role function**,
- Social/familial **isolation/cut-offs or losses**
- Rigid inflexible personality
- Access to lethal means (esp. **firearms**)
- Substance abuse

Men as a High Risk Group

- 80% of suicides
- Gender disparity highest in elders (especially white)
- Gender issues include:
  - Poor help-seeking
  - Men less likely to talk to someone
    - Difficulty recognizing and expressing emotions
  - Increased substance abuse
  - Use more lethal means
  - Feeling like a burden
  - Struggle between belongingness and independence

Warning Signs

What have you seen that tells you that a person is at increased risk?

- In your center?

- In the community/home?

Clear Signs Of A Suicidal Crisis

1. Someone threatening to hurt or kill themselves
2. Someone looking for the means (gun, pills, rope etc.) to kill themselves
3. Someone showing clear distress/ agitation/ anxiety

Get the facts and take action!

Call **911** if lethal means is present
Call **Crisis Hotline** if no means present

Warning Signs of Suicide in Elders

- Direct or ***indirect*** communication
  - Hopelessness, Purposelessness, Isolation,
- Giving away possessions
- Getting affairs in order
- Saying good bye
- Sudden interest or disinterest in religion (change in interest)
- A specific plan for how they will die

Any of these signs invite a conversation to explore what is happening in the person's life!

Warning Signs: Depression

Physical
- Aches, pains, or physical complaints
- Marked changes in appetite
- Change in sleep patterns
- Fatigue

Emotional
- Pervasive sadness
- Apathy
- Decreased pleasure
- Crying for no apparent reason
- Indifference to others

Changes in Thoughts and Feelings
- Feelings of hopelessness and helplessness
- Feelings of worthlessness
- Impaired concentration
- Problems with memory
- Indecisiveness
- Recurrent thoughts of death and suicide

Changes in Behavior
- Loss of interest in previously enjoyed activities
- Neglect of personal appearance
- Withdrawal from people
- Increased use of alcohol
- Increased agitation / anxiety
- Talking about the "end"

Adapted from Schmall V, Lawson L, Stiehl R. Depression in Later Life: Recognition and Treatment. Pacific Northwest Extension publication. Corvallis, Ore, 1993

Protective Factors

☑ **Skills** to think, communicate, solve problems, manage anger and other negative emotions,

☑ **Purpose & value** in life-hope for future, pets, life focus…

☑ **Personal characteristics**- health, positive outlook, spirituality or religious belief

☑ **Supports**- friends, family, and other caring people, health care access, transportation

☑ **Safe Environment –** restricted access to lethal means

From a Suicidal Person's Point of View

- **Crisis** point has been reached
- **Pain** is unbearable
- **Solutions** to problems seem unavailable
- **Thinking** is affected

- HOWEVER:
- **Ambivalence** exists
- **Communicating** distress is common
- **Invitations** to help are often extended
  - Less often or open for older adults

How to Help?

Intervention

- **It all starts with a conversation**
- **Active intervention** is needed
- **Engagement** is essential
- Importance of connections/ **breaking isolation**
- Reduce the level of risk by removing all **lethal means**
- **Invitations** are often extended to people based on fit
- **Invitations** are often extended to people based on opportunity and availability

What IS Helpful

1) **Show You Care—Listen carefully—Be genuine**

"I'm concerned about you . . . about how you feel."

2) **Ask the Question—Be direct, caring and non-confrontational**

"Are you thinking about ending your life?"

3) **Get Help—Do not leave him/her alone**

"You're not alone. Let me help you."

Role Play

Resources for Help

What are YOUR resources?

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

Resources for Help

To address the Crisis

- **911 or Law enforcement**
- Statewide Crisis Hotline (888-568-1112)
- Local Crisis Agency, Mental Health Clinicians and Facilities
- Hospital emergency room staff or PCP office/rural health center in rural areas

For follow-up, support & information after the crisis

- Private counselors/therapist
- Faith Community
- Local Health Center
- 211
- Maine's Intentional Warmline: 1-866-771-9276

When to Call Crisis

- Crisis clinicians are:
  - Available 24 / 7
  - Clinicians can often come to your location for an assessment
- Call for a phone consult when you are:
  - Concerned about someone's mental health
  - Need advice about how to help someone in distress
  - Worried about someone and need another opinion
- The phone call is free

1-888-568-1112

Crisis Intervention Teams

The Crisis Intervention Team program trains police, correctional officers and first responders about mental illness and methods to deal with mental health emergency and crisis situations safely.

But it is not just a training, CIT transforms how the entire community responds to psychiatric crisis by creating an ongoing collaboration that supports jail diversion

If you need to call the police for a mental health emergency, ask for a CIT trained officer

Key Actions For Healthcare Providers

- **Routine standard screening for depression,**
- **Use collaborative Tx of depression,**
- **Optimize treatment of pain, anxiety… to address quality of life issues,**
- **Include collateral folks in treatment discussions**
- **Active management after a suicide attempt or crisis.**
  - **Means restriction and safety planning**
  - **Increased outreach, care management and follow-up**
  - **Referrals for community programs**

Key Actions for Aging Service Providers

- **Training for staff on Warning signs and Risk factors and intervention skills**
- **Depression screening in non-clinical and community settings**
- **Center-based social programs**
- **Outreach, outreach, outreach**
  - **Target isolation**
  - **Activate family and social; supports**
  - **Meals on Wheels**
  - **Home visiting**
  - **Mail carriers, Faith community, Home handyman services…**
  - **Other?...**

Take Care of Yourself

- Acknowledge the intensity of your feelings
- Seek support from others, de-brief
- Share your feelings with family/friends
- Avoid over – involvement. Never act in isolation
- Know that you are not responsible for another person's choice to end their life

MSPP Training and Technical Assistance

- *Suicide Prevention Gatekeeper Training*
- *Suicide Prevention: Training of Trainers*
  - *Supports capacity to offer Awareness Sessions*
- *Suicide Prevention Protocol Development Training & TA*
- *Suicide Assessment for Clinicians*
- *Safety Planning: A Critical Tool to Manage Suicidality*
- *Non-Suicidal Self Injury; Addressing the Risk*

Contact NAMI Maine Suicide Prevention Training Coordinator for more details
mspp@namimaine.org

Contact: For Additional Support

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Resources

- See Handout

Before you leave . . . .

Any Questions??

Thank you for learning about suicide prevention . . . .

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