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 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
- Suicide deaths are 2.3 times the number of homicides (homicides=19,362)
- 10th leading cause of death across the lifespan
  - 2nd leading cause of death for 15-34 year olds
- Males account for 77% of suicide deaths
- Veterans account for approximately 17% of all suicides
- Since 2009, suicides have exceeded motor vehicle crash related deaths

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

Suicide Death Rates: Maine, the Northeast and United States, 2000-2016 (age-adjusted rate per 100,000 population)

- Maine
- Northeast
- United States


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
- 227 suicide deaths per year on average
- Firearms most prevalent method of suicide (52%)
### Age-specific Death Rates, by Age & Sex, Maine, 2014-2016 (3 years combined)

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>Rate (Males)</th>
<th>Rate (Females)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>28.6</td>
<td>Supp</td>
</tr>
<tr>
<td>15-24</td>
<td>34.1</td>
<td>6.4</td>
</tr>
<tr>
<td>25-34</td>
<td>5.6</td>
<td>1.6</td>
</tr>
<tr>
<td>35-44</td>
<td>11.6</td>
<td>11.6</td>
</tr>
<tr>
<td>45-54</td>
<td>11.7</td>
<td>21.5</td>
</tr>
<tr>
<td>55-64</td>
<td>11.8</td>
<td>11.8</td>
</tr>
<tr>
<td>65-74</td>
<td>25.1</td>
<td>6.1</td>
</tr>
<tr>
<td>75-84</td>
<td>30.7</td>
<td>63.6*</td>
</tr>
<tr>
<td>85+</td>
<td>Supp</td>
<td>Supp</td>
</tr>
</tbody>
</table>

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

Map showing the number of deaths due to intentional self-harm per 100,000 adults aged 65 and older.
**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


**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

<table>
<thead>
<tr>
<th>Physical</th>
<th>Changes in Thoughts and Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aches, pains, or physical complaints</td>
<td>• Feelings of hopelessness and helplessness</td>
</tr>
<tr>
<td>• Marked changes in appetite</td>
<td>• Feelings of worthlessness</td>
</tr>
<tr>
<td>• Change in sleep patterns</td>
<td>• Impaired concentration</td>
</tr>
<tr>
<td>• Fatigue</td>
<td>• Problems with memory</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pervasive sadness</td>
</tr>
<tr>
<td>• Apathy</td>
</tr>
<tr>
<td>• Decreased pleasure</td>
</tr>
<tr>
<td>• Crying for no apparent reason</td>
</tr>
<tr>
<td>• Indifference to others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in Thoughts and Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Loss of interest in previously enjoyed activities</td>
</tr>
<tr>
<td>• Neglect of personal appearance</td>
</tr>
<tr>
<td>• Withdrawal from people</td>
</tr>
<tr>
<td>• Increased use of alcohol</td>
</tr>
<tr>
<td>• Increased agitation / anxiety</td>
</tr>
<tr>
<td>• Talking about the &quot;end&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Loss of interest in previously enjoyed activities</td>
</tr>
<tr>
<td>• Neglect of personal appearance</td>
</tr>
<tr>
<td>• Withdrawal from people</td>
</tr>
<tr>
<td>• Increased use of alcohol</td>
</tr>
<tr>
<td>• Increased agitation / anxiety</td>
</tr>
<tr>
<td>• Talking about the &quot;end&quot;</td>
</tr>
</tbody>
</table>


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?

- 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?

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greg A Marley, LCSW</td>
<td>207-622-5767 ext. 2302</td>
<td><a href="mailto:gmarley@namimaine.org">gmarley@namimaine.org</a></td>
</tr>
<tr>
<td>Training Program Inquiries</td>
<td>207-622-5767 ext. 2310</td>
<td><a href="mailto:MSPP@namimaine.org">MSPP@namimaine.org</a></td>
</tr>
<tr>
<td>Dee Kerry</td>
<td>620-0806 Maine Medical Association</td>
<td><a href="mailto:dkerry@mainemed.com">dkerry@mainemed.com</a></td>
</tr>
<tr>
<td>Sheila Nelson, MSPP Program Coordinator</td>
<td>207-287-3856</td>
<td><a href="mailto:Sheila.Nelson@maine.gov">Sheila.Nelson@maine.gov</a></td>
</tr>
</tbody>
</table>

### Resources

- See Handout

### Before you leave . . .

**Any Questions??**

Thank you for learning about suicide prevention . . .