Enhancing Suicide Prevention Among Older Adults

Using a Blended Model Approach

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By the end of this presentation one older adult will have died by suicide.
• Recognize the importance of meeting the mental health needs of a rapidly aging society

• Identify challenges in addressing mental health needs and the competencies required

• Become more knowledgeable about the effectiveness of “blended training” to strengthen community-based mental health care for older adults
Competencies

- Background - Knowledge
- Risk Factors - Knowledge
- Resilience Factors - Knowledge
- Warning Signs - Knowledge
- Difficult Discussions - Values
- Question - Skills
- Persuade - Skills
- Refer - Skills
“I am 6 feet tall.

The way I have felt these past few months, it is as though I am in a very small room, and the room is filled with water, up to about 5’10’, and my feet are glued to the floor, and it’s all I can do to breathe.”

• 20-22% of older adults have a mental health disorder

• Depression is amongst the most prevalent of the disorders

• Untreated depression is leading cause of suicide

(Snowden, Steinman, & Frederick, 2008)
Suicide and Aging

- In 2005, average suicide rate for all Americans: 10.9 per 100,000, 65+: 14.3, men 85+: 17.8

- Women attempt more (3 female -1 male), men succeed more

- 70% of suicides involve firearms, 22% suffocation or hanging, 11% overdose

(Snowden, Steinman, & Frederick, 2008)
For every 2 homicides, 3 people complete suicide yearly—data that has been constant for 100 years

“Still the effort seems unhurried. Every 17 minutes in America, someone commits suicide. Where is the public concern and outrage?”

Kay Redfield Jamison
Author of Night Falls Fast: Understanding Suicide
• Less than 5% of social workers concentrate on aging

• Less than 3% of Master of Social Work (MSW) graduates select aging as an area of specialty

• 25% of masters programs lack a gerontology course

(Whitaker, T., Weismiller, T., & Clark, E., 2006)
A national survey of social workers found:

• 93% of respondents had worked with suicidal clients

• 21.2% had received formal training in their MSW programs

• 67.4% indicated their training had been inadequate

(Feldman & Freedenthal, 2006)
• 50% of psychology trainees have no formal training related to suicide

• 5% had a client fatally suicide

• 99% treated one suicidal client in grad school

• 22% will experience a client fatal suicide during their career

• They are inadequately trained for assessment, intervention and management
Impact on Workforce

We know that students and workers:

• Do not receive systematic training

• Are anxious and unprepared

• Will encounter suicidal clients
Creating Competent Workforce

Increase supply of trained practitioners:

• Define competencies required (knowledge, skills and values)

• Provide cost-effective training and delivery

• Train practitioners
“Our society tends to regard suicide among older adults as more acceptable than suicide among younger people”.

- Yeates Conwell, MD
Meet Mr. Peters
What is Happening to Mr. Peters

- Verbalizing being “at the end of his rope”
- Socially isolated, widower, few friends
- Recent health problems
- Poor self-care
- Appears “sad”

What are the challenges in helping Mr. Peters?
Suicide Practice Competencies

Knowledge

Skills

Values/attitudes
Helping Mr. Peters

• **Knowledge:**
  
  • “What do I need to know?”

• **Skills:**
  
  • “What do I need to know how to do?”

• **Values/Attitudes**
  
  • “What are my barriers to helping”
• Understand suicide as a major public health problem

• Understand the nature of suicide and describe relevant research

• Understand the common causes of suicidal behavior

• Recognize and identify at least five risk factors for suicide

• Recognize and identify at least five protective factors against suicide
Knowledge

• Describe groups at high risk for suicide

• Recognize suicide warning signs

• Demonstrate knowledge of referral information, access, and contacts
Skills

- Demonstrate basic engagement and helping skills when warning signs are present
- Ask clarifying questions to validate suicidal intent when warning signs are present
- Demonstrate active listening skills with a suicidal person in role-play
Skills

- Demonstrate basic active listening skills in persuading a suicidal person to accept help

- Demonstrate ability to make a successful referral in role-play situations

- Report a high level of self-confidence and comfort in an interview situation, which self-report is confirmed by external ratings

- Describe how to get help for someone in crisis
• Understand and manage one's own reactions to suicide

• Present non-judgmental and non-adversarial stance with older adults at risk for suicide

• Recognize the potential impact of ageism relating to older adults and self-harm
Current Research
Thomas Joiner – *Why People Die By Suicide*

- Builds upon previous theories and concludes that suicide is the result of:
  - A sense of burden on loved ones
  - A sense of isolation and not belonging
  - A gradually learned ability to tolerate danger, fear, and pain that overcomes the instinct to self-preservation
Joiner’s Theory of Suicide

Those Who Desire Suicide

Perceived Burdenomeness

Thwarted Belongingness

Those Who Are Capable of Suicide

Serious Attempt of Death by Suicide

Joiner, Thomas (2005) Why People Die By Suicide
Knowledge- Risk Factors

S: Male sex
A: Older age
D: Depression
P: Previous attempt
E: Ethanol abuse
R: Rational thinking loss
S: Social supports lacking
O: Organized plan
N: No spouse
S: Sickness

Score is mapped on a risk assessment scale
- Low Risk 0-4
- Medium Risk 5-6
- High Risk 7-10
Knowledge-Protective Factors

• Protective factors, even if present, may not counteract significant acute risk

• Internal: Ability to cope with stress, feeling effective, religious beliefs, frustration tolerance, absence of psychosis

• External: Responsibility to children or beloved pets, positive therapeutic relationships, social supports

• “Need to belong is so powerful that the when satisfied it can prevent suicide, even when burdensomeness and the acquired ability enact lethal self injury are in place.” (Joiner, 2005)
Be alert for imminent warning signs that someone may be at risk of suicide, for example:

- Talking about suicide or death
- Giving direct verbal cues, such as "I wish I were dead" and "I'm going to end it all"
- Giving less direct verbal cues, such as "What's the point of living?", "Soon you won't have to worry about me," and "Who cares if I'm dead, anyway?"
- Isolating him- or herself from friends and family
- Expressing the belief that life is meaningless or hopeless
- Giving away cherished possessions
- Exhibiting a sudden and unexplained improvement in mood after being depressed or withdrawn
- Neglecting his or her appearance and hygiene
Fear

- Myth that people who talk about suicide won’t do it
- This can be immobilizing to potential responders
- Need to dispel myth in order to help helpers act
Fear

• Most people from gatekeepers to trained clinicians find it hard to discuss suicide

• 9th question in DSM IV (The patient has had repeated thoughts about death (other than the fear of dying), suicide with or without a plan or has made a suicide attempt.) and PHQ-9 (thoughts that you would be better off dead or of hurting yourself in some way) is difficult for people to ask

• Comments include:
  • “The word suicide sticks in my throat.”
  • “They are already depressed. I don’t’ want to put the idea in their head.” (Quinette, 2011)
Fear

• May lead to responses such as, “You’re not thinking of suicide are you” or “Don’t talk like that—it’s foolish”

• The communicator may be asking “Am I a burden” or “Do I belong to a group that cares?”

• Not responding with concern or additional questions sends the message that it’s okay to proceed
Asking questions

• Goal of suicide prevention training is to teach responders to ask clarifying questions such as, “What do you mean, ‘take care of you dog after Saturday’? What’s happening on Saturday? And what do you mean take a ‘long, long rest’?”

• These clarifying questions create an active dialogue by which the true meaning of the speaker’s statement can be correctly understood.
• The simple art of active listening, gentle questioning, and coming to an understanding of a distressed person’s communications lies at the heart of successful healing.

• The power of the clarifying question can assist the ambivalent person to elaborate on the meaning of a statement, and thus better understand their own circumstances and capacity for change (Miller and Rollnick, 2002).

• However, at some point a straightforward question regarding suicidal intent is required, e.g., “Are you thinking of killing yourself?”
Persuading

- Those most at risk are often most reluctant to see a professional
- Reasons for reluctance can include fear, stigma, shame, feeling you should be able to handle problems yourself
- During a period of ambivalence and internal struggle a caring dialogue with active listening skills and gentle questioning can help
- This, when coupled with a belief in a positive outcome and specific referral resources, bring the greatest hope
Referrals
• Can be most difficult step
• Problems include lack of resources and lack of professionals trained in working with suicidal older adults

Facilitating referrals can include
• Accompany the suicidal person to the resource
• Secure an agreement from the suicidal person to see a professional and follow up to see that the appointment was kept
• Secure an agreement to see a professional, or accept help, even if in the future
• Secure an agreement to stay alive (not a no-suicide contract)
Referrals

- Hospital Emergency Room
- Local Mental Health Agencies
- Local Mental Health Board
- Local Crisis Hotlines
- National Crisis Hotlines
- Family physician
- 911
- Local Police/Sheriff
- Local Clergy
IGSW Blended Training Program

• Combines electronic tools (e-learning) and traditional training
  
  • E-learning Component
    • Online course
  
  • Traditional training
    • Face-to-Face
Characteristics of Blended Training Program

Online Course
• Self-paced study
• Expert commentators and contributors
• Forums
• Instructional Activities
• Case Studies
• Self assessment
• Evaluation

Face-to-Face Sessions
• Skill Practice
• Participant discussion
• Create an informal network
Benefits of Blended Training Program

Benefits for the Learner
- Time-savings
- Opportunity for advanced training
- Development of critical thinking
- Full development of competencies
- Focus on application

Benefits for the Organization
- Cost-effective training
- Time-savings
- Consistency in training
- Opportunity for advanced training
- Competent workforce
Suicide Prevention Blended Training Program

Program funded to include:

- Blended training
- Bridging aging and mental health silos
- Using an already existing coalition
- Identify a network of providers
- Creation of a Supervisor Guide
Program Highlights

• Year 1 and 2
  • Created a 4 hour, 4 CEU online course on Suicide Prevention among Older Adults
  • Delivered three face to face sessions – 6 hours
  • Offered the program in 3 regions of the state

• Year 3
  • Created a Supervisor Guide to use within agencies and for group of learners from various agencies
  • Piloted the Guide in 2 regions
Program Highlights

- 160 from 85 agencies were trained
- Feedback was very positive
- High level of course completion and satisfaction
- Significant change in competencies pre and post training
Program Highlights

Comments included:

“Great information. I enjoyed the in-person trainings as a supplement to the on-line course.”

“The mixed model is a great way to take a course. With this model you get the discussion piece as well as the information.”

“This was a rich course fleshed out by the interaction in class.”

“Being quite young and new in this profession, it was a real eye opener for me and greatly expanded my knowledge on the issue of suicide in general.”

“Overall, the material covered was wonderful…particularly concerning the role of the practitioner.”

“The course helped me resolve some of my own issues around the suicide of a close friend.”
Next Steps

How can you train your staff?

• Keep competencies in mind
• IGSW online course on Suicide Prevention among Older Adults
• IGSW Supervisor Guide for face to face training
• QPR Theory and training for gatekeepers
• Think about looking for funding for this type of program from Dept. of Aging, MH or DPH since online course and Supervisor Guide already completed
• Other resources include SPRC, Samaritans


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