# Suicide Among the Elderly -- Suicide Prevention Summit Butte County

Patrick Arbore, Ed.D.
Director & Founder Center for Elderly Suicide Prevention & Grief Related Services
Institute on Aging – San Francisco, CA

Good morning and I want to thank certainly Betsy and Anne and her committee for putting this together, but also for including me and I'm very happy to be here. Some volunteers have passed out just a little--it's called a pretest with five questions on that. If you have that in front of you, would you answer those questions now?

## Center for Elderly Suicide Prevention

- 24-hour Friendship Line for the Elderly:
- Local Number in Bay Area
- (415) 752-3778
- **Nationwide Toll Free Number:**
- **(800) 971-0016**
- Contact: Patrick Arbore, (415) 750-4180x230 or parbore@ioaging.org

2

As Betsy said, Institute on Aging and my program, Center For Elderly Suicide Prevention, is one of the partners with Cal Mesa and we are very proud and happy and just feel so good about the work that is being done in the counties and that we have an opportunity to provide hopefully just an additional arm of support, just another option, just another opportunity for family members, older people themselves to maybe get some additional caring and compassionate attention and I think that we all deserve that. And if you could fill out those five questions on the pretest and then when I'm done, I'll give you a minute to turn that over and there's a post-test and then I'll collect those and that's something that Cal Mesa had wanted me to do.

As I was driving up here this morning from San Francisco and although, I'm not from Butte County, but I have to say that my roots are in rural America. I was born and raised on a dairy farm in Western Pennsylvania and so, I'm always very happy to be in the counties particularly in the superior region because just the air feels better and so I'm happy to be here. And I was thinking about a gentleman who was 64 when he died by suicide and I had the privilege of reading his suicide note and it was very brief, but I found it was very important to hear the voices of people who have died as a result of suicide in addition to survivors who are going to be speaking later. And his suicide note was very cryptic, but it read, I'm sorry was the beginning. I'm sorry, it's impossible to live with this pain any longer. I've got to go. Love and then he signed his name.

## Center for Elderly Suicide Prevention

- 24-hour Friendship Line for the Elderly:
- Local Number in Bay Area
- (415) 752-3778
- **Nationwide Toll Free Number:**
- **(800) 971-0016**
- Contact: Patrick Arbore, (415) 750-4180x230 or parbore@ioaging.org

2

And his, you know, girlfriend of many, many years, as she talked to me about his death because part of our grief related services is that we have been doing traumatic loss group for many, many years and she just, not surprisingly, just burst into tears and she said, you know, he had two numbers on his kitchen table. And he had shot himself in his backyard and on his kitchen table was my number at the office and her cell phone number and he didn't call either one of us, but what was so, I think, important about suicide deaths is first of all, we remember, we remember them. And secondly, we learn from them and they're really the most important people in this room today are those who have died by suicide. And I just, you know, as I was driving up here just allowed his life to kind of fill my heart so that I could speak from a different part of me, not just this cerebral part, but also this deeper, soulful part of me.

And I was struck by one of the questions that I think somebody was asking over there about terminal illness and what this gentleman was struggling with for many, many years certainly depression and anxiety, but also his chronic illnesses, although, he was certainly not terminal, but his perception was that he couldn't go on this way. So, although he wasn't you know, diagnosed with a terminal disease, in his mind he felt terminal. So, I think there is two components to that question, one is a diagnosis, you know, or a prognosis, but the other is what is the perception of the individual themselves. And I've been working in the field of aging since 1973 and as you can see, I'm not young and so hopefully, I've gained some knowledge along the path here,

## Center for Elderly Suicide Prevention

- 24-hour Friendship Line for the Elderly:
- Local Number in Bay Area
- (415) 752-3778
- **Nationwide Toll Free Number:**
- **(800) 971-0016**
- Contact: Patrick Arbore, (415) 750-4180x230 or parbore@ioaging.org

2

but what I realize so much is that so many older people who are depressed or bereaved or dealing with illness will say to me, older age is like a terminal illness. So, you know, I just think it's important to kind of look at the context of that question and I think all those components of it are very, very important. But what I'm happy to talk about for a few moments as I go into some issues related to elderly suicide and elderly suicide prevention you know and in a short time frame, you know, there's a lot, but I'm just not going to push it all on you. You have the slides and I'll just kind of go through some of them that I think are more important.

Our program began in 1973 and it's called as you can see the 24-hour Friendship Line for the Elderly and that's how we answer the phone. And what we were aware of, you know, and if you read the literature back in the 1960's or early '70s is that older people and pretty much to this day are the least number of callers to traditional suicide or crisis intervention programs across the United States and Canada. And in San Francisco City and county it was then the San Francisco Commission on Aging was aware of this data that you've been hearing about in terms of older people and their rates of suicide and yet, those callers were not calling in any kind of significant numbers to the San Francisco Suicide Prevention. So, I was very fortunate at that time to be there when we were discussing, well, what could we do, kind of on a short term basis in terms of trying to target that population a little bit more strategically.

And so, there was a group of us that came up with why don't we just call it the Friendship Line for the Elderly, but answer the phone, hello, Friendship Line, how may

## Center for Elderly Suicide Prevention

- 24-hour Friendship Line for the Elderly:
- Local Number in Bay Area
- (415) 752-3778
- **Nationwide Toll Free Number:**
- **(800) 971-0016**
- Contact: Patrick Arbore, (415) 750-4180x230 or parbore@ioaging.org

2

I help you. And what we wanted to do was have a invitation for a conversation rather than when people answer the phone, hello, suicide prevention or crisis intervention that for a lot of older people, that's just too in your face, that's too intense and so, that isn't something that the older cohort group is really comfortable with. And so, we decided to do that and what I started to do just because I had a great deal of love and compassion for older people was that I was able to over the years continue that work and extend that work and then we began our own 501c3 not-for-profit corporation with our own board of directors and we were a separate entity for many years. But as funders said to me, you know Patrick, you're up against it here because first of all, old is in your title, death is in your title, suicide is in your title, grief is in your title, good luck attracting funders.

And so, in 1997 we emerged with Institute on Aging because their mission and the mission of the Center for Elderly Suicide Prevention really converged in terms of wanting to help older people remain as independent as possible, keeping in mind that that value of independence is such a crucial value, not just for older people but for younger people as well. But values and I'm going to talk about that in a little bit, values are so incredibly important when you're doing suicide prevention work. But a couple of things about our 24-hour program were both a hotline as well as a warm line and I brought brochures and I think they're in the back and I have extras that I will leave back there as well. And we have you know, a local number, but we also have our 800-number and that would be the number that people are more than welcome to use.

## Center for Elderly Suicide Prevention

- 24-hour Friendship Line for the Elderly:
- Local Number in Bay Area
- (415) 752-3778
- **Nationwide Toll Free Number:**
- **(800) 971-0016**
- Contact: Patrick Arbore, (415) 750-4180x230 or parbore@ioaging.org

2

And as Betsy said, I've been in Butte County, I don't have the privilege of meeting some of you over the years, and so it's always nice to be here. I was just here on Wednesday because there was a brain injury grief and loss program. I don't know if anybody went to that and I was asked to talk about grief and loss as it relates to trauma because that's another very important element when it comes to elderly suicide prevention, but we answer the phone, hello Friendship Line as I said. What we don't do is that we don't tell people how to feel which I think is really crucial in terms of when you suggest to people that the Friendship Line is there for them. They can certainly be anonymous. It's confidential. There's no fee attached and what we invite is for an older person or their caregiver or younger disabled folks to be able to just have a space where they can explore their own inner feelings and use whatever vocabulary they want to use to try to discuss what's going on with them.

We know that older people as you saw in some of the slides have a rate of suicide that is higher for younger people. Although, out in the community when I give talks across the country, people still assume that younger people have the highest rate of suicide and oftentimes, older people are neglected and that's why I was very pleased and excited that Cal Mesa in developing this partnerships recognized the fact that older people need to have a voice as well and they need options and so, I'm very happy that Friendship Line can be an option.

## Friendship Line Stats

- Receives approximately 2,000 in-coming calls per month
- Makes approximately 3,000 out-going calls per month (emotional support – Med reminders
- Approximately 200 counseling visits per month

3

Just in terms of some stats based on Friendship Line data, I remember back in 1973 when we began this program, if we had 10 callers in a month, I can't tell you how exciting that was, you know, and it's always helpful to be young at those times because you're just feeling like, oh my god this is really moving. And now, we receive approximately about 2,000 incoming calls per month and we make about 3,000 outgoing calls per month including emotional support and that's the warm line category.

And that's something that I hope you think about that if you know people that maybe they're not going to be willing to make call outs because what I realize and the gentleman I was referring to who died by suicide was a very reluctant person when it comes to asking for help, that he just wasn't willing to do that even though helpless there. And the thing that he did do though is the night before he killed himself, he did go to the Emergency Room at his local hospital and his girlfriend had called me and said, you know, that she was relieved and I said you know, I'm glad that he did that, but I'm really concerned and I said, you know, and so I called him but he didn't pick up his phone and he is in a different county and it wasn't, I just couldn't get there. And then she went up that next morning and by the time she got there, the Coroner's office or the Coroner's staffs were there and the Police said he had shot himself.

After that, one of the issues with older people is that they may have seen a primary care physician, they may have seen someone else in the medical or the helping profession and they still went home and killed themselves. And so, I think what we

## Friendship Line Stats

- Receives approximately 2,000 in-coming calls per month
- Makes approximately 3,000 out-going calls per month (emotional support – Med reminders
- Approximately 200 counseling visits per month

3

have to do is and why I'm so pleased here in Butte County that you have assembled with so many people is that I think we have to remind everybody not to take people's lives for granted that they are going to appear tomorrow. They may not and so, we have a warm line component because our program is probably more aptly called depression prevention rather than suicide prevention because as [inaudible]. It's such an important risk factor and depression is something that is often not recognized in older people. It's hard to recognize and respond to that.

## Scope of the Problem of Suicide

According to the American Association of Suicide for 2009 in the U.S.:

- Older adults made up 12.9% of population but represented 15.9% of the suicides
- Average of 1 older adult death by suicide every 90 minutes
- 3.7 male deaths by suicide for each female death by suicide for all ages

I'm not going to look at these stats because you have a lot of statistics.

# Elderly Suicide Deaths: Butte County 2008*

- Population all ages – 220,577
- Population 55+ – 58,556
- 12 deaths by suicide among 55+ for a rate of 20.49 per 100,000 population – of those 12 deaths, 5 were 75+

*Center for Health Statistics

## Society's Dilemma

- Is suicide among the elderly a rational solution to a set of problems?
- Is it a psychiatric disorder?
- Is it a response to a disorder?
- Is it a response to severe psychological pain that results from diagnosable psychiatric disorders?

But the dilemma that I see when it comes to elderly suicide has to do with, is suicide among the elderly a rational solution as you heard the supervisor mentioned today to a set of problems. Is it a psychiatric disorder, is it a response to a disorder or is it a response to a severe psychological pain such as depression or anxiety or whatever? And that's something we have to talk about because when I'm on panels where people are talking about other age groups, when people mention youth and certainly when my own son who is 32, when he was a teenager he was very suicidal. And so, I recognized the importance of providing options and programs for young and adults, but when it comes to older people and I know you've heard this and you might have participated in these discussions, there is a sense that well, if you're older, well, if you want to take your own life, all right, you know, that's your choice, it's your right, but we don't say that about people 35 or 16. And then you know, we say, well the person has, you know is, you know they've heard this about this gentleman I was referring to, they said, well he was old and I said, how old do you think he was and they said, well, he's probably in his 80's. He was 64. You know, that isn't very old and I think we have to really, you know, look at this more carefully and I think these questions are really relevant to all of us when it comes to issues related to older adults.

## Acute and Chronic Suicide in the Elderly

- Acute suicide that leads to death may be attributed to natural causes or accidental causes thus leading to an underestimate of the frequency of suicide
- More difficult for clinicians is chronic suicide – failure to eat; sustained drug and alcohol abuse; refusal to use life-sustaining meds; self-neglect

The other factor that I see and as mentioned in the literature has to do with acute versus chronic suicides. You know, we teach our volunteers and our staff when we answer the Friendship Line, when you get a call from somebody who says, I'm thinking about killing myself. I have pills or I have firearms or whatever, is that you know, you get snapped into action, you know. It's clear the person called the Friendship Line, part of them is really struggling between I want to die and yet, I want to live because why am I calling you when I could just sit here and kill myself. And so, those calls are pretty clear, straightforward.

The calls that are much more difficult for the volunteers and staff, but also I think harder for us in society, families and friends has to do with, you know this more chronic, you know, which is I just stopped eating. I'm not going to do dialysis anymore. I'm not taking my diabetic medication or my blood pressure medication or whatever. And what does that mean? I often get calls from therapists who have will say to me, I've been a therapist for 30 years and I've never had a suicidal individual, but now I'm working with a couple in their 70's who have been married 35 years or 40 years or whatever and one of the couple wants to stop taking their meds or stop their health care and I don't know what to do. And I think these cases are really very [inaudible] a lot of thought and a lot of discussion certainly more than I can do today.

## Risk Factors for Suicide in Late Life

- Age – persons 75+ have the highest prevalence of suicide in our society
- Psychiatric disorders are the most important risk factor – especially depression and alcohol abuse
- Older adults with *three or more prior* depressive episodes were more likely to report suicidal ideation than those with two or fewer prior episodes

And in terms of risk factors for suicide in later life, you know certainly age has already been mentioned, depression, substance abuse are important risk factors, physical illness.

## Risk Factors Continued

- Physical illness may contribute to suicide in over 1/3 of older persons
- Illnesses include central nervous systems (especially AZ); malignancies, cardiopulmonary conditions; urogenital diseases in men; those with mixed AZ and vascular dementia may be at a particularly high risk for suicidal ideation

You know, to me it is also about just mortality, you know. You know when we're younger, we look at all this time that we have. It's like, oh I don't have to worry about retirement or whatever, and then all of a sudden you turn 60, you know which for some of us that was quite a shock. For me, I was like I work in aging all my life and I turned 60, I want to tell everybody I saw that I need to talk about what turning 60 felt like and I urged all of us to really listen to older people when they say, I need to talk about this. I don't know what to do. One older woman said to me, you know, I knew how to do my 40's, my 50's, even my 60's, but I'm in my 80's and I don't know what to do with that. I don't know how to even think about it. I can't even wrap my mind around it and I said, well, let's just start with that, you know, just tell me about your birthday, just tell me what that was like. Tell me about people that you know who were older or maybe older than you.

And then we have these illnesses particularly the dread of Alzheimer's disease, this fear and it certainly a legitimate one that I may enter my 80's or my 90's and then I might be really struck by dementia and then I lose, that insidious nature of that disease, I lose the sense of self. I might live with that for 10 years or 12 years and many of you in this room probably know people like that. And so, I really can relate and empathize with people who say, I am terrified that I am going to get this disease and so, I'd rather kill myself, you know and so, we need to kind of open up communication. We need to open up connections.

# Risk Factors Continued

- Physical illness may contribute to suicide in over 1/3 of older persons
- Illnesses include central nervous systems (especially AZ); malignancies, cardiopulmonary conditions; urogenital diseases in men; those with mixed AZ and vascular dementia may be at a particularly high risk for suicidal ideation

Dr. Jerry Motto has often said, he is a retired psychiatrist from UCSF and he said, you know, connections are paramount. Connections are what bind us to life and that's what we're all doing here is connecting and my hope is that when we end this day that people stay connected and that's really what our Friendship Line is all about.

# Risk Factors Continued

- Hopelessness
- Loss of pleasurable activities
- Significant cycling of mood
- Coping styles – acting out vs. expressing
- Stressful events especially bereavement, divorce, medical illness

Other risk factors have to do with just stressors in general, hopelessness, et cetera.

# Assessment Data

- It is important to assess the **social context** in which the individual lives
- Results in a dynamic formulation because it not only describes the current situation but indlcates hypotheses about what is driving the person to behave in manipulative ways.
- The formulation should allow the clinician to develop hypotheses about the client's future behavior as well

And so, we think about assessment. How do I assess for suicide among the elderly? Well, one of the things that the literatures suggest and I certainly support that is that assessment takes place in a social context. We need to be able to kind of meet people where they live. It might be more convenient at times to have them come to the clinic or setting, but I really applaud those of you who go out into the field and meet people in their homes or when they live in trailers or wherever they live that you're out there meeting them because I think that is so crucial. When I give talks on hoarding behavior for example, you know, people who hoard are just really trying to barricade themselves by something and now they wind up in their 80's and they've learned that hoarding isn't helping them and they are maybe faced for the first time with some of these really dark feelings that they don't know how to manage.

## Issues in Assessment of Older Suicidal Adults

- Distinguishing between normal, idiosyncratic, and diverse characteristics of aging and pathologic conditions
- Baseline data are often lacking from the individual's middle years
- Standardized tools and functional assessment is meaningful if placed in the context of the person's past life and hopes and expectations of the future

And it's good to be out there when you can see the context in which people's lives are lived. And so, what we have to do which is maybe a little different from working with the younger population is that we sometimes confuse aging with, again, as some older people said to me as I said earlier, with something terminal that or isn't that just what it's like to be in your 70's is to be kind of down. You know, it's not. It's just like somebody 32 being depressed. You saw some of that data in terms of how many bad days are you having.

# Issues Continued

- Few standardized assessment tools included any older subjects in the development of the tool
- Assessments should include: cognitive function; demoralization; depression; paranoia; substance abuse; psychopathology; suicide risk

And so, they're not enough. Again, standardized assessment tools that have been normed on older adults and we need to do more work in that area, but we also need to assess for cognitive functioning. Demoralization is, is your life now devoid of meaning, because your life now as an older person may have started to shrink because of mobility issues or transportation issues or other health related issues or macular degeneration, so we need to look at that,

## Assessment of Values

- Values are ideals that matter most to people in life---determine one's actions even before one's actions can be subjected to critical thought
- Vanlaere, Bouckaert & Gastmans (2007) examine three of these values – autonomy, dignity and responsibility

But I mentioned values before and one of the things in the literature and what again I hear all the time from older people when I talk to them and this gentleman who died by suicide as I implied I knew him and he was fiercely independent, fiercely independent. That value, belief really had a tremendous influence on his life and the thing about values and why I mentioned that and I asked you to think about what do you value, what are your beliefs and attitudes because the thing about values, beliefs, and attitudes, they are in our lives from a result of many tributaries, such as family of origin, church groups, teachers, whatever. And we don't--we just see that as that's who I am. I don't even think about it and what happens to people then is that there's no pause button.

## Autonomy and Older Adults

- People who lose the ability to ead an autonomous life see themselves as burdens rather than complete human beings
- Dependency is labeled as a disability – cannot be a complete person
- Loss of autonomy contributes to feelings of hopelessness and low self-esteem

If my independence is being threatened, my autonomy through fears of illnesses or I'm going to be dependent on somebody, that might immediately launch me into I can't live like this. I can't be here. I don't want to be here. I don't want to be dependent. I don't want to put a lot of financial resources. As one older person said to me the other day, he said, you know, he said I have this illness and I'm really worried about it and he said, but it is crucial to me that I leave my adult son, my adult daughter, money. That's what I can do and if I have to have a long ordeal with health issues and that's going to cost a lot of money, I'm not willing to do that because his value was, I am going to leave my loved ones financial security, you know. And I just you know, again, it just moves like that. There's no pause button and so, I tried to get him to talk about that a little bit more, is that are there other things you could leave--anyway, but I just think it's really important to think about that, you know, autonomy, independence, you know. Dependency in our culture is labeled a disability, so you can't be a complete person if you are dependent. What I try to say is interdependence; that's what we're all talking about here. That's what this whole Cal Mesa project is about. It's partners, you know, it's not just talking about this institution or that organization. It's people partnering, it's people reaching out to one another to say, hey, maybe I can help. You know, it's like collaboration and so, Friendship Line you know is really just, again another, you know, again menu item on this helping table so that people have just another opportunity, you know.

# Autonomy Continued

- True autonomy is rarely possible for someone who is dying
- Battin (2005) writes "the principle does insist that free, considered, individual choice, where one is the architect of one's own life and the chooser of one's own deepest values, must be respected

True autonomy is rarely, rarely there for all of us even though we might want to say, I want to have as much control in my dying as I possibly can, but how likely is that, you know. Most people say to me, I want to die in my sleep, but not everybody dies in their sleep. We die in so many other ways. And so, we might not have the type of autonomy that we want. Margaret Battin who was a past president of the American Association of Suicidology writes: The principle does insist that free considered individual choice where one is the architect of one's own life and the chooser of one's own deepest values must be respected. So, when I'm dealing with older people, what I'm saying to them is I really want to know what you believe in. I really want to know what matters to you so that we can start talking about it. So, the person can be more conscious of what that is, you know. Oh, my god, when I just think about dependent, I want to kill myself, I mean and you know you've heard this or maybe even thought it yourself, but what we want to do in terms of prevention is try to open up a conversation. Let's connect about that. Let's talk about that.

# Dignity

- Autonomy is closely related to dignity
- Some authors state that the risk of becoming incompetent is a major motivator for committing suicide before it is too late
- Older people take their own lives to prevent mental deterioration from taking away what they love about themselves and what others love about them

Dignity is another.

## Responsibility

- The fear of being a financial burden on others is greater than their fear of death
- They fear being the object of other people's responsibility
- Through suicide older people reassert themselves as moral agents who accept responsibility toward their relatives and society

Responsibility is another. The fear of being a financial burden as I said is really very, very important to us. The fear of being the object of another's responsibility is a problem.

## Values Summary

- Intolerability – the main reason underlying suicide – is closely linked to the values a person holds
- Whether an older person views living in a dependent living situation as intolerable is determined by things like fear of losing one's independence and dignity

So, when we look at these values that it comes to intolerability, you know, I can't tolerate, you know. This is overwhelming and then we have to look at as you see these gender discrepancies where men of any age--thank you, men of any age are more likely to resist help because if a man says I need help, slack down upon that is shame, weakness. I shall take care of myself and we need to be aware when we cross that threshold into intolerable, you know, as this gentleman said, it's impossible to live with this pain, you know and his girlfriend as she said to me, she said and this isn't just physical pain. This is a mental health issue that he just couldn't find ways to manage his depression and just resisted, resisted, resisted.

# Treatment

- Clinicians must aggressively address the problems that may have exacerbated the crisis – treating a depressive disorder, treating alcohol abuse or dependence, or supporting the person to adjust to a recent loss
- In the case of chronic or terminal illnesses, the professional will attempt to help the person adapt and adjust to the problem

And so, again, we have to aggressively, but compassionately, look at the scope of this problem as we're doing today, whether here in this county or across the state. We need to really look at it and in the case of chronic or terminal illnesses, the professional will attempt to help the person adapt and adjust to this issue. And I wanted to mention if you're interested in looking at more related to terminal illnesses and older adults, look to the work of Yeates Conwell, C-O-N-W-E-L-L. And he has done some rigorous research on older people and terminal illness and what his conclusions were is that older people cling to life who have had a prognosis of terminal illnesses. It's not that people don't think about suicide, but what he said is that that there is still this part that clings to living and it's something to think about.

# Prevention

- One strategy is based on the traditional telephone crisis intervention model – telephone contact has been shown to decrease the expected frequency of suicide among the elderly
- Primary prevention – educating professionals and the general public about risk factors

## Implications for Community Members and Professionals

- Older people have high rates of suicide
- Knowing risk factors will help identify older people who are at high risk for suicide
- Inquire about vague suicidal thoughts, wishes to die, past attempts, etc.
- Be able to engage both the identified client and family in a discussion of suicide risk and prevention: Intervention is prevention

So, what are the implications and I know my time is running down here is that we know older people have one of the highest rates of suicide. Knowing the risk factors, being aware and particularly as I'm saying, being able to ask--thank you, being able to ask about issues related to values, what do you believe in, what are your attitudes, what is the meaning in your life, but then talk about what are the connections, you know. Connections are what binds us to life and we need to be able to think about that and so, I have some references there as well for you.

## Implications Continued

- Professionals need to examine their own views on euthanasia and assisted suicide; they must also examine their own ageism in order to avoid the trap of thinking "It's understandable that he would want to die under those circumstances"
- Be aware of the risk of suicide and one's own attitude about suicide
- Take care of yourself; get support for you

The final thing I want to say because I always feel it's important when there's any kind of suicide talk is to be able to mention Dr. Edwin Shneidman who was really the father of the suicide prevention movement in the United States and he was at this work for probably 50 years and he died I think it was about a year and a half or two years ago. And if anybody had heard him talk, I know you would think very highly of him, but he says something really so important for us as community members which is he writes, for himself the core data to elicit from a potentially suicidal person are not a family history, not an analysis of who they are or a demographic survey or a psychiatric account or a psychodynamic interview or a self report of a mental illness, but rather keeping all of that information in mind, what is directly to the suicidal person's point, namely, a full response to the true basic questions in clinical suicidology. Ask the person where do you hurt and how may I help you? Where do you hurt and how may I help you and then allow time. The gift of time and the gift of your attention on that individual can be another very helpful intervention. Thank you very much and if you could do the post-test, which is on the other side of that, I would appreciate that. Thank you very much.
**Audience member:** [Inaudible]
**Patrick Arbore:** And I just want to say, there's a couple of words about the Cal Mesa project for us in this area is that Cal Mesa as you heard from the EAG group in terms of the marketing and networking and the Cal Mesa project is designed and I like their message which is compassion, caring and action. And the Friendship Line is a partner here with the Department of Mental Health with Anne. I just met with some of the

## Implications Continued

- Professionals need to examine their own views on euthanasia and assisted suicide; they must also examine their own ageism in order to avoid the trap of thinking "It's understandable that he would want to die under those circumstances"
- Be aware of the risk of suicide and one's own attitude about suicide
- Take care of yourself; get support for you

Mental Health Directors at a meeting the other night in Sacramento and what we're trying to do again is to provide just additional support and focus so that as you're working with people and trying to help people in terms of reducing suicide risk that you know that there is this whole program of support that is working with you. One of the other partners who is subcontracting with us is the effort which is a suicide prevention hotline that is also available to people here in your county, as well as our 24-hour hotline, warm line and that's all supported through the grant of Cal Mesa. Questions? I'm not sure what that is. That's a hook. Oh, that's the hook. Thank you very much. One question. That's two questions, okay.

**Audience member:** A quick question: A couple of years ago when I attended one of your trainings you gave us the number to the San Francisco number and then when we tried to use it, it was always busy or not adequately staff. Do you have more staffing now than--

**Patrick Arbore:** We do service out of Cal Mesa. Okay, great. One of the issues sadly is that that Friendship Line is really the only hotline, warm line that focuses on the needs of people who are older and so, particularly late at night which we reserve for suicidal crisis only from 11 at night to 8 in the morning can get very busy. And so, we're right in the middle of making some decisions so that that won't happen again. Any--yes, go ahead.

**Audience member:** Could you really have [inaudible]?

**Patrick Arbore:** I'm going to be here for lunch and then I have to leave unfortunately after that, but I'll be here for lunch. Yes, yes. Thank you very much.