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Jennelle Liljestrand
Suicide in Older Adults: Helping
Case Managers Engage in Difficult
Conversations

ABSTRACT

Suicide among older adults is an increasing mental health concern in the United States, and yet depression and other signs of suicide often go unnoticed. The film and discussion guide “Talking with Dolores” was funded by the Massachusetts Department of Public Health to increase awareness of warnings of depression and suicide in the elderly and demonstrate ways of conversing with them about suicide. Because of their unique contact with older individuals in their own homes, geriatric case managers are positioned as a gateway to necessary psychosocial support for elders, yet may not be receiving adequate training for the initial detection of severe depression and suicide risk. Professional social workers are frequently put into the position of providing training related to the psychosocial needs of clients who are cared for by geriatric case managers. Thus, case managers and social workers alike may benefit from training tools which might increase capabilities of case managers to confront these emotionally charged issues. This study explores whether geriatric case managers think this film/discussion would be a useful training tool for increasing their awareness and comfort in discussing depression and suicide with clients.

The data from two focus groups of geriatric case managers in Boston, MA indicated that they perceived that the “Talking with Dolores” training effectively reminded them of their important role in providing psychosocial support to their clients and helped them identify signs of suicide, but did not sufficiently provide them with concrete skills in the management of suicidal ideation. The qualitative data revealed some speculation that “Talking with Dolores”

would increase their comfort in discussing depression and suicide with clients. Participants thought it could be a helpful training tool for geriatric case managers. They reported a lack of knowledge and training on the subject was the inhibiting factor for not discussing suicide with their clients. Additional quantitative data showed that the sample's exposure to the Dolores training increased knowledge about suicide risk in the elderly but did not increase their comfort level in discussing suicide with clients.

**SUICIDE IN OLDER ADULTS: HELPING CASE MANAGERS ENGAGE IN
DIFFICULT CONVERSATIONS**

A project based upon an independent investigation in collaboration the producer of the film “Talking with Dolores”, Darlene O’Connor, and submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2013

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CHAPTER I

Introduction

Suicide among older adults is an increasingly concerning mental health issue in the United States (Heisel, 2006). In 2004 alone there were over five thousand reported suicides in adults over 65 in the United States; the suicide rate was 14.3 per 100,000. In the male older adult population the rate is almost double; they are the most at risk population and account for a disproportionate number of suicides (Centers for Disease Control and Prevention, 2007; McIntosh, 1995). As the sheer numbers of older adults grow to the forefront of attention in the mental health field, new approaches must connect high risk elders with existing and effective mental health treatment (Scogin, 2009; Zettle, 2007). Furthermore, increasing numbers of older adults are receiving primarily home health care services instead of primary care; these elders are twice as likely to have major depression, an important risk factor for suicide (Bhar & Brown, 2012; Bruce et al., 2002). Training programs for home care geriatric providers, including case managers, need to address the high risk for depression and suicide in this population. The educational film being examined, "Talking with Dolores," may increase understanding of depression and suicide and thus motivate case managers to more willingly and actively broach the topic of depression and suicide with older adults. The eventual goal of "Talking with Dolores" is to increase identification of depression and suicidality to reduce suicides in this population.

A Public Health Issue

As the post-World War II “baby boomers” age, the population of older adults has become the fastest growing population in the United States (Conwell, Duberstein & Caine, 2002; Hooyman & Unutzer, 2011). Within the next 20 years it is estimated that the population of older adults, defined as over 65 years of age, will double while adults over 85 will multiply by 5 (Institute of Medicine, 2008; Stone & Barbarotta, 2011). The growth of elders in the U.S. is becoming a public health issue due to the increasing need for services in healthcare and social services that do not have enough investment or training in geriatrics. The shortage of geriatric social workers has been recognized for many decades (U.S. Department of Health and Human Services, 1987). Eleven years ago only three percent of the National Association of Social Workers (NASW) reported gerontology as a primary professional focus (Bureau of Labor Statistics, 2004; Hooyman & Unutzer, 2011). Although this number has increased, in 2005 still only 5 percent of social workers were trained in gerontological social work and many currently in the field are nearing retirement (Hooyman & Unutzer, 2011). New avenues must be explored to find ways to increase public and professional awareness and understanding of elder depression and suicide, two areas of concern in this expanding age group (Akincigil et al., 2012; Heisel, 2006).

Depression

Older adults face higher rates of depression than the general population; thus, resources for depression in this growing population will be increasingly in demand (Akincigil et al., 2012; Barcelos-Ferreira, Izbicki, Steffens & Bottino, 2010; Stone & Barbarotta, 2011). Yet depression in elders is commonly misdiagnosed, frequently as insomnia, pain or anxiety, and despite available resources, it is often not treated (Bruce et al., 2002). There is speculation that this is due to elders’ verbal presentation to doctors and a lack of standard screening procedure in

primary care (Gilbody, Richards, Brealey & Hewitt, 2007; Hegel, Carter, Locke & Buckley, 2007; Monteso et al., 2012). Depression and anxiety are the most commonly found psychological disorders in the older adult population (Monteso et al., 2012); statistically 1 out of 5 older adults in the community are experiencing depressive symptoms (Kastenschmidt & Kennedy, 2011). Depression is even more common in elders confined to their home and receiving home health care, suggesting that interventions must focus on case managers who coordinate home care services through home based assessment (Bruce et al., 2002).

Elders face high rates of depression for a multitude of reasons including an increase in social isolation, helplessness, economic factors and perceived burdensomeness, which may be magnified in elders due to pain, chronic illness, and increasingly frequent experiences of loss (Cukrowicz, Cheavens, Van Orden, Ragain & Cook, 2011; McIntosh, 1995). Depressed individuals of all ages use health services at higher rates than the average population. However, it seems that older individuals are not utilizing the specific mental health resources necessary for treatment and prevention of suicide (Scogin, 2009).

Depression as a Risk for Suicide

Depression is the biggest risk factor for elder suicide and is frequently not recognized as such (Bhar & Brown, 2012). Ninety to ninety-five percent of older adults who have committed suicide were clinically diagnosed as depressed (Center for Human Development, 2010). Self-rating inventories have been shown as the most predictive instruments for suicidality (Bhar & Brown, 2012). One such inventory, the Zung Self-Rating Depression Scale (Zung, 1965), yields a mental health outlook score based on seven questions and has proven useful with older adults (Ross, Bernstein, Trent, Hendeson, & Paganini-Hill, 1990). This indicates how suicidality can be easily and directly measured from identifiable symptoms of depression. Unfortunately, many

people, including healthcare providers, believe that depression is a natural part of aging (Center for Human Development, 2010) and it is left unrecognized and untreated.

This myth is damaging because depression is a mental health disorder that can be effectively treated with a combination of antidepressants and/or therapy (Brown, Brown, Bhar & Beck, 2008; Cuijpers, Andersson, Donker, & van Straten, 2011; Dubicka, Elvins & Roberts et al., 2010). At least three forms of therapy, cognitive therapy, interpersonal therapy (Klerman, Weissman, Rounsaville & Chevron, 1984), and behavioral activation (Jacobson, Martell & Dimidjian, 2001) have been recognized as valid and effective ways to treat depression, a condition that appears to be one of the easier psychological disorders to treat (Scogin, 2009; Zettle, 2007). Akincigil et al. (2012) point out that, although antidepressants and psychotherapy have been effective in reducing depression in elders, there are side effects to some medication. For example, some psychotropic drugs have been documented as risk factors for falls, which can be detrimental or even fatal in elders (Hien et al., 2005). However, with the use of therapy and appropriate drug recommendations, such side effects can be monitored and controlled (Akincigil et al., 2012).

Suicide

The aforementioned statistics on depression in older adult populations lead to a critical safety concern: suicide (Heisel, 2006). Older adults were recognized as a priority for intervention in the surgeon general's 1999 *Call to Action to Prevent Suicide* (Adamek & Slater, 2006). Annually, there are over 36,000 reported suicides in the U.S. population, a number that surpasses the number of homicides or motor vehicle fatalities. Suicide was the leading cause of death overall in 2009 (CDC, 2010; Insel, 2012), and the numbers continue to rise (Schmitz et al., 2012). As a subgroup, adults over 65 are at a higher risk than the general population (Heisel,

2006; Insel, 2012). Older adults account for only 12.8% of the United States population but 19% of suicides (Adamek & Slater, 2006). White men over the age of 85 are at the highest risk and are not receiving preventive care to identify primary risk factors, such as depression (Bhar & Brown, 2012; Centers for Disease Control and Prevention, 2008; Center for Human Development, 2010; Heisel, 2006). Suicidal ideation in older adults is an urgent issue because the suicide methods elders choose are more fatal than in the younger populations; it is estimated that 8 out of 10 older males use firearms (Center for Human Development, 2010). These methods, combined with an older and fragile human body, leads to fewer suicide attempts but more suicide completions (Labode & Sher, 2011). One in four suicide attempts end in a death in adults over the age of 75 compared to one in 12 attempts that are successful in the general population (LaBode & Sher, 2011). Elder suicides account for a disproportionate number of suicides. This calls for attention as to why elders are not receiving sufficient support and resources (Center for Human Development, 2010; Labisi, 2006).

It is clear that elders who are receiving primary medical care are not being adequately assessed nor treated for depression or suicidal ideation. Within a sample of suicide cases in older adults, 80% had received healthcare attention within a month before their suicide completion. Forty percent of those suicide cases had seen a healthcare provider within a week before the death and ten percent had seen a healthcare practitioner that same day (Alexopoulos, Bruce, Hull, Sirey & Kakuma, 1999; Center for Human Development, 2010). Although it is possible that visiting the doctor may increase clients' suicidality based on realizing their declining health, this further suggests that primary care doctors are not sufficiently identifying and treating depression and suicidal ideation. Depression is a chronic mental health condition that is not likely to be suddenly triggered by a doctor's visit (American Psychiatric Association, 1994).

Stigmatized views of elders and the myth that depression comes naturally with aging may explain why doctors fail to recognize depression (Center for Human Development, 2010) and thus are not providing appropriate referrals. Based on the data, it appears that elders may be struggling alone with suicidal thoughts, which are most often paired with depression, instead of utilizing resources and treatments (Center for Human Development, 2010). It is clear that elders underutilize mental health services (Bartels, Coakley, Zubritsky, Ware, Miles, Areán et al., 2004). There needs to be increased attention to mental health in non-mental health settings to support protective measures (Alexopoulos, Bruce, Hull, Sirey, & Kakuma, 1999; Smith, 2011).

Home-based case management is a growing geriatric service sector as increasing numbers of older adults opt to stay at home and receive homecare. Many geriatric case managers visit elders living at home and are responsible for general “home assistance” (Bruce et al., 2002), which includes both *providing* basic clinical services as well as *referring and coordinating* clinical and physiological care (Eack, Greeno, Christian-Michaels, Dennis & Anderson, 2004). Case managers are responsible for assessing elders’ needs in all areas related to their quality of life. Because case managers are often given overly general and ambiguous responsibilities for assessing and referring for psychosocial care, it is important that case managers receive basic clinical training in order to recognize indicators of depression or suicidal ideation in an elder client. Most often case managers are the brokers of clinical care, but they are also expected to provide short-term clinical support to elders. Thus, although case managers are not trained to be solely responsible for the mental health of their clients, they are often placed on the frontline and observe day-to-day needs. Therefore they need basic clinical assessment skills to identify and triage those clients who are depressed and suicidal in order to reduce the number of elder suicides.

These geriatric case managers do not always receive adequate training in general mental health care, let alone suicidal ideation. There is a growing consensus that depression and suicide must be emphasized more in training programs for geriatric case managers (Adamek & Slater, 2006; Black, 2007; Katona, 1991; Eack et al., 2004). If case managers can learn to identify signs of suicidal ideation or depression and feel comfortable directly assessing and supporting elders, then they may make appropriate referrals for treatment. This study aims to evaluate the usefulness of a particular film and discussion – “Talking with Dolores” – as a training tool for geriatric case managers in clinical awareness of depression and suicidal ideation.

CHAPTER II

Review of Literature

Barriers for Older Adults Seeking Mental Healthcare

Reluctance in older adults to discuss their mood and emotions has been associated with their under-diagnosis of depression (Mellor, Davidson, McCabe & George, 2008). One study found that half of older adults in the sample did not report their depressive symptoms to their doctor and did not receive treatment as a consequence (O'Connor, Rosewarne, & Bruce, 2001). The psychological barriers preventing older adults from receiving care for depression and suicidal ideation have not been sufficiently investigated. There is an identified gap between need for services and their use. Over the past decade, mental health commissions have been established in the United States to focus on older adults and make recommendations for improvement for the mental health care system (Bartels, 2003; Mackenzie, Scott, Mather & Sareen, 2008). Since there are simple depression screenings and support for suicidal behaviors that are not being employed, additional interventions may be needed to raise awareness and understanding (Gilbody et al., 2007; Hegel, Carter, Locke, & Buckley, 2007; Heisel, 2006).

Several relevant perspectives can help to explain why older adults may not seek available and effective treatments (Heisel, 2006; Karlin & Duffy, 2004). One idea suggests that adults over 75 years of age are psychologically impacted by the memory of surviving the Great Depression and World War II (Karlin & Duffy, 2004). Individuals from families in difficult economic situations between 1929 and 1945 would be especially affected (Montbriand, 2004).

For many in this cohort of elders, mental health and emotional well-being were viewed as a luxury because they needed to focus on employment and nutrition for the family (Karlin & Duffy, 2004). As a consequence, a survival mentality was paramount in which individuals and families were left to their own devices without much additional support. The culture of the Great Depression era may have fostered the habit of not discussing personal matters as a way to hide pain or success from neighbors. It may be for this reason that personal difficulties, such as depression, were, and still may be, frequently viewed as moral failures. It is possible that elders as a generation are resistant to mental health treatment or exploring the possibility of depression in themselves (Blow & Barry, 2012). Nonetheless, it is important to note that individual experiences of this time period varied greatly by economic status and individual family differences (Montbriand, 2004).

Another possible barrier is stigma associated with therapy. During the younger adulthood of current older adults, therapy was stigmatized. Beginning in the 1940s, therapists were commonly referred to as “shrinks,” which comes from the derogatory historical term “headshrinker” (Gadon & Johnson, 2009). “Headshrinkers” was a term used to describe natives of South America who shrunk the heads of their deceased enemies from battle, and the term continued to be used to describe someone who was brutal and uncivilized (Walter, 1991). This term was used in print beginning in 1950 and has since been shown to have negative effects on perceptions of therapy and its effectiveness (Gadon & Johnson, 2009). Older adults would have grown up with the negative influence of this derogatory term and may still be inhibited by this popular misconception of therapy as a mysterious and perhaps unscientific process (Gadon & Johnson, 2009).

There are also physical and logistical barriers that may be preventing many elders from seeking mental health treatment or any other healthcare. Researchers have found that elders engaged more in mental health treatment, and engaged more frequently, when they were in a system in which mental health care was integrated with primary care (Bartels et al., 2004). It only makes sense that convenience and accessibility are important factors to consider when working with a population with physical limitations that impact driving, mobility and ease of access to transportation services (Grunebaum, Luber, Callahan, Leon, Olfson & Portera, 1996). Studies are suggesting new approaches for mental health treatment to cater to the needs of the older population. For example, researchers suggest decreasing the time between referrals and the visit (Bartels et al., 2004; Grunebaum et al., 1996). Bartels et al. (2004) also found that higher mental distress was predictive of greater engagement with mental health treatment. This research suggests that older adults make the effort to overcome the barriers to treatment only when they are suffering from high levels of distress

Professional Ageism

In the United States, aging is viewed and commercially advertised as a process to fear and avoid. Consequently, working with older adults may elicit fears and anxieties about one's own aging process. Case managers or physicians may experience fears about their own aging when caring for an older adult, and thus, avoid conversations about depression and suicidal thoughts (Center for Human Development, 2010). Aging successfully has come to mean staying youthful in appearance and in health (Moody, 2005). From a western white middle-class perspective, "aging successfully" is based on cultural values of independence, productive activity, sociability, and health that are valued in the United States (Tornstam, 1996). Tornstam suggests that younger adults cannot see "gerotranscendence," which he conceptualizes as the

positive and enlightening developmental processes of aging in which the self is redefined through existential questioning. Aging in this country is frequently seen from a deficit perspective; feelings of social isolation, burdensomeness, and depression may be assumed inevitabilities from a provider's perspective. Another example, or perhaps co-occurring explanation, is that providers are not trained to detect depression in elders because the culture in the U.S. is so focused on staying young and maintaining other values of independence (Moody, 2005; Tornstam, 1996).

Identifying Elders at Risk

Although depression is commonplace among adults older than 65, only 25 to 75 percent of cases are identified. These wide ranges of detection rates are evident in residents of nursing homes as well as elders living at home (Mellor, Davidson, McCabe & George, 2008).

Symptoms of depression may be more difficult to identify in the geriatric population.

Depression as an illness manifests itself differently in elders than in the younger population (Katona, 1991). Symptoms in elders may be observed as insomnia or pain, or are hidden in a much more complex medical profile. Depression is even more difficult to identify when combined with other factors common in elders: bereavement, social isolation, frequent or chronic pain, and changes in mobility. Several studies found that acute physical illness was present in the vast majority of suicide cases in older adults, and it was most often determined to be a contributor to the suicide (McIntosh, 1981; Osgood, 1985 as cited in Harper, 1989).

Additionally, some older adults experience decreased cognitive functioning which hinders their ability to monitor their own medications and self-report their changes in mood (Katona, 1991; Mellor et al., 2008). Health care providers, frequently not trained in mental health care, do not

always detect depression in older adults (Gilbody, Richards, Brealey & Hewitt, 2007; Hegel, Carter, Locke & Buckley, 2007; Monteso et al., 2012).

Elders who receive home case management services have been shown to be among an even higher risk category for depression and suicide than elders in the general population. The general population of elders may continue to see their primary care physician or specialist at an outpatient facility or reside in an inpatient setting where there may be a different standard of screening practices and treatment (Bruce et al., 2002). Bruce et al. (2002) demonstrated that of elders receiving care at home, only 22% of those who met criteria for Major Depressive Disorder were receiving treatment. Researchers suggest that under-diagnosis of depression be addressed through increased screening practices validated with the older population (Adamek & Slater, 2006; Katona, 1991). A multidisciplinary and collaborative model for care has been found to be beneficial in complex medical cases of older adults facing physical illnesses compounded by psychosocial and age-related changes (Harper, 1989; Karel, Gatz & Smyer, 2012; Schulberg et al., 2001).

Home-Based Case Management

Given the physical and psychosocial barriers against elders receiving mental health attention, case managers potentially have a key opportunity to screen for such an important mental illness because of their attention to multiple elements of an elder's care and unique role in client homes. Case managers are sometimes the only service providers who screen and assess the needs of older adults living at home and make sure their needs are comprehensively met (Ryan, Sherman, & Judd, 1994). Most importantly, case managers serve as the link between mental health providers, primary care providers, and the client (Oxman, 2003). Studies indicate that older adults are most reluctant to seek help from mental health providers, yet are willing to

accept treatment for depression when their treatment is integrated with primary care (Oxman, 2003). Case managers provide multidisciplinary and integrative care and monitoring that is supervised by a licensed professional or team (Oxman, 2003). This multidisciplinary model has been shown to be most effective with older adults (Karel, Gatz & Smyer, 2012). Studies suggest that with the low numbers of geriatric mental health specialists, care providers such as case managers may need to increase their awareness of their clients' clinical needs that may be overlooked.

Role and Responsibility

Case management has demonstrated positive impacts on the quality of life of clients; thus, attention to quality of life has been integrated into the case management role (Rapp & Chamberlain, 1985; Ryan, Sherman & Judd, 1994). Case managers are responsible for client intake, assessment, care planning and coordination and monitoring and anticipating needs. In addition, when unanticipated concerns arise, case managers are responsible for “crisis intervention” (Ryan, Sherman & Judd, 1984). Thus, case managers often provide short-term clinical services such as psychosocial support to the elder or family and assessment of mental health status (Black, 2007; Eack et al., 2004). Case managers also provide ongoing phone or in-home contact to modify treatment plans, educate clients about treatments, and teach self-management skills as needed (Oxman, 2003). Due to the nature of work with medically complex clients in a home environment, additional clinical concerns arise that the case manager becomes ultimately responsible for (Eack et al., 2004). Case managers are responsible for a broad spectrum of “home assistance” (Bruce et al., 2002) and coordinating and referring for formal and informal support. Usually a licensed clinical team leader supervises case managers (Ryan, Sherman & Judd, 1984).

Although case management was initially a concept of care coordination, cost control and client advocacy, the field has been expanding into a variety of settings that each hold a different set of expectations for the case management role (Thompson, 1998). However, the extent of psychosocial support and “clinical services” are ill defined in many case management positions and areas of responsibility often are not defined with boundaries (Ryan, Sherman & Judd, 1984). Case management can range from basic telephone contact to face-to-face case management with psychotherapy (Oxman, 2003). This confusion has implications for the type of monitoring and advocacy that case managers provide and the quality of psychosocial care clients receive. The term “case manager” is ambiguous in terms of role expectation, training, and care outcome (Ryan, Sherman & Judd, 1984).

Case management, as a field, does not rely on uniform academic criteria in the constitution of its staff; case managers come from a variety of disciplines and educational backgrounds and enter the field without a standardized training (Black, 2007; Ekers, Esk & Valleys, 2010). Some case managers are licensed nurses or social workers, while other case managers may not have a bachelor’s degree but have experience in the field (Eack et al., 2004). In a survey of case managers in Pennsylvania (Eack et al., 2004), 80% only held a bachelor’s degree. Of these bachelor degrees, 50% were in unrelated fields. Training backgrounds are significant since case managers have an essential role in providing services (Ryan, Sherman & Judd, 1984).

Case Management Training

As evidenced by the amount of untreated depression and suicidality in the older population, it is clear that identification and prevention of elder mental illness is of great concern. It is, therefore, noteworthy that case managers receive less psychosocial training that

mental health professionals receive. Even mental health professionals do not receive sufficient training in depression. According to one measure, less than half of professional or paraprofessional carers in residential settings had any kind of formal training in depression (Mellor, Kiehne, McCabe, Davison, Karantzas & George, 2008). This lack of training is important to note given that the majority of mental health professionals encounter suicidal clients (Schmitz et al., 2012). In a national sample of social workers less than one quarter received suicide training during their education, and usually it was not deemed as sufficient (Schmitz et al., 2012). Many case management organizations do not provide a standard set of questions for mental health screening to compensate for this lack of training in their case managers (Black, 2007). Although there is a lack of suicide training even among professional mental health providers, trainings are expanding to the non-professional community, especially to those working in school settings. These “gatekeepers” are adults who regularly have contact with the at-risk school-aged individuals and can be vigilant of indicators of suicidality and make appropriate referrals (Schmitz et al., 2012). Case managers have a similar “gatekeeper” role with at-home clients but do not receive this training.

Case managers are not currently a focus for training in handling suicidality. One sample of case managers interviewed in Pennsylvania reported that the minimal training they currently receive is not applicable to their needs in the field (Eack et al., 2004). The clinical skills training they receive is perceived to be too specific to a psychotherapeutic relationship that is not part of case management. Instead, case managers indicate a need for a basic education on mental illnesses in order to observe and assess symptoms, to make the correct referrals and set up appropriate resources for clients. In addition, case managers reported a need for training in engaging their clients when they are difficult to engage in conversations about their wellness

(Eack et al., 2004). In summary, case managers acknowledge the need for basic mental health training and engagement skills in order to improve the quality of their assessment and service.

Not only do case managers acknowledge this training deficit, but data from Joshi & Pedlar (1992) indicate that case managers highly value training. Ninety-six percent of a sample of Canadian case managers and supervisors were found to believe training to be “important” and even “extremely important.” It is noteworthy that the most commonly reported barrier to training was financial restraints within the agency (Joshi & Pedlar, 1992). Fortunately, it has been shown that such trainings in assessment for depression, especially interactive training programs with skill demonstrations, do significantly improve mental health screening practices in case managers (Quijano et al., 2007).

Summary

Case managers are sent out to assess for functioning and well-being and then arrange and coordinate home-based care services (Mellor, Davidson, McCabe & George, 2008). Although case managers are responsible for client well-being, they may be uncomfortable discussing depression and suicide. Investigations have found that older adults often do not discuss non-physical problems with General Practitioners (GP) because they do not expect to receive treatment for non-physical problems and it seems inappropriate or irrelevant to address them with GP (Mellor, Davidson, McCabe & George, 2008). However, because older adults build “a sense of rapport” (Black, 2007) and a unique relationship with case managers in their own homes, they may feel more comfortable in discussing their emotional concerns with case managers (Mellor, Davidson, McCabe & George, 2008). In fact, older adults, in contrast to younger clients, tend to build stronger alliances with their case managers; one study indicated that among clients with serious mental illness, older adults, possibly because of fewer social and

family supports, had closer relationships with their case managers (Draine & Solomon, 1996). Consequently, case managers may be very likely to encounter mental health issues in older adult clients.

Since case managers are considered to play a pivotal role in clients' care, (Ryan, Sherman & Judd, 1994) it is important that they are included in an initiative to increase awareness and prevention of suicide among older adults. Data suggest that case managers need additional training to identify signs of depression and suicidal ideation and to make appropriate referrals. Case managers, themselves, value and recognize the need for basic mental health training, and some trainings have been validated as significantly effective (Eack et al., 2004; Joshi & Pedlar, 1992; Quijano et al., 2007).

Broader trainings aimed at the approach and culture of an agency, instead of focusing on individual clinicians' clinical skills, have been shown to be very effective in impacting staff behavior and protocol. This may be an important element to consider in the future development of training programs (Bobo, Anderson & Bowman, 1997; Donald, Dower & Bush, 2013). Multifaceted and multidisciplinary trainings may improve the effectiveness and sustainability of suicide prevention (Donald, Dower & Bush, 2013).

CHAPTER III

Methodology

Entertainment has been used as a worldwide public health intervention for decades. Dramas have been especially effective in captivating and playing to the emotions of the audience, and most importantly, dramas are effective in changing attitudes and norms because they stimulate discussion among the audience and show the consequences of behaviors (Piotrow & de Fossard, 2004). Researchers have observed that drama draws out an empathetic emotional response from the audience; audiences often relate to and consider the theme of the drama within the context of their own lives (Sood, Menard & Witte, 2004). In addition, when audience members can relate to a piece of drama, the viewing process can encourage participation and engagement in the material (Ritch & Brennan, 2010). Entertainment-education programs can be very powerful in changing values, attitudes, beliefs and behaviors (Ajzen & Fishbein, 2005; Bambauer & Prigerson, 2006; Motjabai, Olfson, & Mechanic, 2002; Piotrow & de Fossard, 2004; Sood, Menard & Witte, 2004). Attitudes and beliefs can be highly predictive of behavior. Thus, targeting attitudes and beliefs with an educational intervention like “Talking with Dolores” may increase ability to discuss depression and suicide on the part of geriatric case managers.

In an effort to raise awareness and comfort in discussing depression and suicide with older adults, the educational film, “Talking with Dolores,” was examined as a training tool that could be used with geriatric case managers. Originally, this film and its accompanying discussion guide were created by Professor Darlene O’Connor in an effort to empower older

adults to identify mental health needs of themselves and their peers and feel more comfortable discussing difficult topics (Center for Human Development, 2010). This study used focus groups of geriatric case managers to gather qualitative data regarding the appeal of “Talking with Dolores” as a training tool; additionally, quantitative data were collected to measure changes in their knowledge and comfort in discussing depression and suicide after exposure to the film and discussion.

Sample

Participants were case managers or “care managers” employed at a Boston-based non-profit organization that provides direct homecare services and coordinates care for older and disabled adults. “Care Manger” is their employment title, which serves to specify the type of case management work they provide clients. The major responsibilities of care managers are outlined in the job description as developing, initiating and coordinating a service plan based on a needs-assessment. The description includes providing “short term crisis management support” to the clients or their family. These duties are completed by visits to client homes at least every six months. The only educational requirement for the “care manager” position is listed as a “Bachelor degree in human services, social work, nursing or related field. Exception is made for those with needed linguistic capabilities who also have 5 years directly related work experience.”

This purposive sampling technique reflects the study’s interest in suicide risk awareness in geriatric case managers. The actual sample size was thirteen; due to illness not all sixteen case managers on staff attended. The sample was broken down into two focus groups of six and seven participants. The training and focus groups were conducted in a private conference room convenient to participants in Boston, Massachusetts.

Recruitment

Participants were recruited through the Homecare Program Manager. The Program Manager requested that the film and discussion training be used in a staff training that was already scheduled. The staff could choose not to participate in the focus group which was scheduled at the end of the staff training. While recruitment through the manager was not ideal, it provided an expeditious sample. The manager was allowed to observe the first focus group; her involvement and presence is discussed as a limitation of the study. After the Program Manager received a written explanation of the study (Appendix A), she verbally agreed to schedule “Talking with Dolores” as a suicide training session with a research component, intended for the entire case management staff (n = 13). Two smaller focus groups were conducted on January 10, 2013; one group (n = 7) met in the morning and the other (n = 6) met in the afternoon. The case managers were requested to participate in the film and psycho-educational discussion by an email from the Homecare Program Manager (Appendix B). The email presented all of the information about the staff training, including the nature of the film and the time and place. The focus group was explained as not a requirement of the training.

On the day of the training, attending staff were welcomed by the researcher who explained the study and asked those who were willing to participate to sign the Informed Consent Form (Appendix C). The Informed Consent Form discussed the aspects of the research that are confidential, as well as the limitations to confidentiality in the nature of focus groups. The Informed Consent Form indicated that The Human Subjects Review Committee of Smith School for Social Work approved the research. After completion of the study, participants were provided with a list of suicide resources as they left the room (Appendix D).

Instrumentation

There are two instruments employed by this study. There is an instrument designed to collect quantitative data, including demographic data and measures of knowledge and comfort in discussing depression and suicide (Appendix E) before exposure to the film and formatted discussion (Appendix F) and also after exposure (Appendix G). There is an instrument designed to guide collection of the qualitative data (Appendix H), specifically, narrative conversation obtained from the two focus groups after exposure to the film and discussion. The film and discussion consists of 1) a video recording of the 45-minute one-act play, “Talking with Dolores,” and 2) a formatted discussion guide that was employed to lead a ten minute psycho-educational discussion (Appendix F). Conversation in the focus groups was semi-structured, guided by open-ended questions designed to elicit reactions to the film and discussion and opinions about their usefulness in future training programs (Appendix H).

The film of the play, “Talking with Dolores,” depicts “Mo,” a widowed male, over 65, who is living alone and struggling with his thoughts of suicide, wanting to join his late wife in heaven. His neighbor and his nephew both drop by in his living room to talk, and the older man at first tries to hide his pain, but later opens up to discussions with the two visitors. The play, and later the film, was designed to reach out to the greater community and begin educational dialogues between seniors, social workers, senior centers, family members and other caregivers working with older adults. “Talking with Dolores” presents a real life situation and information that is relevant and relatable to the target audience. The film was designed to elicit conversation about this taboo topic and provide the basis for an educational discussion of the high-risk for suicide in older people.

The discussion format that accompanies the film provides statistics on suicide within the older adult population, identifies risk factors, signs and symptoms, and considers how to best

approach the conversation about suicide modeled in the film (Appendix F). This discussion was limited to ten minutes in order to be included in this study. The same discussion script was used in both groups as a way to engage participants in a few minutes of psycho-education and prepare participants for the focus group conversation that followed.

Summary of Procedure

Data collection

Data was collected using two instruments, a focus group and a pre/post questionnaire. Including time for paper work and transitions, the data collection lasted one hour following the 45-minute film. The Program Manager first received a written description of the research (Appendix A). She then invited her case managers to participate in the focus group at the end of a training program on depression and suicide (Appendix B). The day of the training, case managers were invited to enter the research collection room to begin. Then those who wanted to participate signed the Informed Consent Form (Appendix C).

The research started with participants filling out a brief “Opening Questionnaire” to collect quantitative data, including demographic data and preliminary measures of knowledge and comfort in discussing depression and suicide (Appendix E). Next, participants watched the 45-minute intervention film, “Talking with Dolores,” and engaged in a ten-minute psycho-educational formatted discussion about suicide and depression (Appendix F). Following this, participants filled out a “Closing Questionnaire” to collect follow-up measures of knowledge and comfort in discussing depression and suicide (Appendix G). Then participants were facilitated in a focus group conversation. The focus group was audio-recorded using two recorders and then transcribed and coded. Focus group conversations were guided by 7 open-ended questions (Appendix H).

Data Analysis

Quantitative Data

Quantitative data was analyzed by calculating frequencies of 1) demographic data of the participants to be used to present a general description of the sample and 2) preliminary and follow-up data measuring changes in participants' knowledge and comfort in discussing depression and suicide with older clients. Frequencies of participants' age, sex, religion/spirituality and race/ethnicity were calculated in order to explore participant characteristics. Quantitative data was then examined for any associations, consistencies and/or inconsistencies with qualitative thematic data obtained from focus group discussions.

Qualitative Data

The focus groups were analyzed using grounded theory (Henwood & Pidgeon, 2003) to examine data for repetitive themes that emerged related to whether or not participants think that the film/discussion would be an effective staff training instrument for geriatric case managers to heighten awareness and ease interventions related to depression and suicide with older adult clients. Interviews were continually read and coded line-by-line until no new insights or codes arose, and at this point theoretical saturation was reached. Ideas and categories were continually regrouped, eliminated, or extended until categories could be defined and linked together to create repeating ideas, themes and theoretical constructs (Henwood & Pidgeon, 2003).

CHAPTER IV

Findings

This study used focus groups of geriatric case managers to gather qualitative data regarding the appeal of “Talking with Dolores” as a training tool; additionally, the study collected quantitative data to measure changes in knowledge and comfort regarding discussing depression and suicide after exposure to the film and discussion.

Focus group conversations with case managers highlighted the usefulness of this tool for raising awareness and providing education on the issue of suicide in older adults. The focus groups also illuminated the need for further concrete skill training to give case managers the confidence to engage in conversations with clients about their mental health. Additional quantitative data confirmed that the sample’s exposure to the Talking with Dolores training increased knowledge about suicide risk in the elderly but did not increase their comfort level in discussing suicide with clients.

Quantitative Findings

Characteristics of Participants

Data were gathered from two focus groups made up of thirteen (N=13) case managers on staff at a community based case management agency. The demographics of the sample can be seen below in Table 1.

Table 1. Demographics

Characteristic	Number	Percent
Participant's Gender		
Female	11	85
Male	2	15
Race		
African-American/Black	5	38
White/Caucasian	4	30
Haitian-American/Black-Haitian	2	15
Asian	1	8
Latino/a	1	8
Religion		
Spiritual	6	46
Christian	2	15
Evangelical Christian	2	15
Catholic	1	8
Religious	1	8
Age		
<30	4	30
30-40	3	23
40-50	2	15
>50	3	23

As seen in Table 1, participants of the focus groups were racially diverse. Of the two focus groups, all seven participants in Focus Group 1 were female, between the ages of 24 and 50, had a range of experience in both case management and within this particular agency, and self-identified with a range of faiths. The Program Manager was present in the room as an observer in Focus Group 1.

Focus Group 2 consisted of six case managers. The group was made up of two males and four females between the ages of 28 and 68, and also was comprised of a similar mix of Spiritual, Catholic, and Christian individuals. Focus Group 2 was generally more engaged and talkative than Focus Group 1, as evidenced by a lengthier focus group conversation. This group

lasted significantly longer than Focus Group 1 although they were both allotted the same amount of time within the training.

Change in Knowledge and Comfort

No significant differences were found in the quantitative self-report measures of comfort in initiating suicide conversations with an older adult. When asked to rate their comfort on a scale from 0 to 10 both before and after participation in the training, 5 responses remained the same, one decreased by 3, one decreased by 2, one decreased by 1, one increased by 5, one increased by 3 and two increased by 1 and one person reported a 10 after not indicating any response for comfort level on the “Opening Questionnaire.”

However, quantitative measures of knowledge of signs and risk factors for suicide showed a positive change in nearly all participants after the training. All but one participant identified additional and more accurate risk factors and signs for suicide after watching the film. Improvement in knowledge was found in the following areas after participation: depression, untreated depression, loss, change in life situation, white male over 85, giving away possessions, withdrawal, statements about dying, and saying farewell. This follow-up data reflected information that was conveyed in “Talking with Dolores” and the accompanying psycho-educational discussion.

Qualitative Themes

Several important repeating themes emerged from the qualitative data obtained in the focus groups. 1) Case managers reported currently providing psychosocial support for some clients, but this was not believed to be part of their job or always within their ability. 2) There was consensus that current suicide training within the agency was not sufficient and trainings offered off-site or during unpaid time were poorly attended. Thus, participants were unable to

agree on a specific protocol after an encounter with a depressed or suicidal client. However, several participants indicated they would refer to a supervisor or a doctor who had the necessary training. 3) “Talking with Dolores” effectively provided new and important education about suicide in their client population. Most participants believed it effectively increased their awareness of elevated risk in their client population. This was indicated by notable engagement and interest in discussions of suicide risk factors and signs of depression and suicide. 4) Case managers are hesitant to discuss suicide for fear of making the situation or the relationship worse because they did not feel adequately trained. This training program does not give case managers the necessary skills they believe they need, nor the competence to initiate conversations about suicide. 5) Finally, case managers repeatedly expressed a desire for additional concrete skills for an improved suicide training. These five qualitative findings are elaborated as follows.

Psychosocial Support

Case managers viewed the training program as a reminder or refresher on the importance of providing psychosocial support for their clients’ mental health. For some, this was not necessarily new information; many reported understanding the importance of the support they currently provide. Yet, the way the training reinforced and encouraged being aware and open to providing psychosocial support regarding depression or suicidality was evaluated as an important element of the program. In Focus Group 1, Mr. W. commented that case managers have an obligation to provide such support: “we’d have some obligation whether we are professionally trained or not.” Several other case managers also expressed that psychosocial support was included in the case management job. “We go into these people’s homes so there is a lot that we can see that the doctor is not going to see, especially self-neglect. I check on stuff like that when I go and see my client.” Participants seemed to each have perceptions of the emphasis on

psychosocial support in their role as case managers that appeared to be based on individual experiences, often with previous jobs and in previous agencies. Regardless of training and job expectation, after watching “Talking with Dolores,” case managers expressed an appreciation for the reminder of how important psychosocial support is in reducing depression and preventing suicide in their clients. Ms. H. elaborated on feeling responsible and compelled “to identify those clients [at risk] and our end [we need to] make an effort to help them as much [as possible].” Participants indicated that this training reinforced this perception as it reminded case managers of their ability to engage in conversation with older adults at risk in a way that would help their desperation.

The participants of the Focus Group 2 expressed two separate opinions about the role of psychosocial support in their job description and their relationships with their clients. This group indicated that they see themselves in a unique role in client homes. They reported they are present more frequently than doctors and determined that they have quite a different relationship with clients than the doctors: “[clients] can present to the doctor and the doctor sees what they see. But we go home... I walk around the house I see what’s going on. I check on stuff like that when I go and see my client.” Participants in both groups expressed having as a close relationship with some clients, feeling they “knew” their clients. This was especially true when there was a special connection or noted need for connection. Ms. C. described one of her close relationships:

My client does not have a lot of informal supports. He actually calls me from the hospital, no one else does. Usually they don’t but this one does. He really likes having me here, he can check in with me...and I said, “Feel free to call me if you want to say hello.” He’s someone who does not have a lot of people in his life that check in with him.

Ms. B. then added: “Also much depends on how we build the relationship with our clients. Some people, like more superficial, we just talk about whatever needs to be talked about: services. With some we develop some kind of relationships, we are close.” Ms. H. explained her sense of connectivity to several clients was due to a shared ethnic and cultural background. It is a noteworthy theme that a “special” personal connection, sometimes based on shared ethnicity and/or culture, was seen as contributing to more willingness to provide extra psychosocial support.

Although Focus Group 2 discussed these close relationships, at the same time, several case managers, including Ms. H., felt that providing psychosocial support was not a requirement of their job: “someone told me that no, this is not part of the job. It’s almost like something extra that you’re doing that isn’t necessary. So the way I approach my clients now, it’s very – um, we have a sheet with questions we ask. It’s very repetitive. So clients who want to chat, we chat with them but that’s not necessarily the case.” Ms. C. agreed, “We aren’t supposed to get to know them, like in a personal way.” These case managers expressed that psychosocial support did not seem to be required, but they supported their clients in this manner if they wanted someone to talk to. Ms. Q. expressed a similar sense of their working relationship with clearer boundaries, “I don’t think we would have a conversation [about suicide] because our job as a case manager, we just provide services and you know, make sure they’re happy with the services we are providing.” Focus Group 2 expressed unclear ideas about what the client-case manager relationship was supposed to look like.

The case management services were not discussed at length. However, the case managers reached consensus on the requirements of their job, including, visiting the elder’s home, assessing the home situation, connecting them with doctors, nurses or community resources and

setting up any additional supports they might need. One case manager also suggested it was their role to watch out for any “red flags” that would alert them to a safety concern.

Limitations of Time and Caseloads. Case managers also explained that discussing suicide with clients would take too much time and work. It is noteworthy that, when asked what would make case managers anxious or hesitant to start a conversation about suicide, four case managers immediately agreed that discussing suicide would be too demanding for their job: “we don’t have time for that,” and “it’s a lot more work. A lot more work...we already have so much work and there is so little time, we already have 100 plus clients.” Ms. C. added that case managers also need to take care of themselves, “we are so stressed out...we have to keep our own sanity.” Other case managers reported struggling to balance their own needs with the case management work. Ms. H. agreed and expressed her sadness about this dilemma due to large caseloads and not having enough time:

It’s sad, it’s really sad to say but it’s true. If you have to think about that it’s more work that you have to do. Because if there is something going on you’re going to have to bring it to a manager. And [if you] bring it to manager, it’s more questions and you may have to go back to the client. It’s never ending.

Later she succinctly explains why case managers may not discuss suicide with their clients: “because we don’t have to do it. I think it is not necessary.” However, another case manager, Ms. C. did not see such a clear answer. She stated that although discussing or assessing suicide is believed to not be explicitly part of the job, to be a significant time commitment, and case managers are already over-burdened, regardless, case managers would address red flags that arise. She asserts that acting on “red flags [is] part of our job. Like a teacher jumps into different roles too.”

Lack of Training and Protocol

Although the participants in Focus Group 1 recalled receiving training related to suicide at some point, Focus Group 2 disagreed. When Focus Group 2 was asked: “in general in your opinion do geriatric case managers receive training about depression and suicide?” three case managers responded, “no.” Ms. B. elaborated, “no, that’s the first time we talk[ed] about it.” And Ms. H. agreed, “No at least here in this agency, we can’t speak for other agencies.” Mr. M. had received training outside of the case management agency “we did not receive training on the matter on the premises. But every once in a while we are encouraged to attend training that has been given some other places.”

Participants in both groups reported not knowing of a standard protocol for handling cases of suicidality. Currently, they reported making their own personal decisions about how to handle the situation best. Many refer directly to their supervisor, a physician, or Protective Services when they encounter a safety issue with a client. Several case managers reported thinking it was their “duty to report” to a trained professional when there was any suspicion of suicidality or neglect. Ms. B. explained in Focus Group 1 how she would immediately refer her clients in this situation:

If something [were to] change or I pick up on a sign that’s not right, I always call the physician the moment I get in the car. Or for me... I’d just call the nurse, and then I know that they would take it from there. I don’t think its anything, well any of us would just sleep on it, “Oh, I just was having a bad day today.

Ms. Z. agreed she would probably do the same as Ms. B.; “we would reach out to like physicians, family, [another program connected with the agency], counseling, you just try to do as many interventions. Probably meet with your supervisor. Cause two heads are better than one,

you know. Find out what resources are out there.” Case managers in both focus groups agreed that they rely on supervisory resources and higher trained staff to handle specific incidences of suicidal ideation or other safety concerns.

Increased Knowledge after Training Program

In both focus groups, the film and discussion sparked discussion about suicide generally and specifically related to the older adult population. Without questioning from the facilitator, the groups spontaneously discussed signs of suicide seen within the film in addition to how suicide can be very unexpected and difficult to foresee. The film also triggered a conversation about whether suicide is good or bad and the mess it leaves behind for family and friends. Both groups also discussed encounters with depressed clients for whom they provided more psychosocial support than they believed was required of them.

Focus Group 1 discussed the concept of suicide in older adults more thoroughly. The group considered the reasons elders may commit suicide, regardless of the statistic mentioned in the training about most victims of suicide being relatively healthy. The reasons for suicide discussed by the group were all addressed and seen within the main character of the film, including his fear of being a burden to his family or fear of losing control and being treated like a child. This group spent time analyzing the nephew’s conversation about suicide with his uncle (the elder); the group considered how he could have better protected the elder’s safety and how they as case managers would have handled the situation. Ms. B. says of this conversation, “I think it gave [the elder] a sense of control... Cause the sign was clearly there. Cause he talk[ed] about it. Then he asked him the last question he left him with, “are you planning on doing anything tonight.” He didn’t say anything. So he could have talked to him more about that. Ma[d]e sure he [got] a concrete answer before he left.” As seen within Ms. B.’s comment, most

participants considered discussing suicide and providing necessary psychosocial support to be important for the well-being of their clients although time, caseloads, lack of knowledge and training, fear of hurting their relationship with the client, as well as unclear job expectations were all mentioned as limiting factors in providing psychosocial support for suicidality in elders. It is clear that this film increased consideration of suicide as an important issue within these case managers' client population.

As demonstrated by the spontaneous and in-depth discussions about suicide in both groups, case managers reported an increase in awareness of this safety issue. In one questionnaire a participant noted: "Very interesting video, I did not know the increased risk for older white males." The vast majority of participants expressed that the training program effectively conveyed the severity of risk for suicide in the older adult population, which was also seen in the increased knowledge demonstrated in the "Closing Questionnaire." Both focus groups also affirmed that the film and discussion provided education on risk identification. Ms. Q. from the first group elaborated, "I thought [the training] was general enough that we had a good idea of indicators. I didn't know the type of people that generally commit suicide, I didn't know that. That I thought important. But, like I said, [it was] general enough so you have an idea of where to go." Ms. Q. also reported learning signs of suicide from the film and continues, "I think if you didn't know before or weren't looking for it before, this is kind of like a refresher or a reminder of things that you should look at or things that you should pay more attention to. But it's helpful for people who probably didn't know before."

Several participants expressed that the strongest element of this training was the way it increased their awareness of the issue and brought their attention to "red flags" to be aware of in their client population. Several others reported that the strength of the training program was its

function as a reminder that psychosocial support is very important for the well-being of their clients. When asked about the strongest elements of the training program, Ms. H. reported learning “that support is very important. Because I think if [the nephew] didn’t come and he didn’t trip he could have drank the pills. So even for our client who doesn’t have a lot of support, if they have us only, it makes a difference. So, to identify those clients, and [on] our end, to make an effort to help them. Because it’s not only us, there is a lot of support as well in the community and there are other services that are there to cater to elders.” Case managers believed this training program to be effective in providing basic education on identifying signs and risk factors for suicide and reminding case managers of the positive impact of psychosocial support on their clients.

Comfort in Discussing Suicide. Some case managers speculated that they would be more comfortable having a conversation about suicide after participating in the “Talking with Dolores” suicide training. “If [a client] were to approach me, then I would have no problem, at least after seeing this, I would have no problem having a conversation about it.” However, it remains unclear whether the video itself changed the likelihood of case managers reaching out to clients around this topic. Ms. Z. in Focus Group 1 believed that “the video would make them reach out more, but, I would hope that without seeing the video the case manager would reach out anyway if they noticed those signs.” Ms. C also seemed to think case managers were capable of reaching out to provide psychosocial support, regardless, “I think a lot of it is in a way, common sense, people skills. If you’re kind of good at reading the signs in a common sense sort of way then you don’t need a training in some ways. However in my job I would want training. And it’s not easy to talk about so that’s why training is good, so you get some practice doing it.”

Ms. C. concludes, that training and practice is essential because conversations about suicide may be more difficult to put into practice than they are in theory.

Hesitance Remains

Other case managers reported a more qualified feeling of comfort with discussing the topic of suicide. When asked if case managers would be more open to discussing depression or suicide with a client who appeared to be at risk, Ms. Q. explained that she would not be the first to initiate the conversation. “I think they would have to tell me, bring it up.” Ms. H. agreed with Ms. Q. that “if they told me, yes, yes. And there were enough signs. The clients I deal with now, luckily I don’t see, I can’t think of anyone in my caseload right now that shows such a thing.”

Fear of Harm. Many case managers expressed feeling hesitant to initiate or engage in a conversation about suicide due to fears of making the situation worse or harming their relationship with the client, citing a number of reasons for their hesitancy. The participants of the two focus groups reported that feelings of insufficient ability and knowledge made them hesitant to discuss suicide with older adults. Focus Group 2 spent a significant amount of time considering the fear of making the situation worse. Ms. C. from Focus Group 2 was worried about causing trouble by expressing her opinion, “I’m not an expert, I’m not licensed or anything, even though I have a lot of knowledge and information. So it makes sense I don’t want to get myself in a situation where someone would say ‘you told me this.’ Get us [in] trouble or something.” Ms. C. was mostly worried about doing the wrong thing and getting in trouble, while Ms. B. focused on not wanting to hurt the client; “I won’t initiate it. I would just, if the person wants to talk about it I’ll talk and I will try to do as much as I can since he wants to talk about it. But I will alert the doctor because even with more training, we are not experts. And who knows if I help or just hurt. I don’t know. I don’t want the negative consequences of my

interference.” Mr. M. also expressed a fear of harm, in terms of harming his alliance with the client if he brought up the subject:

The delicate aspect of it is like an elder who is suicidal can really tell you, ‘don’t ever come back to my house.’ [He has] the right to stop services at any time he feels like it. So it’s like, we have to be very careful not to break the relationship we are building over the years with these elders.

Case managers expressed concern about the level of their training and their preparedness for what they perceive to be a potentially damaging conversation.

No Hope for Change. Several case managers briefly mentioned in both focus groups that they felt there was no hope for changing someone’s mind and preventing their suicide. In Focus Group 2, Ms H. expressed this sentiment. “In my case there was not much I could have done for him...regardless of how much support they have around them, they will commit suicide.” In the other group, Ms. B. got this same feeling from the director’s comments within the film “I felt that the director already made up her mind. But if you know someone who considers suicide you could help them; I didn’t get that sense from the movie.”

Suggestions for Improving Training

Both focus groups overwhelmingly felt that the Dolores training needed additional concrete information to provide case managers with appropriate tools to increase their competence and comfort assessing or discussing suicide. In Focus Group 2, Ms. C. discussed this point at length:

They could add on to this movie: what can you actually do... I like to build my toolbox... I’m a teacher by training. So doing some practice questions. Writing them down. Pairing up with partners and actually doing it. Like trying to practice. That’s really helpful.

Ms. B. agreed with Ms. C.'s comment by describing the effectiveness of the supervision she received regarding an issue of suicidality, "that's how I was preparing for the conversation with the elder. [My supervisor and I] discussed concrete questions and I wrote them down. So those were the questions I was supposed to ask her. That would be helpful." Ms. Q. supported the comments of the other Focus Group 2 participants, "I think they are right. As a case manager what our next step would be if we suspect our clients are suicidal." Mr. M. brought up the importance of concrete and formal training in Focus Group 1 as well, "I believe more formal training would put case managers in a position to know what will be the next step after my assessment tells me so and so is suicidal." Ms. Z. clarified that she was looking for "more of what you can do to help if you do spot that elder who is suicidal." Most case managers expressed appreciation for learning to identify signs of suicide and the training left them wanting more. In the questionnaire, one noted, "I need more tips of what to say to elders threatening to commit suicide (now that I can identify it) better."

Concrete and formalized training on specific interventions and questions to ask elders at risk were clearly and repeatedly identified as needed for case managers to feel comfortable. Ms. X.'s statement about the Dolores training illustrates the general reaction of the focus groups, "for some it's a reminder, for some it's new information. It depends on the person. But it's not in any way to me a full training."

Summary

The data from the two focus groups indicated that these geriatric case managers believed the Dolores training effectively reminded them of their important role in providing psychosocial support to their clients and helped them identify signs of suicide, but did not sufficiently provide them with concrete skills in the management of suicidal ideation. Although a few case managers

indicated in the focus group that they thought the Dolores training might have increased their comfort in discussing depression and suicide with clients, the quantitative data from the questionnaires indicated there was no significant difference in their self-report of comfort. Even so, they thought it could be a helpful training tool for geriatric case managers. They reported that lack of knowledge and training on the subject was the inhibiting factor in discussing suicide with their clients.

CHAPTER V

Discussion

In 1982, public education was identified as of primary importance for the prevention of suicide in older adults (McIntosh, Hubbard & Santos). The current study indicates that the training tool, “Talking with Dolores,” could play an effective role in the education of geriatric case managers who currently do not receive sufficient training and are working daily with the highest risk population. Focus groups agreed that the training increased awareness of suicide and provided education about signs and risk factors to identify depression and suicide. This was also evidenced by the quantitative measures. Although some participants speculated they would be more likely to converse about suicide after the training, the quantitative data did not indicate an impact on level of comfort in initiating these discussions. However, the study may have implications for educational methods used to train geriatric staff in order to increase awareness of the issue of suicide in older adults. Geriatric case managers from this study did not report much training or preparation for encountering those depressed older clients who are the most at-risk for suicide. The qualitative findings are discussed in more detail as follows.

Qualitative Findings

Psychosocial Support

The results of this study supported evidence in the literature about the elements of psychosocial support provided to clients that are implicitly included in case management. Many case managers reported having close bonds with some clients due to the nature of the case management role and visits to the home, something they distinguished from a doctor’s role. The

study helps to further understand the case manager's unique relationship with clients. The closeness of a case manager's relationship with a client appeared to be dependent on time, whether a client requested additional support or contact, and cultural similarities that bonded the client and case manager. However, a personal relationship with a client was generally seen as outside the job description, and usually developed when the case manager felt personally connected or received a special request from the client. Regardless of the job description, the stress and limitations of time and competing job responsibilities, case managers appear to feel responsible for the general well-being of their clients. Although many case managers felt they would be hesitant to take the extra time to address an issue which they feel unprepared to address, several indicated that clearly visible signs of suicide would be considered a "red flag" acute safety concern that they would address, regardless of the barriers mentioned above.

These responses suggest that case managers enter a client's home with the intent of forming a professional relationship that includes providing brief psychosocial support while assessing for needs and then connecting clients with resources. In these cases, case managers may not have a close enough relationship to pick up on "red flags" for suicidality and may not feel it would be their role to address it even if it was seen. However, when case managers develop a more personal connection and relationship with a client, case managers may spend more time in the client's home and provide much more psychosocial support. Most case managers agreed that if there were a personal connection, they would be more willing and it would feel more role-appropriate to talk about suicide or depression with the client.

This suggests that case managers would sometimes have close enough relationships in which a trained case manager could recognize an at-risk client and feel comfortable and more competent to hold a conversation about suicide. The largest barrier expressed by the current case

managers was a fear of making the situation worse, due to a lack of competence in their skills. The “Talking with Dolores” training could be the necessary training to facilitate discussions about appropriate steps and protocols when encountering a suicidal client. This training is important because the film and discussion emphasize the importance of an elder having a space to discuss their depression and suicidal thoughts and that these discussions will *not* give one ideas to commit suicide who has not already considered it.

Lack of Training and Protocol

The study also confirmed previous literature that indicates there is insufficient mental health training in case management. Case managers enter the field without any educational requirements in mental health or training in suicide, depression, or other mental health risk assessment. Within the participant pool, 30 percent of the case managers were below the age of 30, two age 24, which could suggest a lower degree of experience and general exposure to training in the field. These younger participants indicated never participating in a suicide training. Other participating geriatric case managers, even those who had been working in the agency for years, also reported having little to no suicide training. Others reported some off-site suicide trainings were offered to them. Yet it is clear from the demands and stress indicated in their job, these case managers found it difficult to attend trainings in their own time. They do not feel they have the time to really take care of their own personal health, yet emphasize the importance of including self-care in their personal lives. Suicide trainings seem to be offered infrequently and off-site in a field with many new, young and over-burdened employees who go without training for years.

This study may have provided a “snapshot” of the way case managers are currently responding to suicidality in the field. Participants indicated they would report directly to a

supervisor if an issue of suicide were to arise. They felt they did not have a specific protocol nor sufficient training to handle suicidality, thus, their preference was to consult someone with more credentials to discuss the next steps to take. Insufficient training and feeling incompetent handling topics of mental health were given as major reasons why case managers would not discuss suicide directly with a client.

Several of the participating case managers reported a hesitation to bring up the topic of suicide for fear that they would make something worse. The Dolores training aims to dispel this commonly held belief that talking about suicide with someone can increase the likelihood of suicide. Thus, it seems the Dolores training may be ideal to educate case managers about the importance of allowing a space for an older adult to discuss any thoughts about suicide as it demonstrates a sample conversation within the film and afterwards opens up a discussion about how the conversation went or could have gone. This study shows that the Dolores training program effectively increased the case managers' knowledge of detection methods for at-risk clients; detection of the at-risk older adults within a case management framework may be the first step in getting homebound elders critical mental health attention.

Increased Knowledge after Training Program

Many participants were not aware that their older clients are at higher risk for suicide. As expected in the quantitative measures, case managers self-reported an increased ability to identify signs of suicide after the Dolores training. Case managers also demonstrated retention of new information conveyed in the training; when asked to list risk factors and signs of suicide, participants wrote in more factors and signs after they had participated in the training. Most importantly, this knowledge was specific to elders as an at-risk cohort and appeared to be drawn directly from the training film. This increase in awareness after the training was also evidenced

by participant questions and extended engagement in conversations wider than the scope of the focus group questions. This demonstrated interest in understanding the risk factors and reasoning behind suicide in older adults.

This study suggests that the training successfully provided education and facilitated retention of the information on suicide recognition. An increased knowledge of their client population could eventually translate into an increased competence in case managers' ability to address issues of suicidality. Since incompetence was one reason case managers reported not addressing suicide, it is not surprising that some participants reported believing they would be more likely to reach out to a depressed or suicidal client after the training. Increased competence in mental health may have important implications for the impact such trainings could have on case managers' relationships with clients as a protective factor for suicide.

Hesitance Remains

Regardless of the effectiveness of Talking with Dolores as an educational tool to increase knowledge and competence, it seems that case managers may still be hesitant to discuss suicide with their clients. Although in the focus group there was some speculation that they might feel more comfortable with the topic of suicide, the quantitative self-report measure indicated no change in participants' comfort after the training. The results indicated that the focus group conversations are limited in their capacity to influence case managers to initiate first-hand suicide prevention. It seems participants' implicit feelings of competence did not increase although their explicit knowledge did increase. Participants may need a chance to practice using the new knowledge and recognition skills to feel competent. These case managers still fear making the situation worse and predicted they still would not initiate a conversation about

depression or suicide with their clients, despite the training's aim to dislodge the myth that discussing suicide supports suicide as an option.

Case managers also expressed disbelief that their actions could make a difference. Several believed that providing elders with the opportunity to discuss concerns about depressive symptoms or thoughts of suicide would not help: the elder would commit suicide regardless of any action on their part. One participant also commented that the narrative discussion during part of the film communicated that the main character was going to commit suicide regardless of conversational interventions from the nephew and neighbor. It seems that the Dolores training could be improved by adding a more in-depth and participatory discussion about the message of the film and the potential positive impact of case managers. It is clear from participant feedback that it will be important to further emphasize the positive impact of recognizing suicidality and opening up space for a conversation.

Suggestions for Improving Training

Case managers made specific suggestions to improve the Dolores training for future use as a stand-alone suicide training, which are relevant for both the adaptation of the current training program, as well as for the development of future trainings for case managers. A large majority of participants requested a training to include specific example questions to add to their assessment "toolbox." Some case managers expressed concern of making the situation worse or harming a relationship by saying the wrong thing. Thus, it is essential for future trainings to provide case managers with concrete interviewing skills to build their competence. The suggested practice component with role-plays would build a sense of efficacy for engagement in work with suicidality. The Dolores training was helpful for increasing knowledge, but needs to include additional information and practice to give case managers a clear example of when and

how to approach an elder they suspected to be at-risk for suicide. Case managers' practice competence, and even more understanding of their important role in the lives of their clients, may facilitate a mutual and open exploration of a client's mental health concerns.

Limitations of the Study

The findings within the two focus groups may have implications for "Talking with Dolores" as a future training program with geriatric case managers. However, it is important to consider the limitations of the generalizability of the study. The small sample size of this sample from a single agency limits the generalizability of these findings to other geriatric case managers outside this agency. For example, case managers could report only on their own level of training, which varies not only within the agency, but also across agencies. Thus, their statements are not necessarily reflective of the scope and variation of training other case managers have received across the state and nation. In addition, the presence of a supervising figure in the first focus group may have impacted or biased participants' statements.

Recommendations for Practice

First, the current data suggest the importance of increasing suicide training for case managers. It appears that trainings would be most effective if offered or required within the agency of employment during normal work hours. When trainings are offered off-site and optional, case managers seem to be less likely to attend. This study indicates that case managers would be interested in and value training in depression and suicide. It is also clear that trainings that can increase case management competence have the potential to positively impact the mental health of older adult clients who are at-risk.

"Talking with Dolores" should be modified using the feedback from this study and re-evaluated as a training program. Future Dolores trainings should include opportunities to

practice using example questions to assess for suicide in elders. With this modification, the program should be evaluated for its ability to educate case managers on the next steps to take once they became aware of a client who is depressed or considering suicide. Further research should determine whether participants who role-play questions and discussion about suicide feel more adequately prepared and competent in their skills.

Recommendations for Future Research

It is important for future research to investigate what would motivate case managers to engage with their clients in conversations about mental health. Future research could test what amount and type of practice, scripted questions, protocol or additional education would give case managers the confidence that they could make a positive impact and not make any situation worse. Once they had the confidence and understanding that conversations about depression and suicide could *help* their relationship with their client, not *harm* the relationship, it would be important to investigate whether case managers then believed they could make a difference in the life of a suicidal client. It would be interesting to study if this changed case managers' motivation to engage in this protective factor for suicidality even when they face limitations of time and job demands.

A comparative study could determine the best training approach and protocol out of the range that currently is in practice. Since case managers face high case loads and time restraints and suicide screenings are not explicitly in the job description, research should compare any current suicide screening protocols for case managers and compose a protocol that does not increase working hours or stress. Investigations should compare the importance of *who* presents the training. Fellow case managers could share personal experiences and give direct advice that is perceived as more relevant and applicable to the case managers. This further research could

aid in designing a training that motivates and empowers case managers to increase the quality of life of their clients. This in turn would increase case managers' efficacy and confidence that they play an important role in their clients' mental health.

Conclusion

Not only are new methods, such as the Dolores training, necessary to raise awareness of the public health issue of suicide among older adults, but there needs to be a new focus to these trainings. Mental health trainings should not be limited to professional social workers and doctors. Geriatric case managers seem to be an ideal focus because of their unique relationship with their clients and their current lack of mental health training. From the perspective of older adults, case managers may not carry the same stigma as social workers, so elders may more willingly engage with case managers in difficult conversations (Oxman, 2003), a protective factor against suicidality. As seen in the focus groups, many case managers have unique relationships with clients. Thus, case managers who visit the homes of older adults may have an important opportunity to identify cases of elders who are at high risk for suicide. Identification of older adults at risk is the first step to getting these individuals the support they need to prevent their suicide.

The current study indicates that "Talking with Dolores" combined with its psycho-educational discussion is effective in increasing case managers' awareness of the higher risk for suicide in older adults. It is an effective education for case managers to learn to identify the signs, indicators, and risk factors for suicide in their older clients living at home. With the suggested modifications, this training program could have a significant impact on preparedness, and thus, willingness, on the part of case managers to discuss suicide with their clients. With an additional skills training component and a more in-depth discussion added to the Dolores

training, it could be used to train case managers to make a difference on the frontlines of addressing this key safety issue in their older clients. This study illuminates training possibilities that may be important tools in addressing this increasingly concerning public health issue. The Dolores training and future trainings in suicide for case managers could be important for recognition of suicidality and then linking those identified at-risk clients to the appropriate supportive resources for mental health care to prevent their suicide.

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Appendix A

Letter to Homecare Program Manager

Dear Program Manager:

My name is Jennelle Liljestrand, and I am a graduate student at Smith College School for Social Work. I am conducting research for my Masters thesis to explore the use of an educational film with professional staff working with older adults. This is part of an effort to raise awareness and comfort in discussing depression and suicide in seniors. Older adults are the focus of this study due to their high risk for suicidality and depression that is often overlooked yet treatable. I want to understand if employing a film of a one-act play can function as an effective training tool to increase understanding and ease of broaching these topics with elders.

The total time approximated for this study is 2 hours. I am looking for participants who are case managers at your senior organization and have direct clinical contact with older adults. This study will be conducted through a group discussion about the 45 minute film, "Talking with Dolores." Beforehand there will be a brief questionnaire and informed consent distributed. I will provide a handout of resources and contacts who can further discuss any personal reactions the staff may have about these materials.

Possible benefits from participating in the study include increased education about suicide, depression, and treatment and exposure to a potential training tool. Your staff may learn new methods or gather ideas from colleagues about how to provide better support and mental health screenings for older adults in your community. I hope to meet and discuss my research and the possibility of inviting your staff to participate in this project. I understand this takes time out of staff's busy schedules and I appreciate your generosity in consideration of hosting a focus group on your site. If you have any questions or concerns please do not hesitate to call me at XXX-XXX-XXXX or email me at jliljest@smith.edu.

Sincerely,

Jennelle Liljestrand
Smith School for Social Work '13
Bedford VAMC
200 Springs Road,
Bedford, MA

Appendix B

Email Invitation from Program Manager to Homecare Program Manager

Dear Case Management Staff,

You are requested to participate in a training program on depression and suicide within the geriatric population. Depression and suicide are increasing public health issues that is even more of a concern in geriatrics who live at home and receive home health care. For this reason it is important to participate in this training program being evaluated as an educational tool for case managers. The training will consist of a 45-minute film and a ten-minute psycho-educational discussion. You will also be asked to participate in a 45-minute focus group following the training program in order to help the researcher explore the tool's usefulness in increasing knowledge and comfort discussing depression and suicide.

This research project is being conducted by a social work student from Smith School for Social Work who is an Intern at the Bedford VA Medical Center. The entire training will take no longer than 2 hours and will be scheduled into your work day on Thursday, January 10th, 2012. Half of you will participate in a morning training and half will participate in an afternoon training. You will be reminded that although this program is part of staff training, if at any point you feel uncomfortable participating in the research you may leave and be assigned alternative suicide training from your agency.

Thank you for your participation.

Appendix C

Informed Consent Form

Dear Participant,

My name is Jennelle Liljestrand, and I am a graduate student at Smith College School for Social Work. I am conducting research for my Master's thesis to explore the usefulness of an educational film designed to increase expertise in geriatric professionals who might be working with depressed and suicidal older adults. Specifically, I am interested in whether you, as case managers on the front line of work with the elderly, think that this film would increase awareness and comfort in discussing depression and suicide on the part of other geriatric case managers.

In the present study I seek to understand if providing educational information about suicide and viewing a play about an elder considering and discussing suicide can increase the likelihood of you identifying depression and suicide in your clients and broaching the topic.

The total time approximated for this study is 2 hours. To participate you must be a Case Manager, and a direct caregiver to older adults. This study will be conducted through a focus group discussion about the film you watched and the psycho-educational discussion. First, you will be asked to answer a brief questionnaire. Second, you will be shown a 45-minute film. You will then participate in a group discussion based on your opinions and personal experiences of the film. Immediately following the focus group you will have the option to share any additional thoughts or feelings in one final questionnaire.

Because this study addresses a stigmatized topic and may bring up personal experiences with depression or suicide, there is a risk that participation in the study could cause negative emotions to arise. However, to minimize discomfort, there are no questions asked about your personal experiences of suicidal thoughts. Resources and contact information will be provided and we encourage you to contact a professional for further support regarding these difficult topics.

Possible benefits from participating in the study include increased education about suicide, depression, and treatment and exposure to a potential training tool. You may learn new methods or gather ideas from colleagues about how to provide better support and mental health screenings for older adults in your community. You will have the opportunity to share your thoughts, opinions, experiences and feelings with others and an opportunity to speak about a taboo subject that may be important to you. Your responses could be contributing to the development of knowledge in mental health work for the older adult population. It is also possible that you will feel more comfortable reaching out for support in the future, a protective health measure. Compensation can only be provided in the form of tea, coffee and a healthy snack.

To protect the confidentiality of what is said during this focus group, by signing below you are agreeing to keep in confidence what is said by others during this study and not reveal any identifying information about other members of your focus group discussion. Additionally, you

are not asked to provide any names or identifying information about yourself, outside of the demographic information requested. All data from the questionnaires and audio recorders will be kept in a secure location for a period of three years or until no longer needed, as required by federal guidelines, and data stored electronically will be fully protected. I will remove any possible identifying information before sharing it with my research advisor at Smith School for Social Work. When material from this study is used for future presentation and possible publication, any possible identifying information will be removed.

Your participation in this study is voluntary. You have the right to refuse to answer any question on the survey or during the focus group meeting. You may withdraw from the study at any time by leaving the room. If you do this, any answers you provided to any questionnaires will be deleted. However, once you participate in the focus group, your voice will remain on the audio recorder but will not be included in any transcription or analysis or later presentation. You will have 7 days to withdraw after the focus group, contact jliljest@smith.edu or call XXX-XXXX. The Smith College School for Social Work Human Subjects Review Committee has reviewed and approved this study.

If you have any additional questions, please feel free to contact me directly at jliljest@smith.edu. Should you have any concerns about your rights or any aspect of the study, you are encouraged to contact me XXX-XXX-XXXX or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413)585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature: _____ Date: _____

Appendix D

Suicide Resources

Center for Elderly Suicide Prevention: Friendship line:
(800) 971-0016

Suicide Crisis Line Phone:
1-800-SUICIDE
24-hour emergency: 1(800)273-TALK

You are encouraged consult other staff at your agency for support around these difficult issues of depression and suicide.

Appendix E

Opening Questionnaire

Participant code # _____

1. In what year were you born?
2. How would you identify your gender?
3. How would you identify your race and ethnicity?
4. If you consider yourself religious or spiritual, how do you identify yourself?
5. What is your position?
6. Think of an older male you interact with regularly who you suspect may be depressed or feeling helpless or worthless. How comfortable do you currently feel about initiating a conversation about his thoughts of suicide? Please circle below:

On a scale from 0-10, 0 being not at all comfortable to 10 being very comfortable:

0 1 2 3 4 5 6 7 8 9 10

Not comfortable
at all

Very comfortable

7. Please list 5 risk factors for suicide in older adults and 5 indications/signs an elder may be considering suicide:

Appendix F

Psycho-educational Facilitated Discussion

10 minutes to occur directly after the film (adapted from Discussion Guide: CHD, 2010).

This film was created in an effort to increase awareness about the risks of suicide as well as provide information on the basic signs and symptoms of depression and suicide. Older white males over the age of 85 have been identified as at highest risk for suicide and elders who receive home healthcare are at twice the risk of other elders who may still see primary care in a hospital setting. There are over 5,000 suicides of older adults (65+) per year in the United States. Most elders who die by suicide are in relatively good health, 80% of elders have seen a health care provider within a month of their death, 40% within a week, and 10% have seen a health care provider the day of their suicide.

Why or why not do you think Mo commits suicide?

(Allow audience to contribute some ideas, 1 minute)

What makes him more likely to commit suicide?

(Allow audience to contribute a few ideas, 1 minute)

Mo's symptoms of depression that can be seen in the drama are:

- social withdrawal
- irritability
- tired
- loss of interest in activities, trips
- no longer concerned about his health, ignoring his diet

Indications we can see that Mo may be considering suicide:

- feeling helpless, without control, feels like a child
- statements of hopelessness
- putting affairs in order
- giving away possessions
- failure to follow health advice
- saying goodbye (in subtle ways)

Some factors that put Mo at risk for suicide:

- older white male
- death of loved one
- feeling loss of control
- loss of autonomy, mobility
- depression
- major life change

Do you think the conversation with Matt will increase or decrease Mo's risk?

There are several common myths you may have heard about suicide and depression that this film hopes to debunk through this discussion:

- 1) Talking about suicide gives depressed individuals dangerous ideas.
 - In reality, it has been shown that having conversations about suicide reduces the risk.
 -
- 2) Symptoms of depression are a natural part of aging and nothing can be done.
 - In reality, depression is easily treatable and is a high risk factor for suicide: 90-95% of people who commit suicide have had clinical depression.
 - Unfortunately among doctors and our society in general there is stigma associated with aging.

Appendix G

Closing Questionnaire

Participant code # : _____

1. Think of an older male you interact with regularly who you suspect may be depressed or feeling helpless or worthless. How comfortable do you currently feel about initiating a conversation about his thoughts of suicide? Please circle below:

On a scale from 0-10, 0 being not at all comfortable to 10 being very comfortable:

0 1 2 3 4 5 6 7 8 9 10

Not comfortable
at all

Very comfortable

2. Please list 5 risk factors for suicide in older adults and 5 indications/signs an elder may be considering suicide:

3. Please share any remaining thoughts and anything you did not get to share with the group for any reason.

Appendix H

Focus Group

Script of Ground Rules for Focus Group

Thank you for taking the next 30 minutes to participate in this conversation to help us understand the educational implications for this film based on your personal experience of it. Please be aware of the space and limited time here and give each member present equal opportunity to share their thoughts. Please wait until each person is finished speaking before you take your turn.

If you need to use the restroom or get water, feel free to get up and take a break. Remember that you are allowed to leave the room at any time if you want to drop out of the study for any reason, no questions asked.

Open-Ended Qualitative Focus Group Questions:

1. In general, do geriatric case managers receive trainings about depression and suicide?
2. Did you think the training effectively conveyed the importance of suicide and depression awareness and provided education on risk identification?
3. After learning the information included in this training, do you think case managers would be more open to having a conversation with an older adult that you suspected to be depressed or having suicidal thoughts? (Recall the conversation the nephew had with Mo.)
4. Do you think this film would help case managers recognize signs of suicide or depression in someone you know?
5. When case managers are concerned about suicidal ideation, do you think they generally make appropriate referrals and take steps to protect their clients? What do they usually do?
6. What do you think makes case managers most hesitant or anxious when thinking about starting such conversations with elders?
7. What are the strongest aspects of this film and discussion for training with case managers?