4

Depression, Addiction, and Suicide

Case 4.1 Alcoholism

Allison H. Burfield

An inner city Emergency Department (ED) receives a report about an incoming 72-year-old man found disoriented, smelling of alcohol with a suspected hip fracture. Upon arrival to the ED, the patient, John Riley, has a blood alcohol level (BAL) of 0.17. He is 6 ft 1 in. and weighs 180 lbs. The emergency room doctor completes an X-ray of John's hip and does not find a fracture; however, the doctor notes old bruising on his arms and legs. His liver function tests of alanine aminotransferase (ALT) and aspartate aminotransferase (AST) are elevated; ALT = 53 IU/L and AST = 40 IU/L, so an additional gamma-glutamyltransferase (GGT) was ordered indicating an elevated level at 72 IU/L.

1. What are the characteristic signs and symptoms of impaired liver function?

Rob Pearson, registered nurse (RN), the psych liaison nurse is paged to complete a psych evaluation on John to find out more about his alcohol consumption. John reports he only had two glasses of wine today.

2. Rob, RN, knows that John is minimizing his alcohol use and refers to http://hubpages.com/hub/How-to-calculate-BAC to estimate his actual consumption from the BAC Table for Men. Rob, RN, finds how many drinks John has really consumed?
3. What does Rob, RN, realize about the importance of accurate alcohol screening?
4. Rob, RN, understands that his questions should focus on which of the following?
   a. Making John admit to his "real" alcohol consumption
   b. Increasing John's feelings of guilt over his drinking will help him learn to stop.
   c. John's perceptions of his drinking behaviors and the consequences of his drinking
   d. Teaching John the alcohol content in one drink

Rob, RN, finds that John is drinking daily and uses the CAGE questionnaire (Ewing, 1984). He asks:

Have you ever felt you should **C**ut down on your drinking?

Have people **A**nnoyed you by criticizing your drinking?

Have you ever felt bad or **G**uilty about your drinking?

Have you ever had an **E**ye opener drink first thing in the morning to steady your nerves or get rid of a hangover?

John states that he feels like he should cut down on his drinking and his daughter is constantly "on his case" about how much he drinks. He states, "If only I had the resources and ability to stop." John feels that he began drinking after his wife died 2 years ago. John relates when he tries to stop drinking, his hands start to shake, and he drinks a glass of wine to steady his nerves. He reports on average drinking daily 7–8 glasses of wine. The maximum number of drinks John reports consuming is 1 gallon of wine.

5. How much is one alcoholic drink defined as?
6. What are the potential risks with habitual and/or excessive alcohol use?
7. What additional signs and symptoms of alcohol-related abuse or dependence might be evident in the initial assessment?

Rob, RN, completes the Short Michigan Alcoholism Screening Test–Geriatric Version (SMAST-G) on John: http://www.positiveaging.org/provider/pdfs/alcohol_smast_g.pdf (Blow, 1991). John scores 9 out of 10, indicating alcohol is a problem. Rob, RN, also knows John has been drinking daily since his wife's death.

8. What criteria must be met from the *DSM-IV-TR* (American Psychiatric Association, 2000) to classify John as alcohol dependent?

John states he will simply stop drinking on his own at home.

9. Rob, RN, strongly encourages John to transfer to their mental health floor and explains to John that receiving additional medical attention is imperative, because should he attempt to stop drinking at home, he is at the highest risk for the following:
   a. Withdrawal
   b. Continuing to drink
   c. Becoming nutritionally impaired
   d. Increasing his isolation, putting him at risk for depression

John agrees to enter into the detox program and signs voluntarily to transfer to the unit.

Additional Resources

The CAGE Questionnaire (Non-copyrighted) http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/16_CAGE.pdf

http://www.mentalneurologicalprimarycare.org/downloads/primary_care/11-1_CAGE_questionnaire.pdf

Centers for Disease Control and Prevention: Alcohol http://www.cdc.gov/alcohol/faqs.htm

U.S. Department of Health and Human Services and Substance Abuse and Mental Health Services Administration (SAMHSA) http://ncadistore.samhsa.gov/catalog/facts.aspx?topic=3

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: Author.

Blow, F. C. (1991). Short Michigan Alcohol Screening Test–Geriatric Version (SMAST-G) Ann Arbor, University of Michigan Alcohol Research Center.

Ewing, J. A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association, 252,* 1905–1907.

Moore, A., Seeman, T., Morgenstern, H., Beck, J., & Reuben, D. (2002). Are there differences between older persons who screen positive on the CAGE questionnaire and the Short Michigan Alcoholism Screening Test-Geriatric Version? *Journal of the American Geriatrics Society, 50,* 858–862.

Case 4.2 Prescription Pain Medication Misuse

Allison H. Burfield

Beatrice Christopher is an 80-year-old widowed Caucasian woman who has a history of benzodiazepine dependence. She has seen every prescriber in her small town to "prescription shop" and has got multiple prescriptions for her anxiety and pain. Beatrice has mild to moderate osteoarthritis (OA) and reports a score of 3–5 on a visual analogue scale for pain. Her Mini-Mental State Examination (MMSE) or Folstein test indicates she has a score of 24 or no cognitive impairment. She is oriented to person, place, and time. She lives in her three-bedroom ranch style home with her grown son who has a history of mental illness.

1. What are the risks with multi-prescriber medication seeking behaviors?
2. What steps can be taken to reduce the incidence of multiple prescriptions for the same controlled substance?
3. What questions should be asked to determine whether a patient's pain medications are being misused?

Beatrice establishes an appointment with a new primary care provider. In her initial appointment, she describes to her doctor her history of OA and "severe" arthritic pain. Her primary care physician prescribes propoxyphene napsylate (Darvon-N 50) and acetaminophen 325 mg 1–2 tablets every 4–6 hours. Her MMSE drops from 24 to between 10 and 12 (moderate cognitive impairment). Over the next 4 weeks, Beatrice falls three times and luckily is not severely injured. When attending church, her fellow church friends notice she has multiple bruises to her arms and face and is easily confused. Beatrice chuckles and states she has taken some falls. Her church pastor notices her struggles and hears from other parishioners the concerns they have for her health. Her pastor speaks with Beatrice and recommends a community program that helps the elderly in their community with their health care needs.

Community Link is a volunteer program where nurses, clinical pharmacists, social workers, and other allied health professionals volunteer their time to improve the

quality of life and health outcomes for the elderly in their community. After Beatrice's initial evaluation by Madelyn, one of the program's registered nurses (RNs), she refers Beatrice to the clinical pharmacist to review her medications. Madelyn, RN, highlights her concerns about polypharmacy, medication misuse, and adverse events with her current regimen.

After Beatrice signs a consent to release information, her primary care physician is contacted in regards to the clinical pharmacist's (Jim, RPh, PhD) recommendations to taper and stop her propoxyphene. The physician states he has concern that she will simply ask for codeine or an oxycodone hydrochloride (OxyCotin) in the absence of some type of opioid pain medication.

4. Abruptly stopping benzodiazepines or opioids put her at highest risk for the following: (Select all that apply)
    1. Breakthrough pain
    2. Shopping for another doctor
    3. Finding another controlled substance as a substitute
    4. Symptoms of withdrawal
    5. What are the signs and symptoms of opioid withdrawal?
    6. When stopping opioids, how long until withdrawal symptoms are evident?

After evaluating Beatrice's renal and liver function, Jim, RPh, PhD, recommends placing Beatrice on regular acetaminophen 500 mg every 4 hours around the clock, 6 a.m., 10 a.m., 2 p.m., 6 p.m., and 10 p.m. The clinical pharmacist recommends she have a sixth dose, should she wake in the middle of the night with pain. The goal is to titrate the propoxyphene dose down to be discontinued, however, still allowing for pain coverage. She is transitioned to Darvon without acetaminophen, as starting her new medication regimen in addition to the existing acetaminophen (Tylenol) would exceed the daily dose recommended of acetaminophen.

5. The clinical pharmacist also understands that the use of benzodiazepines and opioid put her at significant risk for the following:
    a. Falls
    b. Constipation
    c. Accidental overdose
    d. All of the above

The physician agrees to transition her benzodiazepines from diazepam (Valium) to lorazepam (Ativan) to then switch to oxazepam (Serax). This step-down program of shorter half-life benzo's will attempt to convert her over to the shortest acting sedative possible to reduce the risk of falls. Beatrice admits that she has a history of depression, pain and "horrible" anxiety, but agrees to this treatment plan. Beatrice's new treatment will be taking Buspar (buspirone) 30 mg daily for her anxiety, continue the acetaminophen, and over the next 2 weeks completely taper her off of the oxazepam.

Her primary care physician has doubts as to whether Beatrice will be able to adhere to this treatment plan, as her son reports she has a history of stealing his benzodiazepines and oxycodone. The case management records on Beatrice also note that she has reported her son steals her medications, and in the past, she has come up short at the end of the month.

6. What recommendations could the nurse give to increase the probability that Beatrice will adhere to her new care plan?

Additional Resources

Certification Commission for Health Information Technology, http://www.cchit.org/

Narcotics Anonymous, http://www.na.org/

Reference

Townsend, M. (2007). Substance-related disorders. In M. Townsend (Ed.), *Essentials of psychiatric mental health nursing: Concepts of care in evidence-based practice* (4th ed., pp. 278–280). Philadelphia: F.A. Davis.

Case 4.3 Depression

Robin Bartlett and Donald D. Kautz

James Edwards, an 88-year-old retired factory worker, resides in an independent living apartment in a continuing care retirement community (CCRC). He is relatively healthy, still able to care for his personal needs, and is able to drive. His four children, who all live within a 30-mile radius of the CCRC, have arranged for monthly cleaning of his apartment. They see him most every weekend and once or twice during the week to go with him to appointments or to socialize. Mr. Edwards has a history of bladder cancer and has an ileal conduit for urinary diversion for which he provides his own care. He also has Type II diabetes and is fully capable of injecting his own insulin, along with taking responsibility for self-care of this disease. All things considered, he has been relatively healthy in recent years, caring for his wife of 66 years who suffered from dementia and died 2 years ago. Since the death of his wife, Mr. Edwards has grown increasingly isolated. He used to play golf regularly and help other residents of the CCRC with transportation and other small projects for which they sought his help.

In recent months, however, Mr. Edwards has reported to his children that he no longer finds pleasure in golf or helping others, and prefers instead to sit in his apartment watching television, playing games on his computer, or even just sitting alone without engaging in any activities. The family has grown increasingly concerned about their father and has decided to investigate his symptoms despite the fact that their father insists he is just fine.

Mr. Edward's internist recommends a home visit from a nurse practitioner specializing in geriatric mental health. After taking a medical history from the client, the nurse practitioner explains he would like to use a questionnaire known as the Geriatric Depression Scale (GDS) to illicit further data.

1. Using the Web site, http://consultgerirn.org/uploads/File/trythis/issue04.pdf, describe the purpose, reliability, and method of using the GDS. (Kurlowicz & Greenberg, 2007) Would you consider implementing this scale in working with the elderly (explain your reason)?

To answer questions 2 and 3 below, refer to the American Psychological Association's Web site http://www.apa.org/helpcenter/aging-depression.aspx

2. What are some of the physical effects of depression on older people?
3. What are some actions a nurse might suggest to the family as they grapple with their father's symptoms?

To answer questions 4–6, please refer to the Centers for Disease Control and Prevention Web site at http://www.cdc.gov/aging/mentalhealth/depression.htm

4. Describe four of the many symptoms of depression.
5. The family asks the nurse, "How common is depression in older adults?" Which of the following is the best response?
   a. Depression is rare in older adults, almost never occurs (<1%).
   b. Depression is extremely common in older adults (>50%); in fact it is a normal part of aging.
   c. Depression estimates range from <1% (among community dwelling older adults) to 13.5% (among those receiving home-based health care).
   d. Depression among older adults is only seen in those persons living in skilled care nursing facilities (about 25% of these older adults are depressed).
6. The family asks you to describe how depression might be different in their father than in a younger adult. What could you tell them about depression in older adults?

The family wants to explore online information about depression among older adults

7. What are three reputable Web sites to which you might refer this family?

Refer to the Geriatric Mental Health Foundation's Web site to answer questions 8 and 9 at http://www.gmhfonline.org/gmhf/consumer/depression.html

8. Mr. Edwards family asks the nurse, "Is depression in older adults treatable?" What could the nurse accurately tell the family?
9. After their father saw the geriatric health care practitioner, he received an antidepressant medication as a treatment for his depression. The family asks the nurse, "How long will it take for our father to start to feel better from his symptoms of depression?" What is an accurate response to this question?
10. Mr. Edward's daughter inquires about alternative and complementary measures to assist with his depression. What herbal and supplemental agents have been studied? What mind–body techniques have been used? Cite the source for your findings.

References

Kurlowicz, L., & Greenberg, S. A. (2007). *Try this—Issue 4 the geriatric depression scale (GDS).* Hartford Institute of Geriatric Nursing. Retrieved from http://consultgerirn.org/uploads/File/trythis/issue04.pdf

Mayo Clinic Staff. (2010). *Depression (major depression) alternative medicine.* Retrieved from http://www.mayoclinic.com/health/depression/DS00175/DSECTION=alternative-medicine

Case 4.4 Gambling Addiction

Donna J. Bowles

Jenny Parker is in her second year as a public health nurse in a small Midwest river town. Prior to this position, she worked on a medical–surgical floor in a large teaching hospital for several years and then joined the home health services of that organization where she stayed for a decade. Jenny finds working with the community a challenging, yet rewarding area to practice. She is the only registered nurse (RN) within her Public Health Department. She spent most of the first year of employment conducting a needs assessment and becoming familiar with the community.

What transpired the second year has definitely affected the social and economic climate of the community; a casino boat opened in a nearby town. A political vote was held, and the casino was highly supported by the majority. New jobs came available, a new tax base for the county, and a new source of entertainment. In addition, grant monies for education, health care, and social services were promised by the casino owners.

Despite all the excitement and favorable views, Jenny has been informed of problems, which have surfaced in recent months. The town mayor contacted her to be a member of a task force to explore the effects of gambling on the elderly population.

1. What other types of individuals from the community might be invited to serve as members on the task force with Jenny?

Jenny has read various e-mails sent to the mayor's office complaining about the casino and asking, actually demanding, the top town officials take action. Letters from family members of elderly individuals address numerous concerns such as that with Martha O'Riley. She is an 84-year-old widow who has been visiting the casino regularly for months. Her daughter states, "everything was fine until the slot machines took over her life." Martha lives alone in the rural section of town and does not drive. She is an insulin dependent diabetic, has hypertension, and coronary artery disease. Her only hobby is working cross-word puzzles. Otherwise, watching television, light housekeeping, and preparing simple meals describe her life since losing her spouse 4 years ago. Her daughter calls daily and stops by every weekend.

Martha saw an ad on television for "Senior Day" at the casino. There was valet parking, a buffet meal, door prizes every hour, and $20 worth of free tokens to play the slot machines. All the old people in the ad looked liked they were having so much fun.

She knew her neighbor down the road had secured a part-time position at the casino. Since she gave up driving in her 60s, she arranged a ride with the neighbor.

2. Martha's lifestyle situation is common to many older people; what do you think has attracted her to gambling?

Martha's daughter was not terribly concerned with her mother's early visits to the casino. The neighbor providing transportation worked a couple of 4-hour shifts per week at the casino, and Martha initially went only once a week. However, when the neighbor changed to full-time status, Martha began leaving home at 7 a.m. and returning after 4 p.m. in order to visit the casino.

3. Based on Martha's active medical problems, what concerns might her daughter have for her physical well-being while she is away from home for most of the day?

In addition to physical health concerns, Martha's daughter is concerned about a gambling addiction being present with her mother. One of the members on the task force with Jenny is a psychologist. He explains that in 1980, the American Psychological Association included pathological gambling in their *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. By including pathological gambling, it gave official medical recognition of the problem as a disease. Pathological gambling is also identified as a disease by the World Health Organization. The psychologist prepares a hand-out for the committee members based on *DSM-IV* (American Psychiatric Association, 1992). He explains that a person who exhibits at least five of the following behaviors may be a pathological gambler:

- Committing crimes to get money to gamble
- Feeling restless or irritable when trying to cut back or quit gambling
- Gambling to escape problems or feelings of sadness or anxiety
- Gambling larger amounts of money to try to make back previous losses
- Having had many unsuccessful attempts to cut back or quit gambling
- Losing a job, relationship, or educational or career opportunity due to gambling
- Lying about the amount of time or money spent gambling
- Needing to borrow money to get by due to gambling losses
- Needing to gamble larger amounts of money in order to feel excitement
- Spending a lot of time thinking about gambling, such as past experiences or ways to get more money with which to gamble.

In addition to this *DSM-IV* screen for pathological gambling, Jenny shares a screening tool for assessing problem gambling she discovered in a recent nursing journal article.

4. Using the Internet, find at least (2) screening tools and cite the name, a brief description, and the reference source for each.

5. Jenny asks the psychologist for information regarding risk factors for problem gambling. What would the psychologist likely share with the committee in regard to risk factors?

Another member of the task force represents the state's Gaming Association. He shares that every state in the nation, with the exception of Hawaii and Utah, has some form of legalized gambling. Furthermore, from 1975 to 1998, the number of people aged 65 years or older, who had gambled in their lifetime, increased from 35% to 80% and that number is expected to continue to climb (American Gaming Association, 2008).

Martha O'Riley's daughter's other primary concern for her mother is financially focused. She states her mother is debt-free and she needs to remain so. She receives $1400 per month from Social Security and has several hundred thousand dollars in stock investments her late husband left. Martha has refused to tell her daughter any information about her spending at the casino. She has repeated several times, "I am an adult, fully competent, and it's my business only."

6. What are your thoughts on Martha's response? Is her daughter's concern justified?

Another member of the task force is a 76-year-old female who was invited based on her past gambling experiences. Ethyl Moore played poker on the Internet after retiring from a life-long career as a school teacher. She states that what started as a way to pass time for an hour or so a day became a compulsion, which overruled her

entire being. Over a 6-year span, Ethyl neglected her physical needs, became socially isolated, and took a second mortgage on her home to support the gaming. An intervention by her family and close friends was arranged, and she has not gambled in any form for nearly a decade. Ethyl is a member of Gamblers Anonymous (GA) and continues to attend meetings at least monthly.

7. Prepare a brief review of this support group. Include the date of origin, framework, and how Gamblers Anonymous is designed to assist those with a gaming addiction.

After the initial meeting of the community task force, Jenny drafts a strategic plan for the group to discuss and further develop. Her overall goal is to "prevent gambling of any form to become a public health issue."

8. What are examples of devastating outcomes in the lives of gambling-addicted elderly people Jenny is attempting to address?

Additional Resources

Christensen, M. H., & Patsdaughter, C. A. (2004). Gambling behaviors in black older adults: perceived effects on health. *Journal of Gerontological Nursing, 30*(4), 34–39.

Lichtenburg, P. A., Martin, F., & Anderson, C. (2009). Gambling in older adults: an emerging problem. *Journal of Addictions Nursing,* 20(3):119–123.

References

American Gaming Association (2008). State of the states. The AGA survey of casino entertainment. Retrieved from http://www.americangaming.org/assets/files/aga_2008_sos.pdf

American Psychiatric Association. (1992). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Compulsive gambling: Risk factors. (January 2009). *Mayo Clinic.com.* Retrieved from http://www.mayoclinic.com/health/compulsive-gambling/DS00443/DSECTION=risk-factors

Gamblers Anonymous. Retrieved from http://www.gamblersanonymous.org/about.html

Case 4.5 Risk for Suicide

Allison H. Burfield

In a small college town, Susan Cooper, the nurse coordinator for the medical home initiative in a local primary care provider's office, assesses a new client. The nurse introduces herself and goes over the intake form with Helen Wright to plan for her care management. Ms. Wright was referred by the local Emergency Department (ED) because of repeated visits and complaints of "no one caring" for her, or her well-being. The ED staff voiced concern for Ms. Wright, because she is estranged from her family, lives by herself, and has a long history of bipolar disorder. Ms. Wright's recent visits to the ED center on vague somatic complaints, and she often leaves before being seen by the doctor, stating, they are wasting her time, and what is the point?

1. What is a key benefit of medical home models for care coordination?
2. Because of the referral information, what should the nurse assess for in Ms. Wright's initial appointment?

Nurse Susan reviews Ms. Wright's chart and finds she is a 72-year-old widow, who has lived in the same house for the last 40 years. Her husband died 7 years ago. Ms. Wright states her health has been poor, especially since she was recently diagnosed with diabetes. The ED report indicates her Type II diabetes is well managed, along with her hypertension. Her clinical notes indicate that she often displays attention-seeking behaviors with vague physical symptoms. She reports taking Ambien (zolpidem) 10 mg, as needed at bedtime due to an inability sleep; Remeron (mirtazapine) 15 mg at bedtime; Prozac (fluoxetine hydrochloride) 20 mg daily, admitting she sometimes forgets to take the morning dose, so sometimes takes it in the afternoon or evening; Lithium 600 mg 3 times a day; Xanax (alprazolam) 0.50 mg as needed for anxiety; Glucophage (metformin) 500 mg twice a day with meals; and Calan (verapamil) 240 mg daily. Her Hemoglobin A1C is 6.5, her morning fasting blood sugar was 112, her lithium level is 1.0, and her blood pressure is 118/74. Ms. Wright states she often finds that life is not worth living and wishes she would die. Ms. Wright states her children are ungrateful, and refuse to visit her. Notes on her chart indicate that family members have been present at ED visits in the past, but Ms. Wright is verbally abusive and her mood is labile at times.

3. What are common symptoms that the nurse should be aware of to screen for depression in Ms. Wright?
4. What additional information would the nurse assess to determine suicide risk?
5. What protective factors could help reduce suicide risk?

Ms. Wright has a flattened affect and makes poor eye contact; she is oriented to person, place, and time. She reports difficulty sleeping at times and anxiety when she is unable to fall asleep. The nurse notes Ms. Wright is well-groomed and has a body mass index (BMI) of 23 with a petite 5 ft 2 in. frame. Ms. Wright has no limitations with her range of motion and states that she goes to the grocery store weekly. She states she used to attend church, but no longer attends now, because "those old cronies are just busy bodies."

6. What areas should the nurse probe into more detail about to assess suicide risk with Ms. Wright?
7. How should the nurse approach asking whether Ms. Wright is having suicidal thoughts?

Nurse Susan asks, "How do you feel about living by yourself?" Ms. Wright crosses her arms and says, "Well I am fine, what a silly question . . . my family says I am not easy to live with, because some days I am up, but most days I am down. They get tired of listening, so now I am just tired of living." Ms. Wright reports to Susan that she feels passive about suicide and denies having a plan. She states she has attempted suicide in the past about 20 years ago by overdosing on her medications; however, she denies a current suicide plan, stating she knows that would be wrong.

8. What type of safety plan should the nurse establish with Ms. Wright?

Ms. Wright agrees to enter into a verbal contract and see the social worker at their practice to establish a mental health care plan along with managing her diabetes

and high blood pressure with the primary care doctor. Nurse Susan gives a hotline number that is available 24/7, should Ms. Wright feel alone and want someone to talk with: National Suicide Prevention Lifeline http://www.suicidepreventionlifeline.org/ 1-800-273-TALK (8255).

The nurse takes this opportunity to review Ms. Wright's medications and develop a medication therapy management (MTM) plan to improve her care outcomes (Cooper & Burfield, 2007). The nurse reminds Ms. Wright to take her lithium after meals with plenty of water to reduce stomach upset, and to have her lithium level checked monthly.

9. Ms. Wright's medication regimen put her at the highest risk for which of the following? Select all that apply.

a. Neurotoxicity

b. Falls

c. Constipation

d. Bradycardia

Nurse Susan recommends a medication review by the clinical pharmacist and with the care planning team at their clinic. Susan, registered nurse (RN), explains that she has concern about the combination of her medications and the risk of medication interactions and her risk of falling. The nurse explains that her Prozac should only be taken first thing in the morning, as this medication can cause excitability making it difficult to go to sleep if taken too close to bedtime. Ms. Wright verbalizes an understanding of her medications and agrees to return for further coordination of services. Ms. Wright states she feels much better having someone to talk to and knowing she can come to this one location and access all of her care.

Additional Resources

Agency for Healthcare Research and Quality (AHRQ) http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm

National Center for Health Statistics http://www.cdc.gov/ViolencePrevention/suicide/

National Institute of Mental Health http://www.nimh.nih.gov/health/topics/older-adults-and-mental-health/index.shtml

National Strategy for Suicide Prevention http://mentalhealth.samhsa.gov/suicideprevention/elderly.asp

References

Centers for Disease Control and Prevention. (2007). *Web-based inquiry statistics query and reporting system (WISQARS)*. National Center for Injury Prevention and Control CDC Web site. Retrieved from http://www.cdc.gov/injury/wisqars/index.html

Cooper, J. W., & Burfield, A. H. (2007). Medication Therapy Management (MTM) strategies for geriatric patient interventions: Medicare part D implementation. *Annals of Long-Term Care: Clinical and Aging, 15*(7), 33–38.