

Suicide among the elderly: the promise of telecommunications[†]

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The study by De Leo and his colleagues published in this issue reports a robust decline in suicide rates among elderly users of a telephone-based system of support and information when compared with general population suicide rates in northern Italy (De Leo *et al*, 2002, this issue). These findings are particularly impressive because the target population of elderly people using the TeleHelp–TeleCheck system was drawn from those who were referred because of social, medical and psychiatric risk factors for suicide: disability, social isolation, psychiatric problems, poor compliance with medical treatment, or waiting for admission to health care services. Users of the system received twice-weekly telephone interviews to provide welfare monitoring and emotional support, and could initiate calls at any time. Users could also trigger an alarm device to initiate a pre-established response network.

The use of telecommunications to provide mental health services to isolated or underserved populations has received increasing attention in the past decade (Jones, 2001). Reports of standardised ratings suggest that, in general, valid mental health clinical assessments can be conducted at a distance using videoconferencing equipment (Grob, 2001; Jones *et al*, 2001). The use of telephone-based mental health services has also been explored, with some useful reports of success. Herman (1999) described a psychoeducational project 'HOPES' that combined automated, interactive, focused medical education and behavioural change programmes. Mahoney *et al* (1998) reported on the development of an automated telephone support system for people caring for someone with Alzheimer's disease. The system had some elements similar to the current project, with weekly monitoring of the caregiver's stress level, a voice-mail support network and

access to experts. However, the present report is unique in that it addresses a particularly thorny clinical challenge in geriatric psychiatry: preventing the occurrence of an infrequent but mortal event, elderly suicide. Many elderly people who commit suicide have established health care providers, and many of these had been seen shortly before the death, suggesting that the detection of suicidal patients is inadequate. It is also likely that some patients with suicidal thoughts are not sharing these thoughts with caregivers, who could help them obtain treatment. Thus, it is not always a lack of health care resources that is to blame for suicide in the elderly, but a 'disconnection' between patient and health care providers. Perhaps it is here that the TeleHelp–TeleCheck intervention provided an essential element in preventing suicide: regular, brief conversations with a supportive person.

WAS IT THE TELEPHONE CARE OR THE REFERRAL TO CARE THAT HELPED?

Although not described as 'teletherapy' or intended to replace psychotherapy, the telephone-based system appears to have the key elements of successful therapy described by Jerome and Julia Frank: a demoralised person, a confiding relationship with a helping person, and a method of increasing the person's sense of mastery (Frank & Frank, 1991). That these elements could be provided using only brief telephone calls is encouraging. However, it is not clear from the current report how many users were referred for formal mental health treatment, or the role of such services in reducing the suicide rate. This information would help determine whether the telephone system reduced the suicide rate by detecting cases for further treatment, or whether the programme itself offered some therapeutic benefit without further referral.

Expanding the use of telecommunications might show that such informal,

supportive, education-based services can have powerful benefits for underserved populations. The bulk of telepsychiatry research and experience continues to use the medical model of consultative diagnosis and treatment of patients already in treatment with primary care providers. The report by De Leo and his colleagues suggests that support systems based on the social model of depression and mental health can have widespread utility. This is important given the expense of physician-based services, which are typically limited either by provider availability or by management of insurance benefits. Telephone-based systems using experienced, supportive interviewers would have lower operating expenses than professional clinical services, and might well be cost-effective in recognising old people at risk.

Few details are given about the operating expenses of the telephone support system. The paucity of cost-benefit analyses continues to be the Achilles' heel of telemedicine programmes, which typically flourish when grant-funded but wither when left to be self-sustaining (Whitten *et al*, 2000). Given the merits of the programme as described, one must ask how it could be replicated in one's own health care environment. Although teleconsultations using two-way video links are reimbursable under Medicare in the USA, the patient must be in a federally defined rural area, and the consultation requested by a health professional. Geriatric case managers operating independently of insurance reimbursement are increasing in numbers, suggesting that families are willing to pay for such services, which might include regular telephone support. More employers are underwriting benefits such as case management of elderly health problems, which could include telephone support and management. Given the benefits demonstrated in this report, telephone support programmes should be considered an essential part of health management services for the elderly.

DO PATIENTS NEED (OR WANT) TO 'SEE' THE DOCTOR?

One of the important findings of the current report is that face-to-face contact, or even a video image, is not required for successful mental health care interventions. This challenges many notions of therapy

[†]See pp. 226–229, this issue.

and mental health care, such as the expectation that the development of empathy requires physical proximity between client and therapist. Our satisfaction ratings of geriatric psychiatry in-patients interviewed using videoconferencing revealed that most older patients found the experience comparable to a face-to-face interview, and a small minority reported that they would prefer the video interview over a traditional face-to-face encounter (further details available from the author upon request). It is possible that some patients would be more comfortable given some physical and emotional space, and perhaps the telephone is a medium well suited to such individuals.

An important health services issue in need of research is the patient's attitude towards and acceptance of the requirement to visit the health care provider to receive services, as opposed to receiving services by telecommunication. Many elderly patients find medical centres intimidating, difficult to negotiate and inconvenient. In our telemedicine research, rural patients gave videoconferencing a higher satisfaction rating than did urban patients, suggesting that distance from health care is a determinant in the acceptability of alternatives to traditional face-to-face encounters (further

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(First received 8 April 2002, accepted 12 April 2002)

details available from the author upon request). As alternatives to clinic-based health care grow, it seems that many patients would just as soon 'shop at home' for health care information, assessment and services.

In summary, De Leo *et al's* report demonstrates the power and importance of using telecommunications to provide mental health care services. Using telecommunications to expand education, support, detection and treatment of mental illness should be a key component of health services planning.

DECLARATION OF INTEREST

None.

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