Mental Health

Kristin's Story

"As an adult, I can look back and know that I have lived most of my life with undiagnosed mental illness," says Kristin Leve. She grew up in a solidly middle-class family—one that she describes as "dysfunctional." "But even with the dysfunction, there was a lot of love," she hastens to add.

"Most families are not functional families," Kristin says, after coming to terms with her own family's problems. "My mom was an alcoholic, and my father was a workaholic."

Kristin's adolescence had begun as many do, with some rebellion, some pushing the limits, but always against the backdrop of a loving family. Then things fell apart. When she was 16, Kristin's parents split up. Her mother went into treatment for her drinking. Old wounds were re-opened: when she was 6, Kristin had been molested by a 16-year-old neighbor. Now, in the face of other harsh realities, this trauma again came to the surface.

Kristin Leve was 17 when she first attempted suicide.

Then from 1988 to 1994, Kristin's family suffered a series of tragedies. Both grandfathers and one grandmother died. Kristin was married in 1992, but the marriage only lasted a couple of months. In 1993, her father died. Within months, Kristin became pregnant and had an abortion.

It was all more than she could take, and in 1994, Kristin again tried to take her own life.

She went into an outpatient treatment program at the University of New Mexico Mental Health Center. She received help with medications, but could not be assigned a case manager because she was not on Medicaid. "I was too sick to work, but not sick enough to get disability," Kristin says, well aware of the broken systems that prevent people from getting the care they need. "I was sort of in the cracks."

"Our nation is dysfunctional, but people don't recognize what's going on," Kristin observes, revealing a perspective much larger than her own crises. "Systems are overburdened, and people in need just aren't getting what they need."

Kristin lived for the next few years with her mother, alternating between periods of crisis and stability. By 2002, she felt stable enough to get her own apartment in downtown Albuquerque.

Before long, however, Kristin couldn't pay her bills and became homeless. She went to Barrett House, a small shelter for women. While there, she was referred down the street to Albuquerque Health Care for the Homeless (AHCH). She met the staff of La Puerta, the behavioral health component of AHCH, and before long, she was in emergency housing through the Albuquerque Mental Health Housing Coalition. There Kristin developed a relationship with Peggy Harter, her case manager, who helped her move into a Shelter Plus Care apartment through AHCH. Kristin began receiving medical and psychiatric care at the AHCH medical clinic and eventually worked with therapist Jill Zomerhuis.
Another important discovery was ArtStreet, a community art space operated by AHCH. Although Kristin had never considered herself an artist before, she began making art and felt at home in the community of people who come together every Thursday and Friday during "open studio" time. Eventually she joined the ArtStreet Client Advisory Council, entered her work in art shows, and not long ago, sold her first piece. "I never thought that would be possible," Kristin says with pride.

In describing the pivotal role of Albuquerque Health Care for the Homeless in her process of healing, Kristin says, "They saved my life. Without HCH, I would have gone on a downward spiral, attempted suicide again, and would probably have been successful…but that hasn't happened."

Now, three years removed from her experience with homelessness, Kristin is reflective: "My experience as a homeless person is not as harsh as some people's—I never had to sleep on the streets. But that doesn't change the fear of not having a roof over your head or knowing how safe you'll be."

When I thank her for her openness, Kristin simply says, "I hope that people can read my story and see elements of themselves and know that something can be done about homelessness."

I first met Kristin Leve in Washington, DC in June 2005. She had just returned from meeting with a staff person who works for her congressional representative from New Mexico. After spending a substantial amount of time discussing policy related to homelessness, affordable housing, and health care access, Kristin said to him, just before leaving, "You've been sitting across from a homeless person for the last hour."

His jaw dropped.

Interview by Jeff Olivet. Originally published in Olivet, J. & Horn, A. (2005). *Every success story is a great story.* Nashville, TN: National Health Care for the Homeless Council.

Understanding Mental Health and Homelessness

"If you're living on the streets and you're not depressed, something's wrong…"

Understanding the differences among feelings, symptoms, and disorders

Anyone working in homeless services must have a basic understanding of the connections between mental health and homelessness. Mental health problems can be both a cause and result of homelessness. Severe mental illness and the stigma surrounding it can be factors leading to homelessness. Likewise, mental health problems can exacerbate or develop from life on the streets and in shelters, due to the overwhelming stress of homelessness and exposure to violence and other traumatic events. "If you're living on the streets and you're not depressed, something's wrong with you," quipped one man who lived several years on the streets.

There is a difference though, between "feeling depressed" and suffering from a major depressive episode, between "feeling stressed" and experiencing post-traumatic stress disorder (PTSD). We all have feelings of sadness, loneliness, and anxiousness at one time or another—often but not always related to specific events going on around us. These feelings are not the same thing as mental illness.

Sometimes feelings translate into symptoms such as not eating or overeating, not sleeping or sleeping too much, or the inability to focus on completing a task. You feel like you cannot get out of bed and face the world, so you call into work and take a "mental health day." One or two symptoms that pass quickly, though, are not the same thing as serious mental illness.

A mental health disorder diagnosis can happen when a specific constellation of symptoms occurs over a set period. For example, a PTSD diagnosis is possible if someone, in response to a traumatic event, develops symptoms that persist for at least one month such as nightmares or flashbacks, feelings of detachment, hyperarousal, and significant distress or problems functioning socially or at work. This experience is much more specific and much more debilitating than being "stressed out" or thinking a lot about something bad that happened.

While not all feelings and symptoms need therapy, medications, or other supports, serious mental illness can be a debilitating, painful, overwhelming experience that a person usually cannot address without some combination of social support, medications, therapy, and other interventions.

Mental health problems are common

Mental health problems are extremely common. One study estimates that "about half of Americans (46.4%) will meet the criteria for a DSM-IV disorder sometime in their life, with first onset usually in childhood or adolescence" (Kessler et al., 2005). More specifically, the general population is likely to experience the following at some point in their lives:

- Anxiety disorders (29%)
- Mood disorders (21%)
- Impulse control disorders (25%)

- Substance use disorders (14%)

While the number is difficult to pin down, most believe that people experiencing homelessness suffer from more mental health problems than people who are in housing.

The role of recovery

The Vision of the President's New Freedom Commission on Mental Health

We envision a future when everyone with a mental illness will recover, a future when mental illness can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community.

The good news is that people can and do recover from mental health problems—sometimes on their own and sometimes with support from other individuals and from professionals. The President's New Freedom Commission on Mental Health released a report in 2003 that espouses a recovery-oriented approach to mental health treatment.

The Freedom Commission's report strives to balance an individual, strengths-based approach with strategies for strengthening the systems of care and support for people suffering from mental illness. This guide attempts to strike a similar balance.

The intersection of mental and physical health

So why, in a guide that attempts to provide medical information for non-medical providers, do we include information on mental health? There is a connection between mental and physical health—the mind and the body—that is both profound and practical. When people experience homelessness, they often neglect their physical health. Minor problems become major ones, and physical illnesses treated easily if detected early enough, go undetected for months and years, and grow into chronic health problems.

These trends magnify when someone experiencing homelessness also suffers from mental illness. Many feel distrustful of the mental health system because of previous disempowering experiences. Suspicion of institutions and difficulty building personal relationships with service providers can interfere with people's willingness to access treatment. Likewise, our fragmented health care systems do not always respond to people's needs. Additionally, mental health problems such as schizophrenia can, over time, cause cognitive deficits that make it difficult for individuals to keep appointments, fill out paperwork, or even remember where to go and when.

The importance of relationship

One of the major reasons it is so important that service providers understand mental illness is that there is a direct relationship between mental health problems and the ability to build a sustaining connection with a client. If a provider is fearful of a hallucinating person, or misunderstands a

client's anger, terror, or pain, there is little chance of developing an authentic relationship. It is only through authentic relationships that the process of healing can happen.

Providers need to remember that diagnoses are often deficit-oriented and reflect a narrow, though important, aspect of a person's experience. Diagnoses should not label or further stigmatize people with mental illness, but can help in sorting out treatment alternatives. We also do not expect that providers become diagnosticians, but instead use this perspective to understand one dimension of how a client might present.

Additionally, as stated earlier, the symptoms and long-term cognitive problems associated with serious mental illness can present very real challenges to people accessing services and navigating confusing services. If people cannot remember an appointment with a case manager or physician, they lose the opportunity for building a relationship. Providers must understand a missed appointment as not simply "non-compliance" or "lack of motivation," but as a possible consequence of fear, suspicion, or memory problems.

Recognizing differences in perspective

It is impossible in just a few pages to present everything outreach workers or other providers should know about mental health. It is also impossible to present a complete picture of all of the perspectives in the area of mental health. It is vital that any discussion of these issues includes real and meaningful input from people with the experience of mental health problems and homelessness. We provided this input in this guide by including pieces written by consumers and by including multiple consumers as reviewers of this guide. It is also important to recognize the growing body of knowledge in the field of psychiatry and mental health treatment. As people understand more about what works for whom in what settings, service providers should use that evidence and knowledge to guide their practice.

In the pages that follow, we hope to provide information and perspectives that will influence how individual service providers think about mental health and homelessness, and how organizations can create programs to serve people who suffer from mental illness and homelessness.

Sources:

Kessler, R. C., Berglund, P. ,Demler, O., Jin, R., Merikangas, K., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593–602.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, Final Report.*

Relating to a Person Experiencing Mental/Emotional Distress

- Always be respectful
- Allow the person a "comfort zone"—do not stare at, hover over, or press the person
- Seek to understand the person's experience; do a lot of listening
- Be slow to give advice
- Affirm the individual's abilities and strengths
- Speak softly, slowly, and clearly
- Be as consistent and predictable as you can
- Communicate rules and expectations in a clear manner
- Work together to set simple, short-term goals
- Remember the person's perceptions may be different from yours
- Do not try to argue against voices or delusions
- Do not take the individual's behavior personally
- Do not blame the person

Call for help if you believe people are at imminent risk of hurting themselves or someone else.

More information on mental health and homelessness:

- Center for Mental Health Services (CMHS) http://www.samhsa.gov/about/cmhs.aspx
- National Empowerment Center (NEC) http://www.power2u.org/
- National Institute of Mental Health (NIMH) http://www.nimh.nih.gov/index.shtml
- Substance Abuse and Mental Health Services Administration (SAMHSA) http://samhsa.gov/
- SAMHSA's Homelessness Resource Center (HRC) http://homeless.samhsa.gov/

Overview of Mental Illness

Mental illness is a term rooted in history that refers collectively to all diagnosable mental disorders. The characteristics of mental disorders are abnormalities in cognition, emotion/mood, or the highest integrative aspects of behavior, such as social interactions or planning future activities. The brain mediates all of these mental functions. It is, in fact, a core tenet of modern science that behavior and our subjective mental lives reflect the overall workings of the brain. Thus, symptoms or disorders related to behavior or our internal experience reflect variations or abnormalities in brain function.

On the more difficult side of the ledger are the terms: disorder, disease, or illness. There can be no doubt that an individual with florid psychosis such as schizophrenia is seriously ill, but for other mental disorders such as depression or attention deficit hyperactivity disorder, the signs and symptoms exist on a continuum and there is no bright line separating health from illness, distress from disease. Moreover, the manifestations of mental disorders vary with age, gender, race, and culture. Ultimately, the dividing line has to do with configuration and severity of symptoms, duration, and functional impairment.

This section will address common manifestations of mental illness, including:

1. Anxiety
2. Psychosis
3. Disorders of mood
4. Disorders of cognition
5. Other symptoms

Manifestations of mental illness

Persons suffering from any of the severe mental disorders present with various symptoms that may include anxiety, disturbances of thought and perception, dysregulation of mood, and cognitive dysfunction. Many of these symptoms may be relatively specific to a particular diagnosis and cultural influence. For example, disturbances of thought most commonly associate with schizophrenia, a type of psychosis.

Similarly, severe disturbances in expression of affect and regulation of mood are most common in depression and bipolar disorder. However, it is also common to see psychotic symptoms in patients diagnosed with mood disorders or to see mood-related symptoms in patients diagnosed with schizophrenia. Symptoms associated with mood, anxiety, thought process, or cognition may occur in any person at some point during his or her illness.

1. Anxiety

Common Signs of Acute Anxiety

- Feelings of fear or dread
- Trembling, restlessness, muscle tension

- Rapid heart rate
- Lightheadedness or dizziness
- Perspiration
- Cold hands/feet
- Shortness of breath

Anxiety is one of the most common and easily understood of the major symptoms of mental disorders. Each of us encounters anxiety in many forms throughout the course of our routine activities. It may often take the concrete form of intense fear experienced in response to an immediately threatening experience such as narrowly avoiding a traffic accident. Such a response is common to a stressful situation, but feelings of anxiety alone do not imply a mental disorder. Strong emotional responses of fear and dread, as well as physical signs of anxiety such as rapid heartbeat and perspiration, typically accompany threatening experiences. Immediate threats to one's safety most intensely arouse anxiety, but it also occurs commonly in response to dangers that are relatively remote or abstract. Intense anxiety may also result from situations that one can only vaguely imagine or anticipate.

Anxiety evolved as a vitally important physiological response to dangerous situations that prepares one to avoid or confront a threat in the environment. The appropriate regulation of anxiety is critical to the survival of virtually every higher organism in every environment. However, when anxiety is persistent and associated with various other symptoms, when it impairs functioning and persists over time, then someone may experience an anxiety disorder such as generalized anxiety, panic attacks, and phobias.

Generalized anxiety represents a more diffuse and nonspecific kind of anxiety most often manifested by excessive worrying, restlessness, and tension occurring over a sustained period. In each case, an anxiety disorder exists if the anxiety experienced is disproportionate to the circumstance, is difficult for the individual to manage, and interferes with functioning over time.

Panic attacks are relatively brief and very intense episodes of anxiety that often occur without a perceptible precipitating event or stimulus. In **phobias**, specific situations or objects that may range from concrete entities such as snakes to experiences such as public speaking arouse high-level anxiety. Phobic responses sometimes generalize and people are unable to leave their homes (e.g., agoraphobia).

In addition to these anxiety disorders, obsessive-compulsive disorder and post-traumatic stress disorder generally relate to the anxiety disorders. In the case of **obsessive-compulsive disorder**, individuals experience a high level of anxiety paired with repetitive disturbing thoughts or behaviors. When such an individual fails to carry out a repetitive behavior such as hand washing, he or she experiences severe anxiety. Thus, while the outward manifestations of obsessive-compulsive disorder may seem related to persistent thoughts and behaviors, severe anxiety may dominate and interfere with functioning.

Post-traumatic stress disorder (PTSD) results from an intense and overwhelmingly fearful event that is often life threatening in nature and outside the realm of usual everyday experience. Examples

include unexpected death of a loved one, severe accidents, family and community violence, natural disasters, and war. The manifestations of PTSD are a sense of loss of control, extreme vulnerability, terror, and dissociation. Typical symptoms include intrusive thoughts characterized by a re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the event, and increased arousal.

2. Psychosis

Disturbances of thought process and perceptions fall into a broad category of symptoms referred to as psychosis. The threshold for determining impaired thought varies somewhat with the cultural context. Like anxiety, psychotic symptoms may occur in other mental disorders. They most characteristically associate with schizophrenia, but psychotic symptoms can also occur in severe mood disorders. **Schizophrenia**, a brain disorder, is prevalent in 1% of the worldwide population across cultures. The disorder most often begins in the late teens or twenties. Some people diagnosed with schizophrenia may need lifelong support and treatment.

Common Manifestations of Schizophrenia

- Hallucinations
- Delusions
- Disorganized thoughts and behaviors
- Loose or illogical thoughts
- Flat or blunted affect
- Concrete thoughts
- Anhedonia (inability to experience pleasure)
- Poor motivation, spontaneity, and initiative

Hallucinations and delusions are among the most commonly observed psychotic symptoms, and both are typical manifestations of schizophrenia. In addition to hallucinations and delusions, patients with psychotic disorders such as schizophrenia frequently have marked disturbances in the logical process of their thoughts. Specifically, psychotic thoughts are illogical, disorganized, or bizarre. These disturbances in thought process frequently produce observable patterns of behavior that are also disorganized and bizarre. These severe disturbances of thought content and process are often the most recognizable and striking features of psychotic disorders such as schizophrenia or bipolar illness. In addition to these symptoms, people with schizophrenia and other psychoses exhibit major problems in motivation and spontaneity.

Hallucinations occur when an individual experiences a sensory impression that has no basis in reality. This impression could involve any of the sensory modalities. Thus, hallucinations may be auditory (hearing), visual (seeing), olfactory (smell), gustatory (taste), or tactile (touch). For example, auditory hallucinations frequently involve the impression that one hears a voice. In each case, the person falsely experiences the sensory impression as real.

A more complex group of symptoms resulting from disordered interpretation of information consists of delusions. A **delusion** is a false belief that an individual holds despite evidence to the contrary. A common example is paranoia, in which a person has delusional beliefs that others want

to harm him or her. Attempts to persuade the person that these beliefs are false typically fail and may even result in the further entrenchment of the beliefs.

Concrete thoughts represent impairment in the ability to think abstractly. Blunting of affect refers to a generally reduced ability to express emotion. Problems with motivation and the inability to initiate activities represent a major source of long-term disability in schizophrenia. Anhedonia reflects a deficit in the ability to experience pleasure and to react appropriately to pleasurable situations. While symptoms such as hallucinations are responsible for much of the acute distress associated with schizophrenia, these other symptoms appear to be responsible for much of the chronic and long-term disability associated with the disorder.

Psychotic symptoms reflect disturbances in the flow, processing, and interpretation of information by the central nervous system. While many of these disorders respond to specific pharmacological interventions, all treatment must occur in the context of a trusting relationship. Much remains to learn about the brain mechanisms that lead to psychosis.

Recognizing and responding to hallucinations

The more distressed I became, the more loudly the voices raged in my head, taking up all the space. It was like having a radio stuck between two stations, creating problems concentrating, sleeping, and protecting myself. Even though I often prayed for a reprieve, I was simply not prepared for the silence either. It wasn't until the voices began to disappear that I understood for the first time what it was like to be truly alone in the world. While people were anxious to help get rid of the voices, they were much less well-equipped to help me deal with the silence.

Laura Prescott

Hallucinations can be frightening because of their illogical, sometimes bizarre, and often pressured nature. The person's terror is often palpable and can distress service providers. It is not always easy to know just how to respond.

When a person senses (sees, hears, feels, smells, tastes) things that do not exist, we refer to these perceptions as hallucinations. Hallucinations may come about for several reasons: various forms of mental illnesses; use of some drugs (legal or illegal); health conditions; injuries; or trauma.

The most frequent hallucinations are auditory, and often include hearing voices, some of which tell the person to do something (known as command hallucinations). You may recognize that individuals have auditory (hearing) hallucinations when they appear preoccupied and unaware of their surroundings, talk to themselves, have difficulty understanding or following conversations, and misinterpret the words and actions of others. They may also isolate themselves or use the radio or other sounds in an effort to tune out the voices.

People experiencing other types of hallucinations (visual, tactile, smell, taste) often interact with the hallucination—visually focusing on something you cannot see; touching, scratching, or brushing things off themselves; sniffing or holding their nose; or spitting out food—when there is no apparent reason to do so.

A person experiencing hallucinations may be very fearful of them and needs your help in establishing a calm environment. Do not invade personal space or touch the person without

permission. Speak slowly, calmly, and quietly, using simple concrete language. Be patient. It may take the person longer to process information. Reduce stimuli. Turn off radios, televisions, bright lights, or anything else if these things cause the person additional stress. Address the person by name or, if you do not know it, ask.

There are two immediate goals when responding to people experiencing hallucinations. The first is to be with them through the experience in a non-judgmental way so that they are not so alone. The second is to help them focus on the present environment rather than on the hallucination.

Reassure the person that you want to help. Explain who you are, what you will do, and why. If other people arrive, explain who they are and how they will help. Be honest and direct. Do not pretend you also experience the hallucination or try to convince the person that the hallucination does not exist. It does exist to him or her. Ask questions such as, "Do you hear voices other than mine? What do they tell you? What do you see/feel/taste/smell?" Tell the person: "I do not hear the voices (see what you see, etc.), but I believe that you do." Ask the person to listen to your voice and not the other voice(s), or to look at you rather than whatever else he or she sees.

Try to create a safe environment. Being "safe" means not exposing people to situations where they are likely to experience force or coercion but rather support as active agents in directing the course of their own healing.

Recognizing and responding to delusions

When people hold to personal beliefs that are inaccurate or exaggerated (for example, that people are after them, that they are royalty or a spy, or a specific well-known person), these beliefs are delusions.

Ask whether there is something you can do to make the person feel more comfortable, and explain your intentions before you act. Earning trust in order to help the person is the goal, while at the same time maintaining safety for all. Delusions can be frightening for both the person experiencing them and for those in contact with that person. Maintaining safety for everyone and providing a calm, clear, and persistent message that you want to help the person in need, while at the same time giving that person the time and space to hear and respond to that message, is the best response you can give.

Remember that people experiencing delusions may not trust you enough to be honest about what they experience, especially if past honesty led to an undesirable outcome such as hospitalization, arrest, forced medication and/or "help" they see as decreasing their sense of safety.

Ask questions about what the delusion is all about, particularly any elements that indicate the potential for harming self or others (e.g., "Are you having any thoughts about hurting yourself or others?"). Do not attack delusions or try to argue or convince the person that the thoughts are wrong or not real. Nor should you indicate that you believe in the delusion. Explain instead, "I believe you tell me this is as you see it." Do not smile, laugh, or shake your head when people describe their delusions.

3. Disturbances of mood

Most of us have an immediate and intuitive understanding of the notion of mood. We readily comprehend what it means to feel sad or happy. These concepts are nonetheless very difficult to formulate in a scientifically precise and quantifiable way; the challenge is greater given the cultural differences associated with the expression of mood. In turn, disorders that impact the regulation of mood are relatively difficult to define and to approach in a quantitative manner. Nevertheless, dysregulation of mood and the expression of mood, or affect, represent a major category of mental disorders.

Disturbances of mood typically manifest themselves as a sustained feeling of sadness or sustained elevation of mood. As with anxiety and psychosis, disturbances of mood may occur in a variety of patterns that associate with different mental disorders. The disorder most closely associated with persistent sadness is **major depression**, while that associated with sustained elevation or fluctuation of mood is **bipolar disorder**. Along with the prevailing feelings of sadness or elation, disorders of mood associate with a host of related symptoms that include disturbances in appetite, sleep patterns, energy level, concentration, and memory over a sustained period.

Symptoms often associated with depression:

- Persistent sadness or despair
- Insomnia (sometimes hypersomnia)
- Decreased or increased appetite
- Psychomotor agitation or retardation
- Anhedonia (inability to experience pleasure)
- Irritability
- Apathy, poor motivation, social withdrawal
- Hopelessness
- Poor self-esteem, feelings of helplessness
- Suicidal ideation

Symptoms often associated with mania:

- Persistently elevated or euphoric mood
- Grandiosity (inappropriately high self-esteem)
- Psychomotor agitation
- Decreased sleep
- Racing thoughts and distractibility
- Poor judgment and impaired impulse control
- Rapid or pressured speech

We do not know why diverse functions such as sleep and appetite alter in disorders of mood. However, depression and mania typically associate with characteristic changes in these basic functions. Mood disorders appear to represent a complex group of behaviors and responses that undergo precise and tightly controlled regulation. Higher organisms that must adapt to changing environments depend on optimal control of basic functions such as sleep, appetite, sex, and physical

activity. This regulation must adapt to daily and seasonal changes in the environment. In addition, behaviors that are more complex undergo a similar, perhaps closely-linked, regulation. Such behaviors include exploration, aggression, and social interaction.

In humans, we believe that these complex behaviors and their regulation associate with the expression of mood. A depressed mood appears to reflect a kind of global damping of these functions, while a manic state may result from an excessive activation of these same functions. Although we continue to learn more about the mechanisms underlying the diverse changes associated with the mood disorders, their appearance as clusters in specific disorders, along with their collective response to specific therapeutics, suggests a common basis in the central nervous system.

People suffering from mood disorders have increased rates of suicide, and though there is limited research, people experiencing homelessness and depression are at even higher risk for suicide. Because the stakes are so high, we feel that it is important that service providers recognize the signs of suicide risk and are ready to intervene appropriately. The following pages provide some tools for assessing and responding to suicide risk.

Suicide

Suicide is a major, preventable public health problem. According to the Centers for Disease Control 2008 Suicide Fact Sheet, suicide is the eleventh leading cause of death in the U.S.

Although there is little research related specifically to suicide and homelessness, we know that many of the key risk factors for suicide are pervasive in the homeless population. For example, according to the National Institute of Mental Health (NIMH), *Suicide in the U.S.: Statistics and Prevention* (revised 2006), research shows that major risk factors include:

- Depression and other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders); more than 90% of people who die by suicide have these risk factors
- Stressful life events, in combination with other risk factors, such as depression
- Family violence, including physical or sexual abuse

It is important for care providers to assess for suicide risk routinely, whether or not someone expresses suicidal ideation. Asking about suicide will not prompt individuals to hurt themselves. In fact, it will likely allay anxiety and give them an opportunity to talk about their concerns. Ask for specific, detailed information in response to your questions. Get consultation when you have any concerns about someone's suicide potential.

Sometimes people will make statements that raise a "red flag" for the listener. For example, "I'm about at the end of my rope"; or "I just don't know if I can go on anymore." Explore the meaning of these statements with the individual. Recognize that most people who express suicidal ideation are ambivalent; they do not want to die but cannot see any viable alternatives.

If you think someone is imminently suicidal, do not leave him or her alone. Get the person help immediately from his or her doctor, the nearest hospital emergency room, or call 911. Eliminate access to weapons or other potential tools for suicide, including unsupervised access to medications.

Assessing suicide risk

The tool below provides a useful acronym to remember specific things to look for and ask about when assessing for suicide risk. First, let the person know that you have concern about his or her safety and well-being. Explain that you want to understand what the person feels, thinks, and experiences. Ask the individual to be as truthful and specific as possible, particularly about whether she or he has a suicide plan, its lethality, and whether the person has the means to carry out the plan.

P.L.A.I.D. P.A.L.S.

Things to watch for when assessing potential suicide risk...

Plan—Do they have one?

Lethality—Is it lethal? Can they die?

Availability—Do they have the means to carry it out?

Illness—Do they have a mental or physical illness?

Depression—Chronic or specific incident(s)?

Previous attempts—How many? How recent?

Alone—Are they alone? Do they have a support system? A partner? Are they alone right now?

Loss—Have they suffered a loss (death, job, relationship, self-esteem)?

Substance abuse (or use)—Drugs, alcohol, medicine? Current, chronic?

San Francisco Suicide Prevention: http://www.sfsuicide.org/

Signs of Depression and Possible Suicide Risk

Talking about dying—any mention of dying, disappearing, jumping, shooting oneself, or other types of self-harm

Recent loss—through death, divorce, separation, broken relationship, loss of job, money, status, self-confidence, self-esteem, loss of religious faith, loss of interest in friends, sex, hobbies, activities previously enjoyed

Change in personality—sad, withdrawn, irritable, anxious, tired, indecisive, apathetic

Change in behavior—cannot concentrate on routine tasks, school, work

Change in sleep patterns—insomnia, often with early waking or oversleeping, nightmares

Change in eating habits—loss of appetite and weight, or overeating

Diminished sexual interest—impotence, menstrual abnormalities (often missed periods)

Fear of losing control—going crazy, harming self or others

Low self-esteem—feeling worthless, shame, overwhelming guilt, self-hatred, "everyone would be better off without me"

No hope for the future—believing things will never get better; that nothing will ever change

REMEMBER: The risk of suicide may be greatest as the depression lifts. Many suicides occur several months after improvement, when a person has energy to act on suicidal thoughts.

Adapted from San Francisco Suicide Prevention: http://www.sfsuicide.org/.

Suicide Myths and Facts

Myth: Suicidal people are fully intent on dying. Nothing others do or say can help.

Fact: Suicide is preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems.

Myth: Suicide happens without warning.

Fact: There are almost always warning signs, but others are often unaware of the significance of the warnings or unsure about what to do.

Myth: People who talk about suicide do not commit suicide.

Fact: Most people who commit suicide talked about or gave definite warning signs of their suicidal intentions.

Myth: Improvement in a suicidal person means the danger is over.

Fact: Many suicides occur several months after the beginning of improvement, when a person has energy to act on suicidal thoughts.

Myth: Suicide is more common in lower socioeconomic groups.

Fact: Suicide cuts across social and economic boundaries.

Myth: All suicidal individuals are depressed.

Fact: Depression often accompanies suicidal feelings but not all persons who attempt or commit suicide are depressed. There may be involvement of other emotional factors.

Myth: Young people are more likely than old people to commit suicide.

Fact: People 65 and older kill themselves at a higher rate than those aged 15–24.

Myth: Asking, "Are you thinking about committing suicide?" may trigger a person to make a suicide attempt.

Fact: Asking direct, caring questions about suicide will often minimize a person's anxiety and act as a deterrent to suicidal behavior.

4. Disturbances of cognition

Cognitive function refers to the general ability to organize, process, and recall information. Cognitive tasks subdivide into a large number of more specific functions, depending on the nature of the information remembered and the circumstances of its recall. In addition, many functions commonly associate with cognition such as the ability to execute complex sequences of tasks.

Disturbances of cognitive function may occur in a variety of disorders. **Dementia** is the progressive deterioration of cognitive function. A number of specific conditions may cause it, including Alzheimer's disease. Impairment of cognitive function may also occur in other mental disorders such as depression. It is common to find profound disturbances of cognition in patients suffering from severe mood disturbances. More recently, there are reports of cognitive deficits in schizophrenia, which is now a major new topic of research. Lastly, cognitive impairment frequently occurs in a host of chemical, metabolic, and infectious diseases that affect brain functioning.

The manifestations of cognitive impairment can vary across an extremely wide range, depending on severity. Short-term memory is one of the earliest affected functions and, as severity increases, retrieval of more remote memories becomes more difficult. The impairment of attention, concentration, and higher intellectual functions can occur as the underlying disease progresses. Language difficulties range from mild word-finding problems to complete inability to comprehend or use language. Functional impairments associated with cognitive deficits can markedly interfere with the ability to perform activities of daily living such as dressing and bathing.

Additionally, people who have long periods of untreated mental illness often have problems completing tasks that might otherwise be straightforward: filling out a form; keeping an appointment; remembering to take medication.

5. Other symptoms

Anxiety, psychosis, mood disturbances, and cognitive impairments are among the most common and disabling manifestations of mental disorders. It is important, however, to appreciate that mental disorders frequently leave no aspect of human experience untouched. Other common manifestations include, for example, other physical symptoms and impaired impulse control.

Adapted from:

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