May 2008

ESPP-HK News

老人精神科速治服務快訊

編者的話

歡迎閱覽新的老人精神科速治服務 (ESPP; Elderly Suicide Prevention Service) 快訊!

五月十二日下午，一場史上罕見的強烈地震，有如晴天霹靂，忽然降臨四川，瞬間便奪去了數以萬計的生命。大地震亦同時摧毀了無數的房屋、公路、水管、電纜，令數以百萬計的老百姓痛失親人之餘，更要面對無處棲身、斷水、斷電、斷通訊更兼餘震不止的絕境。哀鴻遍野，慘絕人寰，令人目不忍視，耳不忍聞。

然而有道：「時窮節乃見」，越是深重的苦難，越能彰顯人性高貴光輝的一面。在這場大災難裡，我們看見不顧個人安危，搶先救人的英雄；看見犧牲自己，保護孩子的母親和老師；更看見無數出錢出力，幫助災民的普通人。人類互相關愛，相濡以沫的精神，在這歷史時刻顯露無遺。

地震是一場大悲劇，但也是一個啓示。在一個重複出現的電視畫面裡，溫家寶總理對地震倖存的孩子們說：「既然活下來，就要好好的活下去。」不錯，不論人生有多少不如意、多少痛苦，既然活下來，就要好好活下去！這也是我們要帶給那些抑鬱絕望，感到生無可戀的長者的信息。

在今期的快訊裡，我們作了另一項新的嘗試，就是透過互聯網，訪問了遠在英國牛津大學的 Professor Robin Jacoby。 Professor Jacoby 是國際知名的老人精神科專家，他與 Dr Catherine Oppenheimer 編撰的 Psychiatry in the Elderly，是老人精神科的經典之作。Professor Jacoby 與 Professor Keith Hawton 合作，對老人自殺問題作了系統的研究，是這方面公認的權威。由於這是初次嘗試，訪問比較簡短，但 Professor Jacoby 意簡言亥，評論一矢中的，值得細味。

快訊的問答環節解答了一些有關治理照顧抑鬱長者常遇到的問題。另外，東區尤德夫人拿打素醫院的老人精神科專科護士呂少鋒先生也撰文介紹了香港東聯網的老人精神科速治服務的概況。文中提到本港每 29.8 小時即有一名長者自殺死亡，發人深省。呂君也是我們編委會的中堅份子。

本刊的園地公開，我們歡迎您的問題和意見，更歡迎您投稿！我們的電子郵箱是 espphk@yahoo.com.hk

—編者

目錄:

醫院管理局 HOSPITAL AUTHORITY

An Electronic Interview with

Prof Robin Jacoby

In this issue we have the pleasure to expand the scope of this newsletter and introduce the first piece of our series of online interviews with experts and opinion leaders in the field of Psychogeriatrics. They would share with us their thoughts on suicidology in later life. It is our honour to have Prof Robin Jacoby of the Oxford University with us this time.

Dear Prof Jacoby,

As editors of an electronic publication for the elderly suicide prevention programme in Hong Kong, we are keen to interview some experts in this field so that local workers can understand more about this topic. Being such a prominent old age psychiatrist and expert on elderly suicide, your name obviously came to our minds. We are so excited when we received your favorable reply to our request. Could we first know – how are you recently?

I am officially retired now but I still come into work every day. It's difficult to give up the habits of a life-time. I am not doing as much cycling as I should, but they are going to install a secure bike shed at work, so that I shall be able to have my bicycle here for running around town. I'd be very happy to do the e-interview, so please fire away.

The Warneford Hospital,
Oxford



Let us begin with this question - in your opinion, can elderly suicide rate be effectively reduced at all?

The suicide rate can certainly be reduced but how much and for how long are the crucial questions. Some of the most effective measures are social ones that reduce access to means, for example making poisons more difficult to acquire. But determined people will always find a way. There are other social factors which cannot be altered - one could not, for instance, demolish all the high-rise buildings in Hong Kong!

As psychiatrists, I think we have two duties and one thing of which we need to remind ourselves. As to the duties, our first is to do everything we can to prevent and treat the mental illnesses that are the root causes of most suicides, notably depression. I warmly applaud what you are doing with your outreach service in Hong Kong. The second duty is to bring to the attention of government those factors over which they have control and which might reduce suicide rates. In the UK an example of this has been the restriction in sale of lethal analgesics to small quantities only. Our efforts need, of course, to be backed up by research so that measures already in use are subject to an audit of their effectiveness, and new measures are started only on the basis of evidence. It goes without saying that an effective means of prevention will be no good if it lasts only the life of a research project. Efforts need to be continuous.

The thing of which we need to remind ourselves is that we are not omnipotent (in any sphere of psychiatry) and that we alone cannot bring down the suicide rate or be responsible for doing so. We have an important role to play, but we also have to understand that people have been committing suicide since time immemorial and psychiatry cannot eradicate the practice.

We entirely agree with you that research and auditing should be an integral part of any intervention we put into use.

Some publications state that voluntary agencies play an important role in suicide prevention. In your opinion, what are the obstacles one has to overcome in order to bring about better cooperative effort across the different sectors and tiers of care?



I agree that voluntary agencies, such as the Samaritans and other volunteer telephone helplines, can play an important role in suicide prevention. As to cooperative effort, I think it's a question of local leadership. This does not have to be medical necessarily, but it may be. The crucial thing is for a leader or a leadership group to emerge and coordinate all the efforts for suicide prevention within a locality. For example, voluntary organisations need to be able to facilitate quick access to psychiatric care in crisis cases. Looking at it the other way round, the implementation of new research-proven preventative measures depends on free communication and confidence between the professionals and the voluntary sector. Although we all attend so many of them these days, I think this means regular meetings between all sectors involved in suicide prevention. If there is an identified leadership, it will become known to the authorities and can press for whatever government initiatives are needed. In summary, unity is the name of the game.

Agree entirely with you the importance of networking. In fact, one of the components of the ESPP programme is the setting up of a Central Steering Committee and a number of Local Steering Committee. These committees consist of major players in the health and welfare sector covering the entire territory and catchment areas of individual ESPP teams. Although we still experience problem with cooperation, these committees must have helped to reduce such problem.

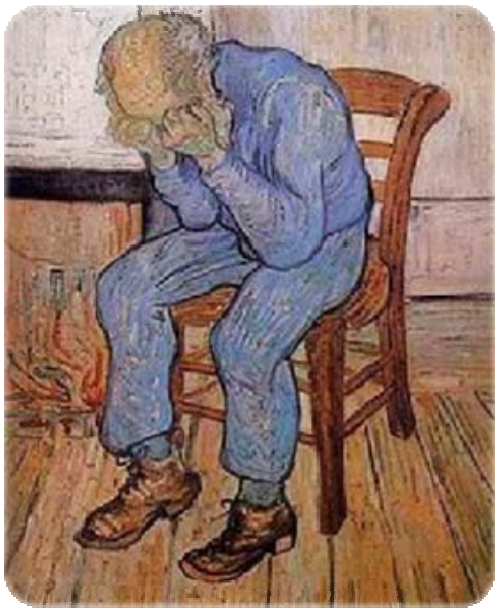
We read with interest the article by your group titled" Suicide in Older People Without Psychiatric Disorder" in International Journal of Geriatric Psychiatry 21(4):363-7, 2006. It is also a rather consistent finding in various psychological autopsy studies that 10-30% of suicide decedents do not have 'diagnosable' mental disorder. A significant portion of them has terminal illness/ untreatable physical symptoms. Do you think mainstream psychiatry would move from an absolutist stance and start to recognize 'rational suicides' in the near future (with due considerations on the criteria and the medical-legal implications)?

I think "rational suicide" does exist insofar as there are people who kill themselves who clearly have no mental illness. In this regard, therefore, it would be wrong for psychiatrists to say that all suicides are their concern.



However, I think it is equally wrong for psychiatrists not to be extremely careful in assessing cases before writing them off as "rational". Our work suggests that some people may have symptoms of depression without reaching the level of 'caseness'. Also, potential suicide decedents often deny mental symptoms in favour of physical ones.

If a psychiatrist is in a position to help someone who appears to be about to commit "rational suicide", I think every effort should be made to dissuade them. For example, some of the most damaged people I have seen are the relatives of people who have committed suicide. In other words, suicide is an aggressive act that can cause lasting harm to close family members who experience enormous guilt, sometimes for the rest of their lives.



That brings up an interesting ethical issue and a clinical dilemma. If a person presenting after a suicidal attempt, has depressive symptoms not reaching clinical' caseness', has clearly understandable reason for such an act (e.g. a chronic, incurable illness incurring significant suffering), has significant risk for further suicidal act (no regret, still determined to 'end his suffering', and actively planning for another go), but refuses to be admitted for in-patient treatment. In your opinion, should he (she) be admitted compulsorily for safe care and treatment? Or should one respect this person's free will and offer only whatever he would accept?

If, after a full assessment, I judge that the person is not suffering from a mental illness, I would not take any action to admit them compulsorily.

Having said that however, I might well seek a second opinion before "releasing" the patient. One thing I would certainly do is write very good and full clinical notes explaining my decision.



Among our readers are a number of keen researchers in suicidology. What is your view would be the main issues for research development in the coming decade?

This question will conclude our interview. With best regards,

I think that the main challenge is to identify risk factors for suicide that can be modified by social measures to reduce the suicide rate; and which will be seen by governments as presenting cost-effective ways by which their intervention could reduce the suicide rate.

Best wishes,

Robin

Prof Robin Jacoby
University of Oxford
Department of Psychiatry
The Warneford Hospital
Oxford
United Kingdom

Interviewers:

Dr PAN, Pey-chyou
Department of Psychiatry, United Christian Hospital, Hong Kong

Dr Joshua TSOH
Department of Psychiatry, Prince of Wales Hospital, Hong Kong

The Late Mr SK CHUI
University Psychiatric Department, Queen Mary Hospital, Hong Kong



速治服務介紹-港島東聯網

HONG KONG EAST CLUSTER 港島東醫院聯網

呂少鋒-老人精神科專科護士
東區尤德夫人那打素醫院

回想起加入「老人精神科速治服務」團隊幾近五個年頭；還記得以前時有聽聞長者厭世尋死的新聞。當時並未完全了解爲何活到一把年紀仍然「看不開」呢？爲甚麼許多艱難辛苦的日子可以涯過（如 SARS 及 97 金融風暴），但到老來卻選擇自己結束生命呢？到現時接觸的個案不斷增加，才漸漸明白到許多長者，面對許多非筆墨形容的挑戰，這些問題往往在晚年時候不停湧現，如年老體弱多病，經濟拮据，老伴甚至親人身故等；情緒困擾加上精神抑鬱的折磨， 令他們產生負面的觀念，在孤獨無助的感覺下選擇放棄自己。

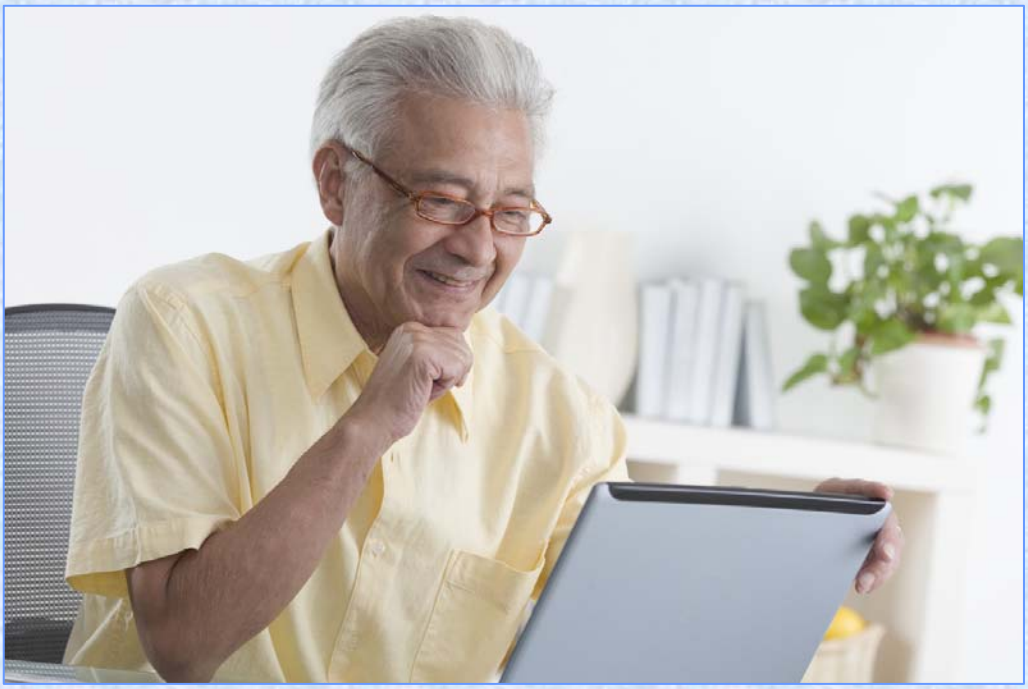
隨著香港老人人口不斷增加，老人自殺個案亦緊隨不下。 根據死因裁判處數字顯示，1995 年六十歲以上組別的自殺率，佔總自殺死亡人數的 31%，而 2005 年的百份比仍然有 30.4%。組別的人數則由 1995 年的 275 人，升至 2005 年的 294 人，這個數字顯示平均每 29.8 小時便一名長者自殺死亡。 正因應這個問題嚴重， 醫院管理局於二零零二年開展「老人精神科速治服務」計劃， 而東區尤德夫人那打素醫院老人精神科亦加入成爲提供服務的團隊之一。當中的成員包括精神科醫生，社康護士及醫務社工等。服務的區分人口約有 620,000 人。而 65 歲以上人口則約有 74000 人，佔區內人口比率的 12.1%。轉介的途徑，包括本區內社會服務機構，私人診所，聯網內各部門，包括專科門診部，各科病房，日間醫院，社康護理部和醫務社會工作部等。

從接收個案後，會於兩個工作天內提供初步接觸，了解個案背景和承諾接受服務，並於七個工作天內探訪受助者，評估精神狀況和自殺風險，作出即時轉介和跟進。對於情緒困擾和抑鬱病徵的長者，會安排「速治診所」的老人精神科醫生診治。輪候時間約需 1 至 2 星期，比一般精神科專科門診輪候時間大爲縮短，令長者可以盡快得到精神科醫生的診治。除了定期會診和藥物治療外，社康護士亦會提供每月不少於一次家訪及電話跟進。團隊內成員亦會透過每月一次個案分享例會，討論跟進情況和進度，在有需要時亦會於老人精神科團隊會議內，與各部門成員討論，令個案能得到更洽當的支援。

醫院管理局 HOSPITAL AUTHORITY



「病向淺中醫」是預防長者自殺的金科玉律。及早察覺自殺風險個案，提供即時及適切的治療，是減低長者自殺最有效的方法。因此「速治服務」亦會定期舉辦社區教育講座，及到社會服務機構提供訓練，協助前線工作人員辨認潛在問題個案，以便即時作出轉介。雖然面對不斷增加的工作量，但當想起可以令病人從自殺邊緣走出來，生命再次燃起希望；不知不覺動力又再湧現起來。





快訊問與答

問題一：我是一間志願機構的家務助理。在工作中，我間中會遇到一些長者談及自殺的念頭或計劃，我是否***應該迴避***這些話題？

答：有些人會擔心與長者談及自殺會增加他們的自殺念頭及機會，但其實，根據不同的研究及文獻記載，***與長者探討或談及自殺並不會增加他們的自殺危機***。相反，他們這時候可能正處於極度抑鬱情緒，並希望得到別人的協助及輔導。有部份的長者會在談話的過程中，感覺到有人明白他們的痛苦和感受；有人重視和關心他們，因而打消他們的自殺念頭。

問題二：最近我七十多歲的媽媽因爲喪偶和多病被診斷患上抑鬱症，並開始服用抗抑鬱藥。請問她是否需要長期服用此藥，***甚麼時候才可停止服藥？***

答：抗抑鬱藥是一些可調節大腦某些化學傳遞物質的藥物，使病人低落的情緒回復正常。療程的長短因人而異，個別病人會有不同程度的反應，病人一般都需要接受六至十二個月或以上的治療，以控制及防止病情復發。根據一些外國的研究指出，***服用抗抑鬱藥物的時間越長久，病情復發的機會越少***。所以病人需要定期覆診，醫生會按照病情與病人和家人商討，決定應該繼續藥物療程，還是逐步減低份量，以至最後完全停止服藥。

問題三：家人或照顧者***如何幫助***家中患有抑鬱症的長者？

答：家人或照顧者一定要有耐性並常常作出安慰。除了支持及鼓勵患病的長者依從醫生指示服用抗抑鬱藥物外，也應該多陪伴他們，使他們明白和感受你們的***關心***。由於患病者較容易疲倦，所以應在日常生活中給與適當的協助，並逐步鼓勵他們多做運動和擴闊社交圈子。



教學活動

Date	Time	Activity and Topics/Speaker	Location	Target Audience	Telephone Number	Geographic Location of target participants
10.4.08	14:30 to 17:30	Elderly Suicide Prevention Programme *CH Chang (APN)*	AHNH POPD	Nursing Staff	2683 7618	NT (East)
30.4.08	18:30 to 20:30	Management of Elderly Patients with Depression, Suicidal Tendency and Confusion *LUI Siu Fung Nurse Specialist (PG)*	Seminar Room, HAHO	Nursing Staff	2814 0950 The HK Anti-Cancer Society	Members of Course on Integrated Professional Oncology, Palliative & Elderly Care
07.05.08	3.30 to 17:00	Elderly Suicide Workshop *Dr MK Wong (SMO)*	T.K.O.H CNS Office	CNS nurses of T.K.O. area	2727 8494	T.K.O. area
10.5.08	10:30 to 11:30	Management of Emotional Problems *Lina AU L.M. RN(Psy)*	TWGHs Yeung Shing Memorial Long Stay Care Home	Residents of TWGHs Yeung Shing Memorial Long Stay Care Home	2814 2817	HKW
24.06.08	15.30 to 17:00	Elderly Suicide *Tony TANG NO (Psy)*	YFS PGS Office	Front-line Workers of Elderly Nursing Homes	2727 8494	K.E. Cluster
24.7.08	15:00 to 17:00	Elderly Suicide Prevention Programme *Lau Yuk Mui NO (Psy)*	Caritas (Tin Yuet) Elderly Centre	Frontline Worker of District Elderly Community Center	2456 8080	NT (West)

****因座位有限，歡迎所屬區域之機構及人仕參加，請先致電查詢報名方法****

ESPP-HK News

May 2008




編輯委員會

本刊由老人精神科速治服務快訊編輯委員製作。委員會成員來自醫院管理局各聯網屬下的老人／老齡精神科服務：

潘佩璆醫生	九龍東聯網精神科顧問醫生
陳華發醫生	東區尤德夫人那打素醫院精神科顧問醫生
梁佩瑤醫生	新界東聯網精神科高級醫生
左美約醫生	新界東聯網精神科副顧問醫生
劉家獻醫生	葵涌醫院老齡精神科醫生
呂少鋒	東區尤德夫人那打素醫院老人精神科專科護士
阮少良	九龍醫院精神科社康護士
陳達亮	瑪麗醫院老人精神科護士長
彭樹良	青山醫院老人精神科社康護士

本刊預計全年出版三期，爲電子刊物

醫院管理局 HOSPITAL AUTHORITY

我們歡迎讀者以電郵方式提問及賜教。電子郵箱地址爲:

espphk@yahoo.com.hk