Suicide Prevention in Older Adulthood

National Suicide Prevention Month

September 2014

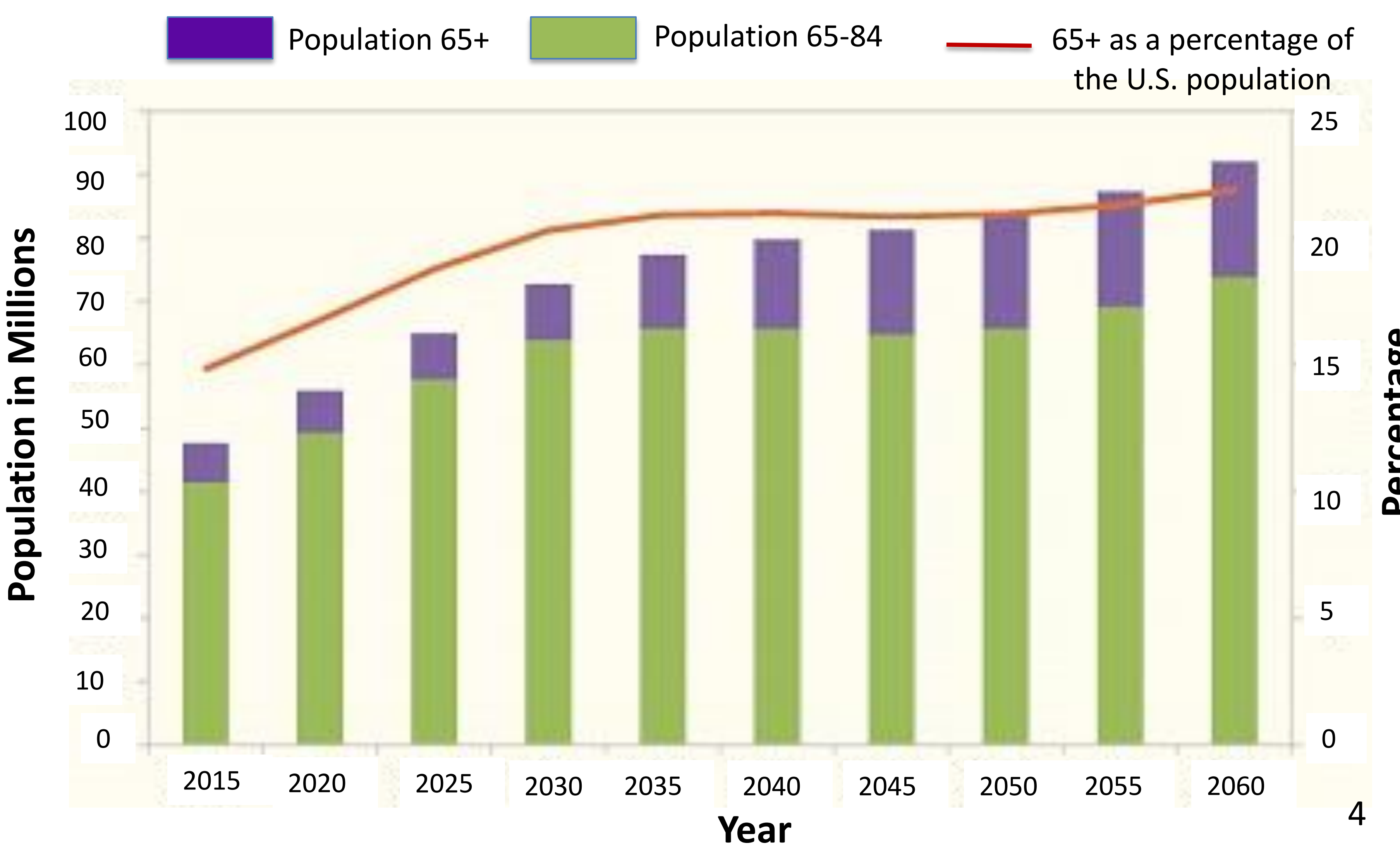
Speakers

- Shannon Skowronski, U.S. Administration for Community Living
- Richard McKeon, U.S. Substance Abuse and Mental Health Services Administration
- Charis Stiles, Institute on Aging
- Mary Quinn & Deborah Helms, Family Services of Merrimack Valley

Suicide in Older Adults
Prevalence, Risk Factors, and Prevention

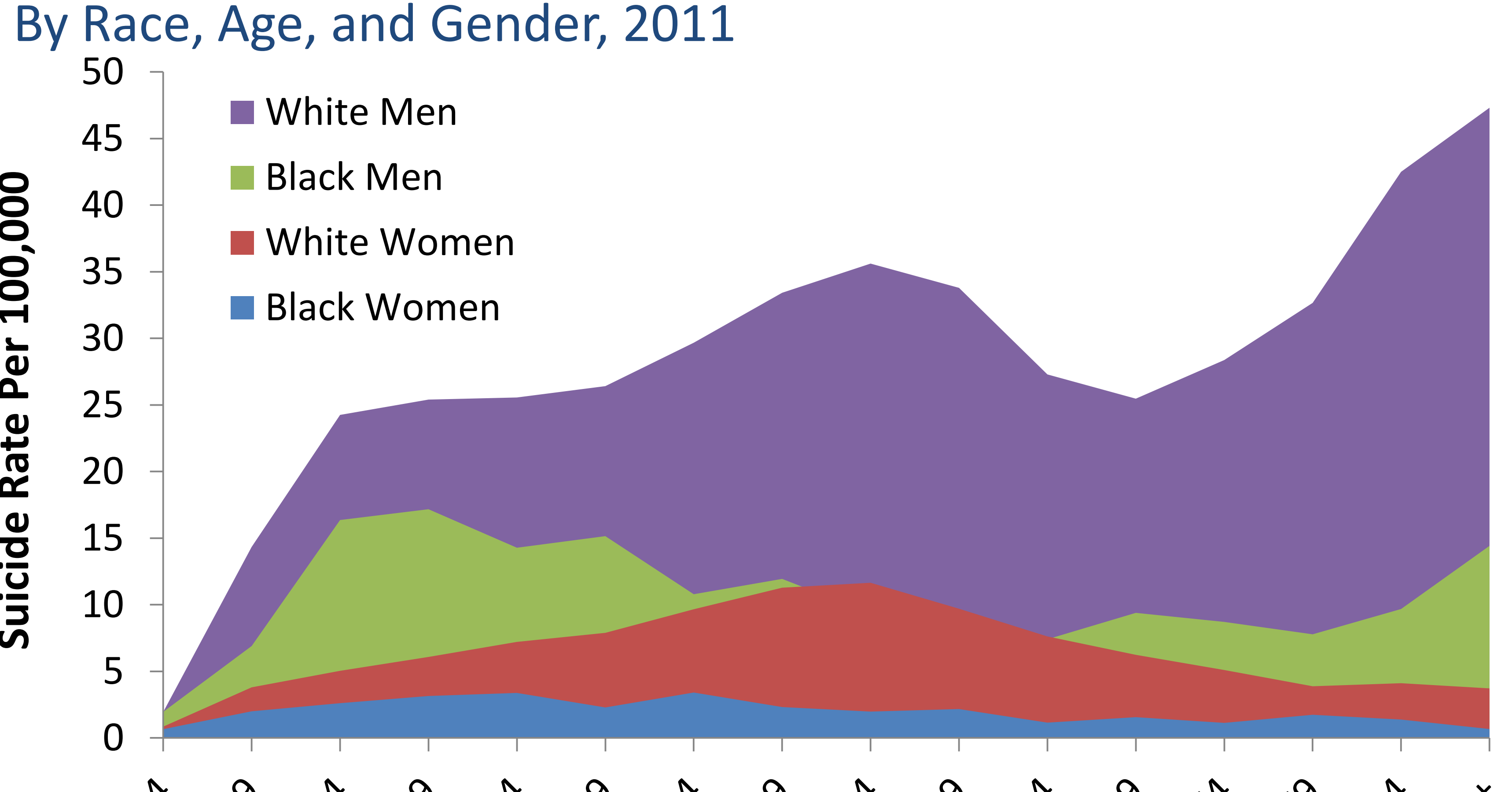
Shannon Skowronski, MPH, MSW
Office of Nutrition and Health Promotion Programs
Administration on Aging
U.S. Administration for Community Living

Population Projection by Age in the U.S.[1]



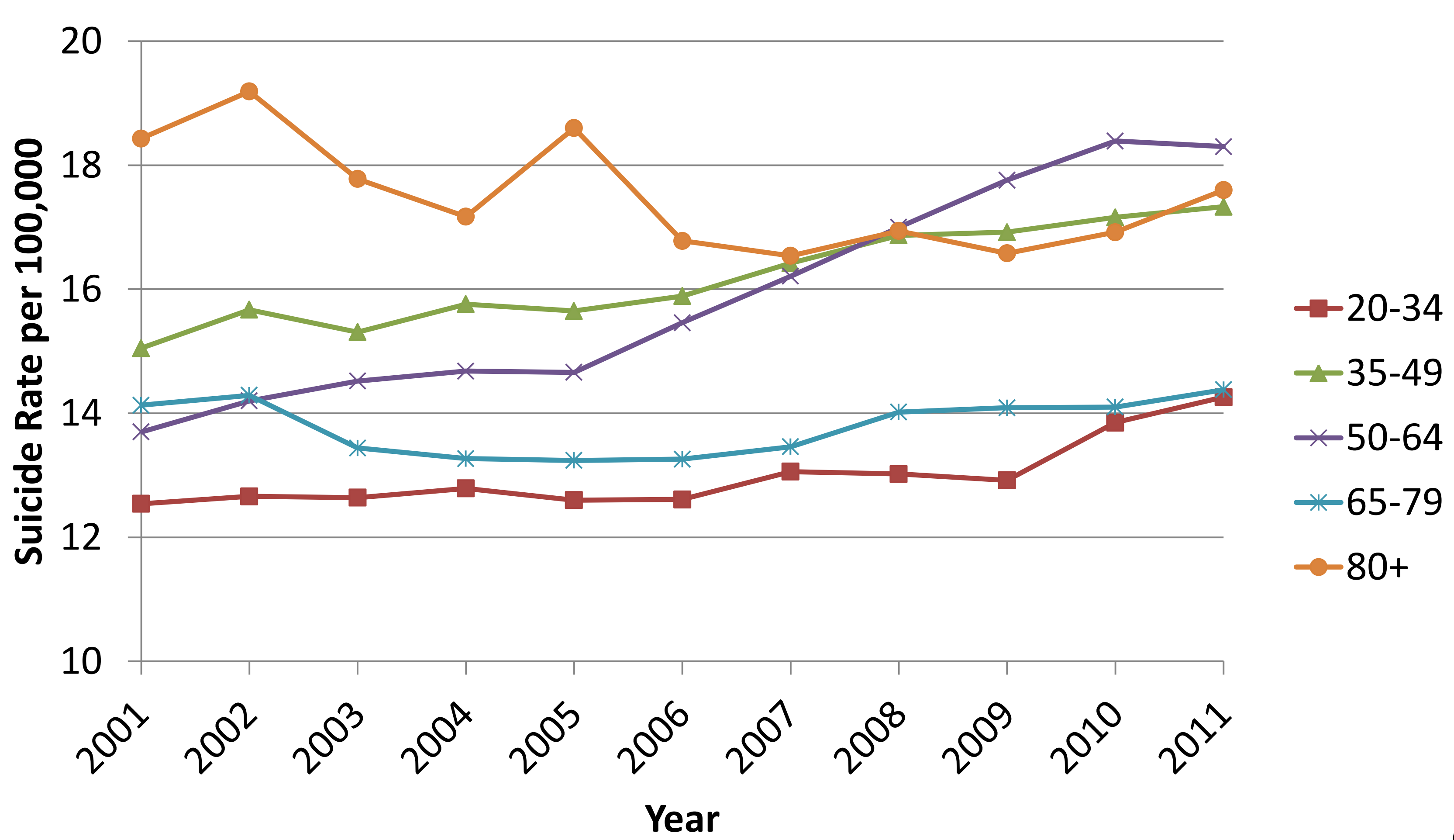
Suicide in the U.S.

By Race, Age, and Gender, 2011



Suicide Rates in the U.S.[3]

By Age, 2001-2011



Late Life Suicide[6]

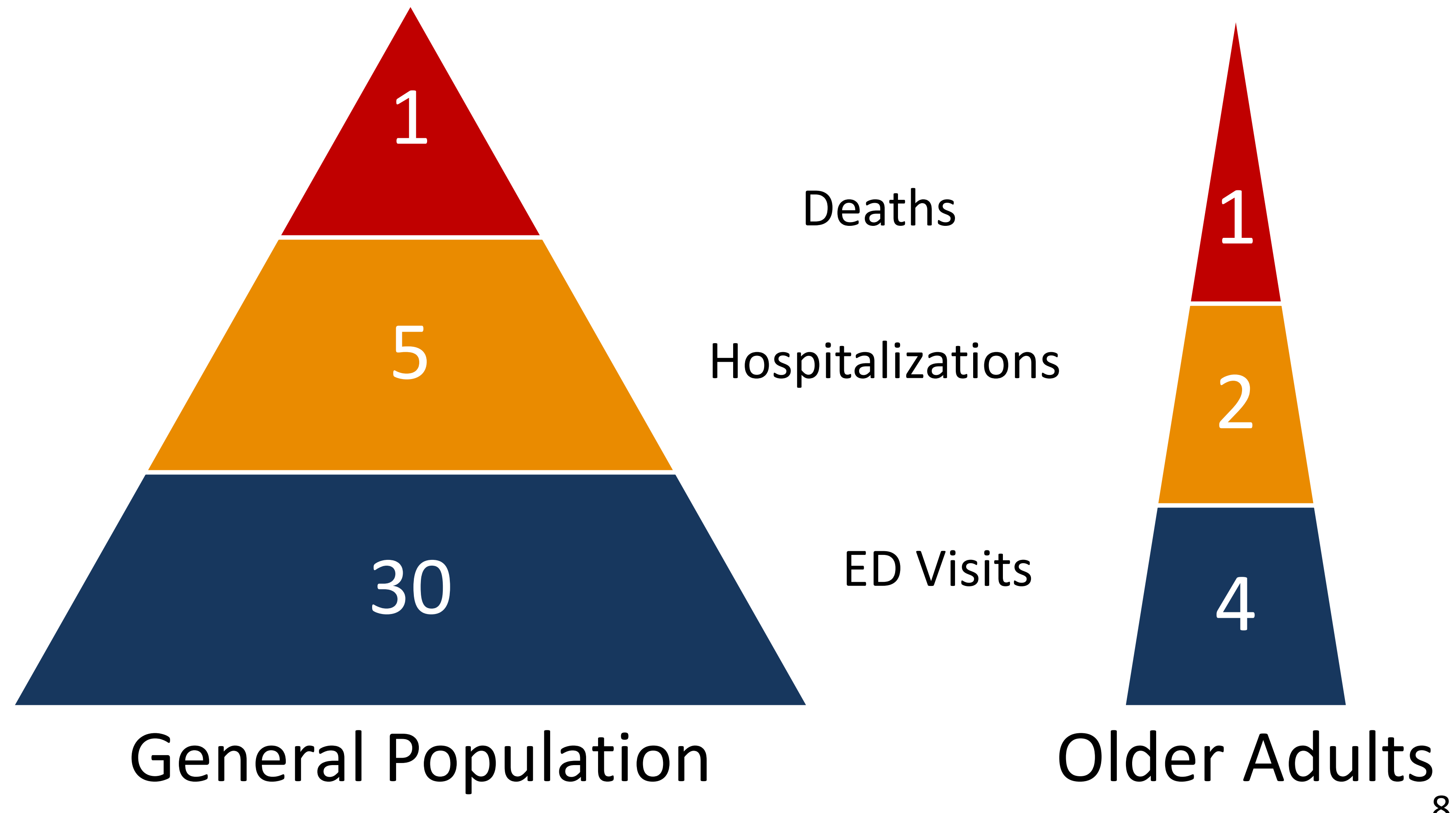
Older people are often:

- More frail
- More isolated
- More planful and determined

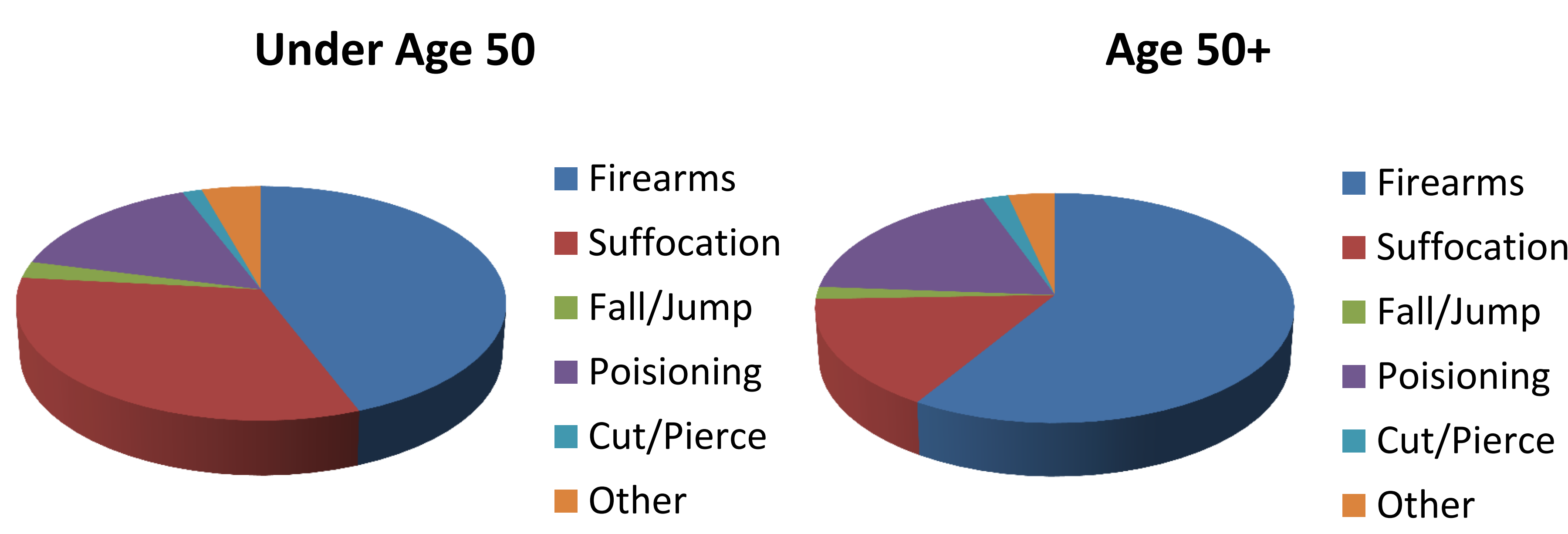
Implying that:

- Interventions must be aggressive
- Prevention efforts are key

Attempted : Completed Suicide[6]



Means[5]



Given what we know about the prevalence and lethality of late life suicide, how can we identify people at risk and what factors can we target?

Five Risk Categories[4]

Psychopathology

Major Psychiatric Illness
Major Anxiety and Substance Abuse Disorders

Personality Traits and Coping Styles

Neuroticism/anxious, rigid coping, obsessive features, not as open to new experience, flat affect

Functioning

Possible neurocognitive deficits and/or age –related neurobiological processes

Physical Health

Cancer, cardiovascular, pulmonary, and gastrointestinal diseases
Chronic pain

Social Context

Isolation, family discord, and bereavement

Risk Categories[4]

Personality and
Coping Style

What can we do to help?

Institute of Medicine – Categories of Prevention[7]

Indicated

Selective

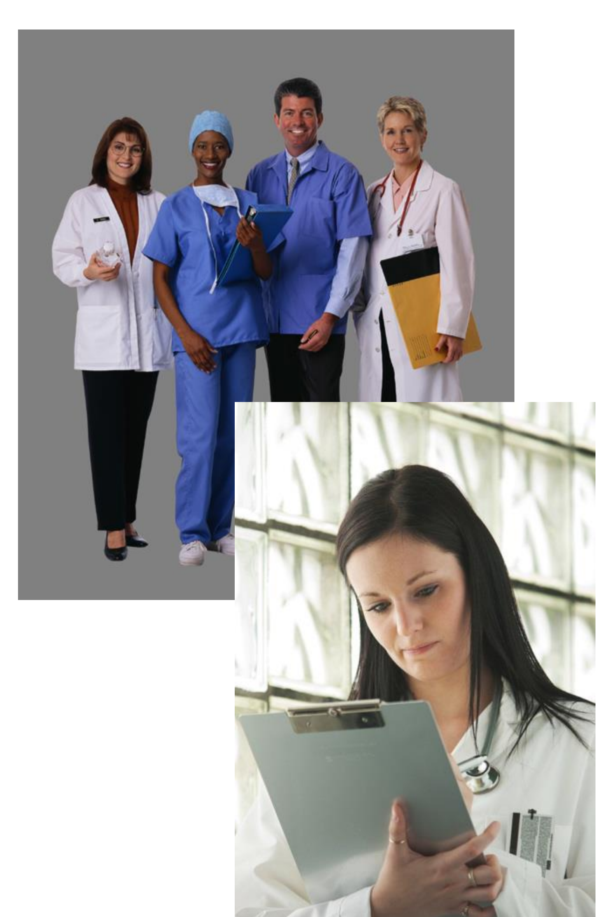
Universal

Indicated Prevention[8]

Target:	Objectives:	Sites to Engage:
Individuals with detectable symptoms and/or other risk factors.	Treat individuals with signs and symptoms to prevent development of condition or suicidal behavior/action.	• Mental Health Care • Primary & Specialty Medical Care • Emergency Services

Indicated Prevention – Examples[8,9]

- Train current and future professionals in detection, intervention, and treatment
- Continuums of care: linking outreach and gatekeeper services to evaluation and health management services
- Implement strategies to provide more accessible, acceptable, and affordable mental health care to elders
- Increase screening/treatment for depression and other behavioral health conditions in primary care
- Offer assertive help after a suicide attempt
- Refer to social and community resources to address needs. Involve and support families/caregivers (if appropriate)



Selective Prevention[8]

Target:	Objectives:	Sites to Engage:
Asymptomatic or pre-symptomatic individuals or groups with distal risk factors for suicide, or who have a higher-than-average risk of developing mental disorders due to the presence of more distal risk factors.	Prevent suicide-related morbidity and mortality through addressing specific characteristics that place older adults at risk	• Rehab or LTC • Pain clinics • Pharmacies • Home Health Care • Community-based social services • Faith communities

Selective Prevention – Examples[8,9, 10, 11]

- Make screening tools available to staff in medical and social service settings
- Provide systematic outreach for assessment and support for older adults, particularly those with one or more risk factors for suicide
- Increase awareness of the losses that are important to people (i.e. retirement, death of loved one, loss of physical function in area important to individual)
- Promote church-based and community programs to contact and support isolated older adults
- Focus medical and social services on reducing disability and enhancing independent functioning
- Increase access to home care and rehabilitation services
- Improve access to pain management and palliative care services
- Identify and treat sleep problems, pain, or other symptoms that decrease quality of life.

Screening for Suicide Risk[6]

1. The goal of suicide risk assessment is not to predict whether or not an older person will die by suicide.
2. The goal is to determine the most appropriate actions to take to keep the older person safe.
3. Action is needed if someone has been identified as at risk for suicide, but those actions depend on their level of risk.

Remember that screening will not prompt someone to attempt suicide or put the idea in their head.

Screening[6]

- Step 1: Initial Screen

  Use validated questions/mood scales (e.g., PHQ-9, Geriatric Depression Scale)

- Step 2 (If positive response to screening)
  - Determine passive vs. active ideation
  - "In the last 2 weeks, have you had any thoughts of hurting or killing yourself?"
  - If yes – active suicidal ideation. Additional screening/assessment are needed (e.g., P4 Screener)

Screening[6]…

Step 3: Based on level of risk, take appropriate action.

Low Risk:

- Express concern
- Get "buy in" to inform primary care physician
- Urge them to remove means
- Consult a supervisor within 48 hours

Moderate Risk:

- All of the above, but consult supervisor that day

High Risk:

- Call supervisor now, with client present (do not leave alone)
- Consider emergency services (i.e., emergency department, mobile crisis unit, and/or 911)

Always make sure you know and follow your agency's policies and procedures.

Universal Prevention[8]

Target:	Objectives:	Sites to Engage:
Entire population, not identified based on individual risk.	Implement broadly directed initiatives to prevent suicide-related morbidity and mortality through reducing risk and enhancing protective factors.	• Media • Legislatures • Policy makers

Universal Prevention – Examples[8,9, 12]

- Educate of the general public, clergy, the media, health care providers, and families on issues related to:
    - Normal aging
    - Ageism and stigma re: mental illness
    - Pain and disability management
    - Depression
    - Substance Abuse/Misuse
    - Risk factors for Suicide

- Limit access to means of suicide

Ideal Approach – Multi-layered

Indicated

Universal

Behavioral Health Screening and Services

- Commercial Insurance
  - Level of coverage varies, but mental health and substance use disorder services, including behavioral health treatment, are one of the 10 essential benefits mandated by the Affordable Care Act
- Medicare:
  - Beginning January 1st, 2014, co-payments for Part B services now same for physical and mental health services for eligible providers
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT) – billable by eligible providers
  - "Welcome to Medicare" and annual "Wellness Visit"
- Medicaid:
  - Largest payer in U.S. for mental health services
  - Covered services vary from state-to-state
- Private foundations or other funders
- Trained volunteers for outreach, friendly visits, telephone check-ins, etc.

Resource Links

Medicare and Your Mental Health Benefits

SBIRT: CMS Brief and Florida BRITE (Business Process Analysis; Initial Training Manual; and Sustainability Manual)

Suicide Prevention Resource Center

Older Adult Suicide Prevention Issue Brief and additional AoA resources

Blog – Robin Williams and Depression

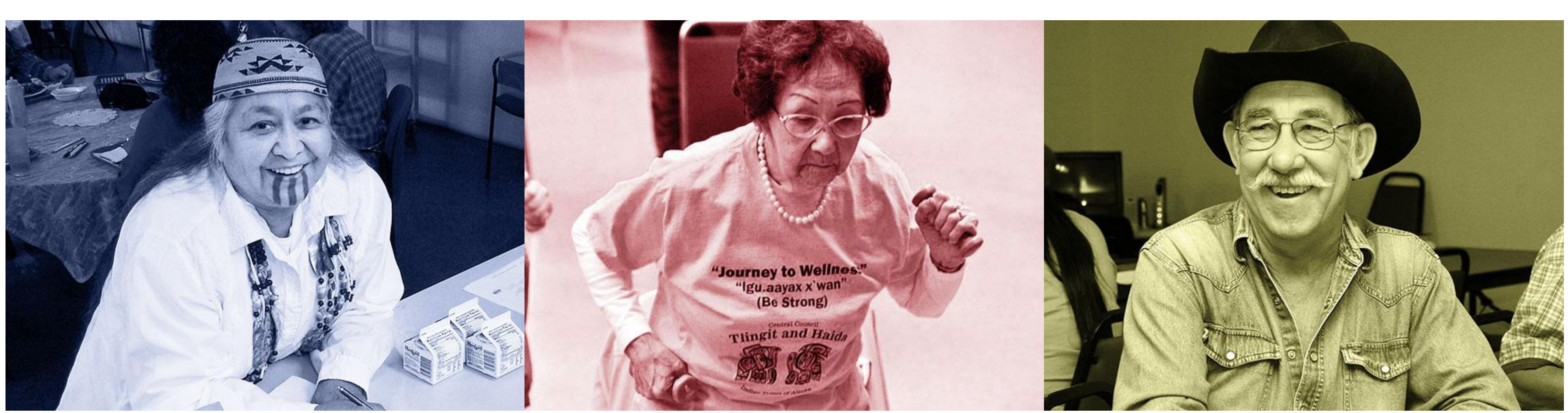
Federally Qualified Health Center Finder

SAMHSA Treatment Finder

Generations – upcoming edition on Older Adult Behavioral Health and Aging (Fall 2014)

For more information:

U.S. Department of Health and Human Services
Administration for Community Living
Washington DC 20201
Phone: (202) 357-0149
Email: shannon.skowronski@acl.gov
Web: http://www.acl.gov/

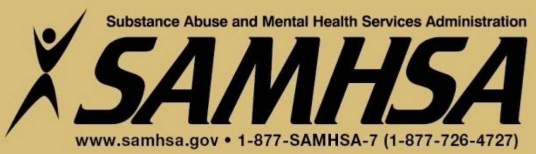


References

1. U.S. Census Bureau (2012). Projections of the Population by Age and Sex for the United States: 2015 to 2060 (NP2012-T12).
2. U.S. Centers for Disease Control and Prevention (2011). Fatal Injury Data: Suicide by Age, Race, and Sex, Accessed September 19th, 2014 from http://www.cdc.gov/injury/wisqars/.
3. U.S. Centers for Disease Control and Prevention (2011). Fatal Injury Data: Suicide by Age – 2001 to 2011. Accessed September 19th, 2014 from http://www.cdc.gov/injury/wisqars/.
4. Conwell, Y. (2014). Suicide in Later Life: Challenges and Priorities for Prevention, *American Journal of Preventative Medicine,* 47(3S2):S244-S250.
5. U.S. Centers for Disease Control and Prevention (2011). Fatal Injury Data: Suicide (select causes). Accessed September 19th, 2014 from http://www.cdc.gov/injury/wisqars/.
6. Van Orden, K. (2013). Suicide in Older Adults: Who is at risk and what can we do about it? , AoA/SAMHSA Older Adult Behavioral Health Technical Assistance Center Webinar
7. Institute of Medicine - Mrazek, PJ. & Haggerty, RJ. (1994). Reducing Risks for Mental Disorders: Fronteirs for Preventative Intervention Research, National Academy Press: *Washington , D.C.*

References continued…

8. Conwell, Y., Van Orden, K., & Caine, ED. (June 2011). Suicide in Older Adults, *Psychiatric Clinical North America,* 34(2):451-468. Accessed September 1st, 2014 at http://www.sciencedirect.com/science/article/pii/S0193953X11000207.
9. Erlangsen et al. (2011). Key Considerations for Preventing Suicide in Older Adults: Consensus Opinions of an Expert Panel, *Crisis,* Vol. 32(2):106-109
10. O'Riley AA. et al (2014). Suicide and death ideation in older adults obtaining aging services, *The American Journal of Geriatric Psychiatry*, American Association for Geriatric Psychiatry, 22(6):614-22.
11. Bernert, RA. et al (2014). Association of Poor Subjective Sleep Quality with Risk for Death by Suicide During a 10-Year Period: A Longitudinal, Population-Based Study of Late Life. *JAMA Psychiatry,* Published online August 13, 2014: doi:10:1001/jamapsychiatry.2014.1126
12. Purcell, M. et al. (August 2012). Family Connectedness Moderates the Association Between Living Alone and Suicide Ideation in a Clinical Sample of Adults 50 Years and Older. *American Journal of Geriatric Psychiatry,* 20:8

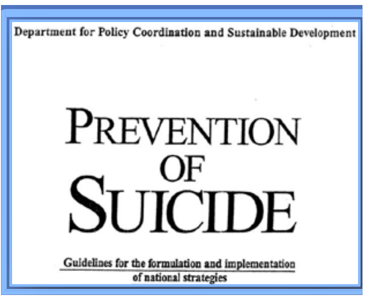


National Initiatives for Suicide Prevention

Richard McKeon Ph.D.

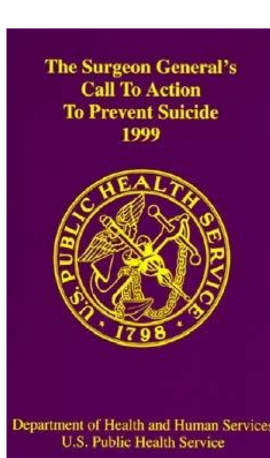
Chief, Suicide Prevention Branch, SAMHSA

Suicide Prevention and Older Adults Webinar
September 29th, 2014

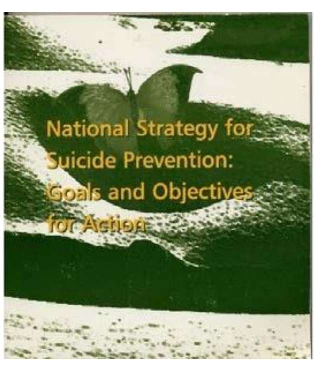

Department for Policy Coordination and Sustainable Development

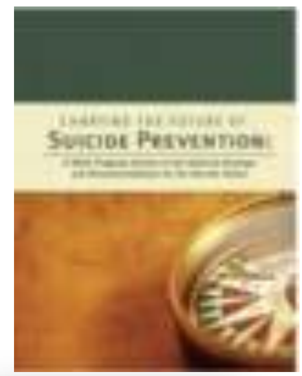
PREVENTION OF SUICIDE

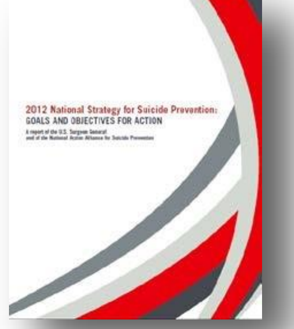
Guidelines for the formulation and implementation of national strategies


The Surgeon General's Call To Action To Prevent Suicide 1999

Department of Health and Human Services
U.S. Public Health Service


National Strategy for Suicide Prevention: Goals and Objectives for Action




2012 National Strategy for Suicide Prevention:
GOALS AND OBJECTIVES FOR ACTION

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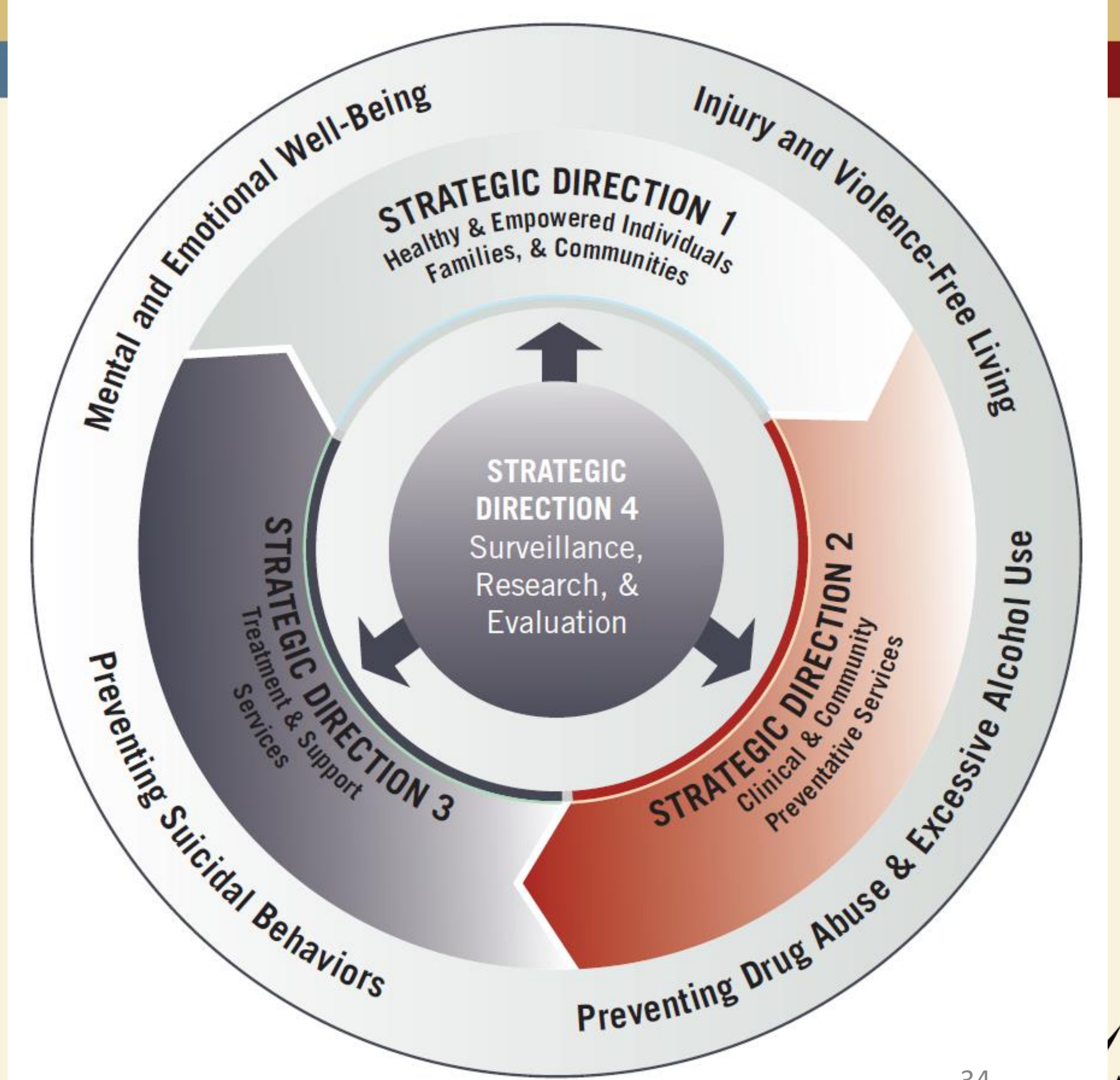
Preventing
suicide
A global imperative
World Health
Organization

2012 National Strategy for Suicide Prevention:
GOALS AND OBJECTIVES FOR ACTION

A report of the U.S. Surgeon General
and of the National Action Alliance for Suicide Prevention

Strategic Directions within the National Strategy for Suicide Prevention



A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov • 1-877-SAMHSA-7

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

- ➔ A public-private partnership established in 2010 to advance the *National Strategy for Suicide Prevention (NSSP)*
- ➔ **Vision:** The National Action Alliance for Suicide Prevention envisions a nation free from the tragic experience of suicide
- ➔ **Mission**: To advance the *NSSP* by:
  - Championing suicide prevention as a national priority
  - Catalyzing efforts to implement high priority objectives of the NSSP
  - Cultivating the resources needed to sustain progress
- ➔ **Founding Leadership:**
  - PUBLIC SECTOR CO-CHAIR, The Honorable John McHugh, Secretary of the Army
  - PRIVATE SECTOR CO-CHAIR, The Honorable Gordon H. Smith, President and CEO, National Association of Broadcasters

National Action Alliance for Suicide Prevention structure

National Action Alliance for Suicide Prevention

Private Co-Chair

Public Co-Chair

SPRC

Executive Secretary

Project Coordinator(s)

EXECUTIVE COMMITTEE

- **Private Sector Members** (senior executives of leading for-profit and non-profit organizations, philanthropic organizations, research and practitioners, and survivors of suicide loss and attempts)
- **Public Sector Members and Ex Officio Members**

Task Force A

Task Force B

Task Force C

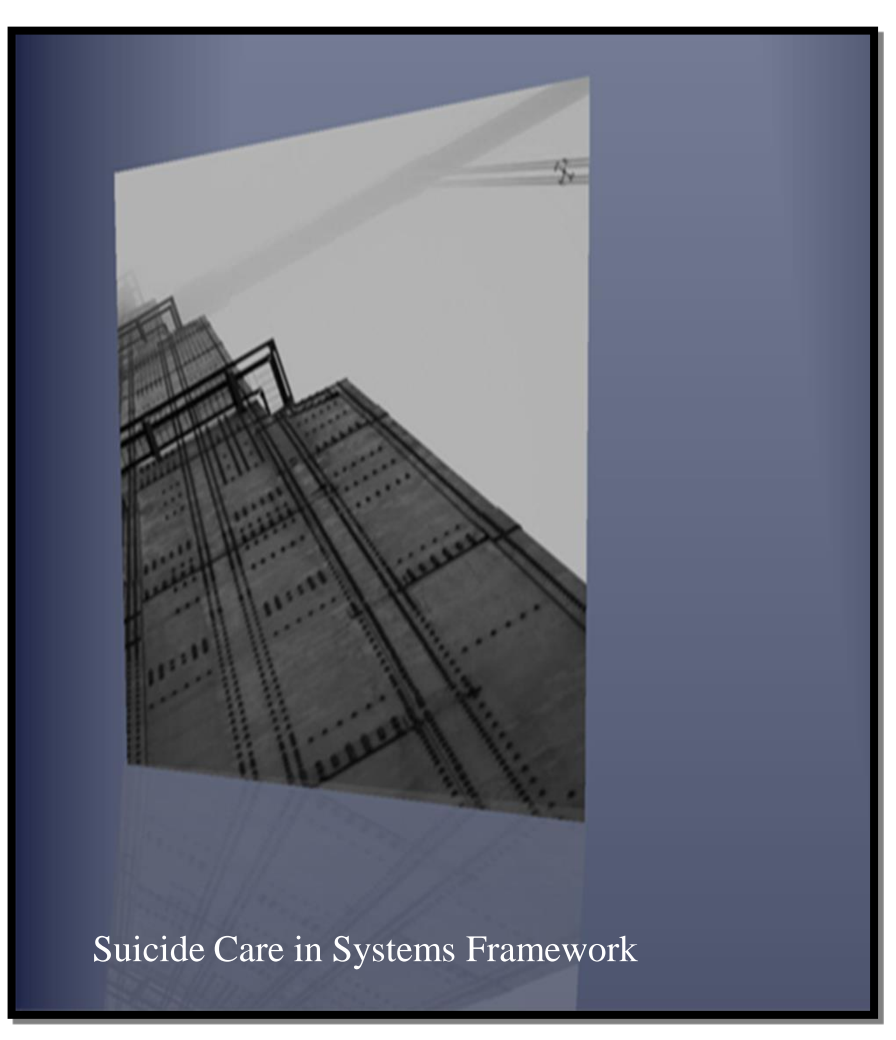
Advisory Groups

National Council for Suicide Prevention

Federal Working Group on Suicide Prevention

Ad Hoc Advisory Groups

Systematic Suicide Care in Healthcare



- Part of the National Strategy for Suicide Prevention http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/
  - GOAL 8: Promote suicide prevention *as a core component of health care services*, to include promoting "zero suicides" (8.1), continuity of care (8.4), coordinating services (8.7), and developing collaboration (8.8).
  - GOAL 9: Promote and implement *effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors*

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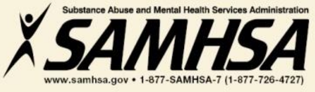
Suicide Prevention as a Core Component of Health Care

- What does it look like?
- The clinical workforce is routinely trained in suicide risk assessment, management, and treatment.
- Accrediting and certifying bodies have standards and guidelines related to suicide prevention.
- Continuity of care during high risk transition times is assured.
- Deaths by suicide and non-fatal suicide attempts are routinely monitored and reviewed to help guide suicide prevention efforts.
- Continuous quality improvement efforts focused on suicide prevention are conducted.
- Evidenced based treatments are available.



Suicidal Thoughts and Behavior in the Past Year among Adults Aged 18 or Older: 2012

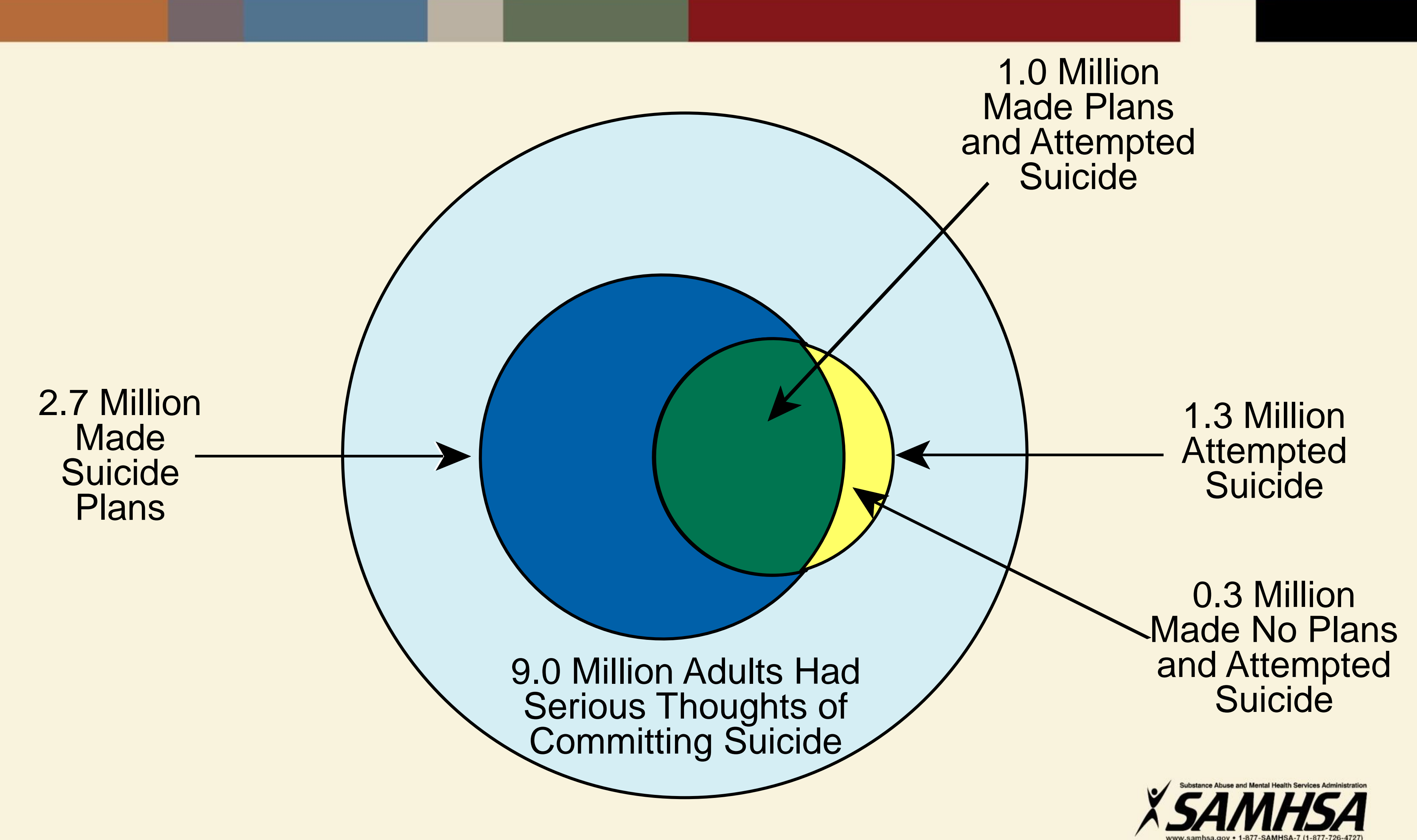
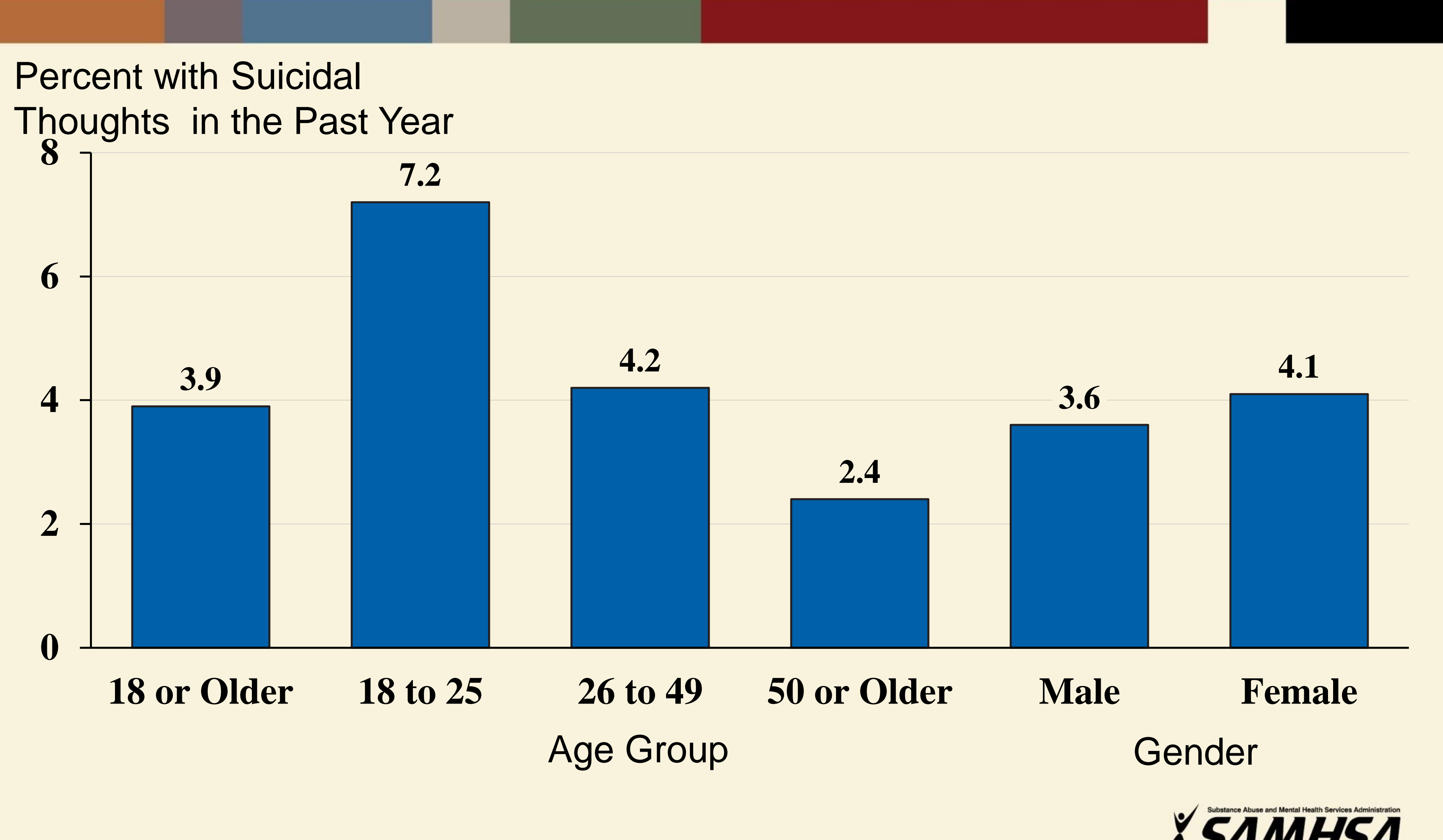


Fig MH 3.1

Suicidal Thoughts in the Past Year among Adults Aged 18 or Older, by Age and Gender: 2012



Substance Abuse and Mental Health Services Administration
SAMHSA
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DAILY DISASTER OF UNPREVENTED AND UNTREATED M/SUDs

Any MI: 45.1 million	SUD: 22.5 million	Diabetes: 25.8 million	Heart Disease: 81.1 million	Hypertension: 74.5 million
37.9 % receiving treatment	**18.3 % receiving treatment**	**84 % receiving treatment**	**74.6 % receiving screenings**	**70.4% receiving treatment**

TOUGH REALITIES

50 percent of those who die by suicide were afflicted with major depression…the suicide rate of people with major depression is 8 x's that of the general population

90 percent of individuals who die by suicide had a mental disorder

TOUGH REALITIES

- **~30+ percent of deaths by suicide involved alcohol use**

Suicide Prevention Requires

- A comprehensive, sustained data driven strategy.
- A comprehensive approach must contain an active, effective community component, as well as an active, effective clinical systems approach.
- Community systems must include workplaces, schools, faith based organizations, justice systems, as well as all health care systems.

Substance Abuse and Mental Health Services Administration
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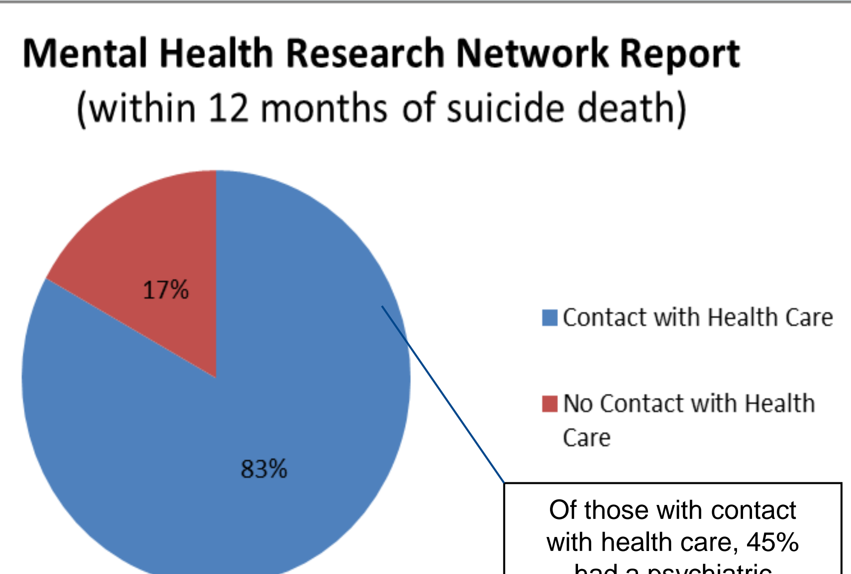
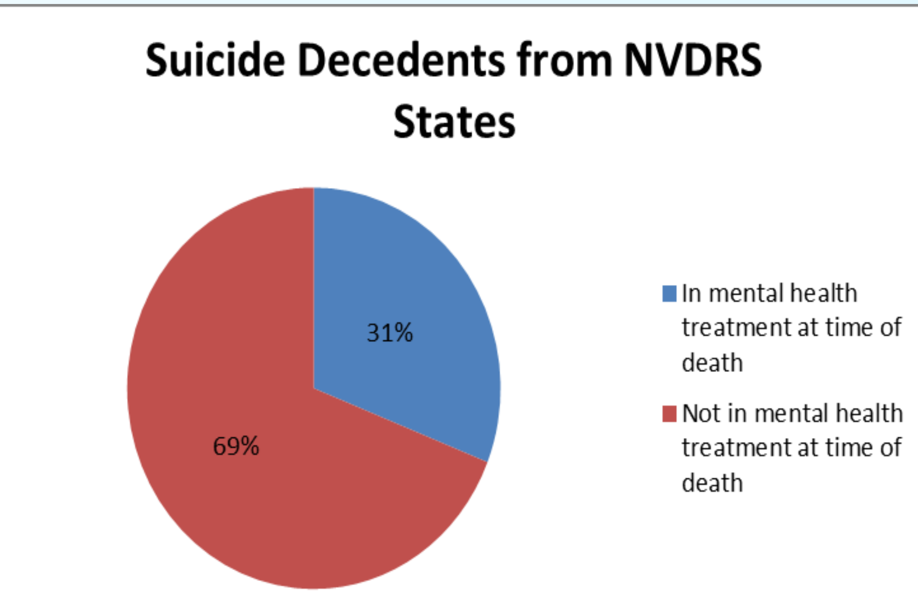
You can't fix what you can't measure….

Perhaps a third of all suicide decedents accessed care prior to death, but few U.S. health care systems track suicide outcomes.



Of those with contact with health care, 45% had a psychiatric diagnoses



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Karch, DL, Logan, J, McDaniel, D, Parks, S, Patel, N, & Centers for Disease Control and Prevention (CDC). (2012). Surveillance for violent deaths—national violent death reporting system, 16 states, 2009. Morbidity and Mortality Weekly Report. Surveillance Summaries (Washington, DC: 2002), 61(6), 1-43.

NIH National Institute of Mental Health

MISSED OPPORTUNITIES = LIVES LOST

77 percent of individuals who die by suicide had visited their primary care doctor within the year

45 percent had visited their primary care doctor within the month

THE QUESTION OF SUICIDE WAS SELDOM RAISED...

Deconstructing Suicide Deaths in the U.S.

✓ = Already Modeled

Data Sources:

1. CDC WISQARS 2010
2. CDC WONDER 2010
3. Bureau of Justice Statistics 2008-2009
4. DoDSER CY 2011 Report
5. Trofimovich et al 2012
6. Department of Veterans Affairs 2012
7. CDC WISQARS 2010 & Owens et al, 2002

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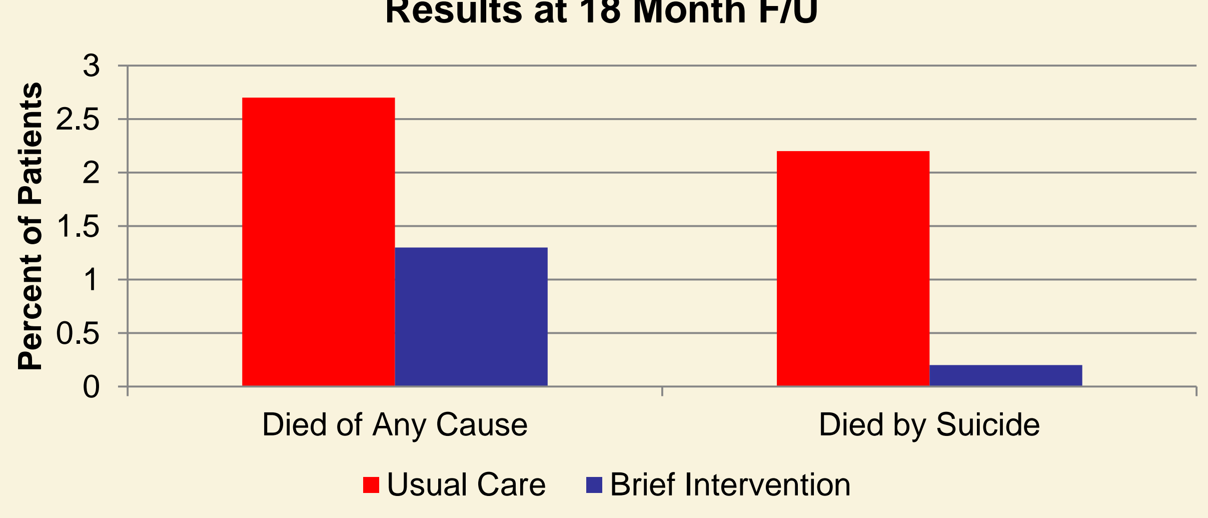
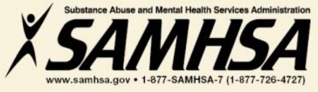
The WHO Multisite Intervention Study on Suicidal Behaviors

- Fleischmann et al (2008)
  - Randomized controlled trial; 1,867 suicide attempt survivors from five countries (all outside US)
  - Brief (1 hour) intervention as close to attempt as possible
  - 9 F/u contacts (phone calls or visits) over 18 months

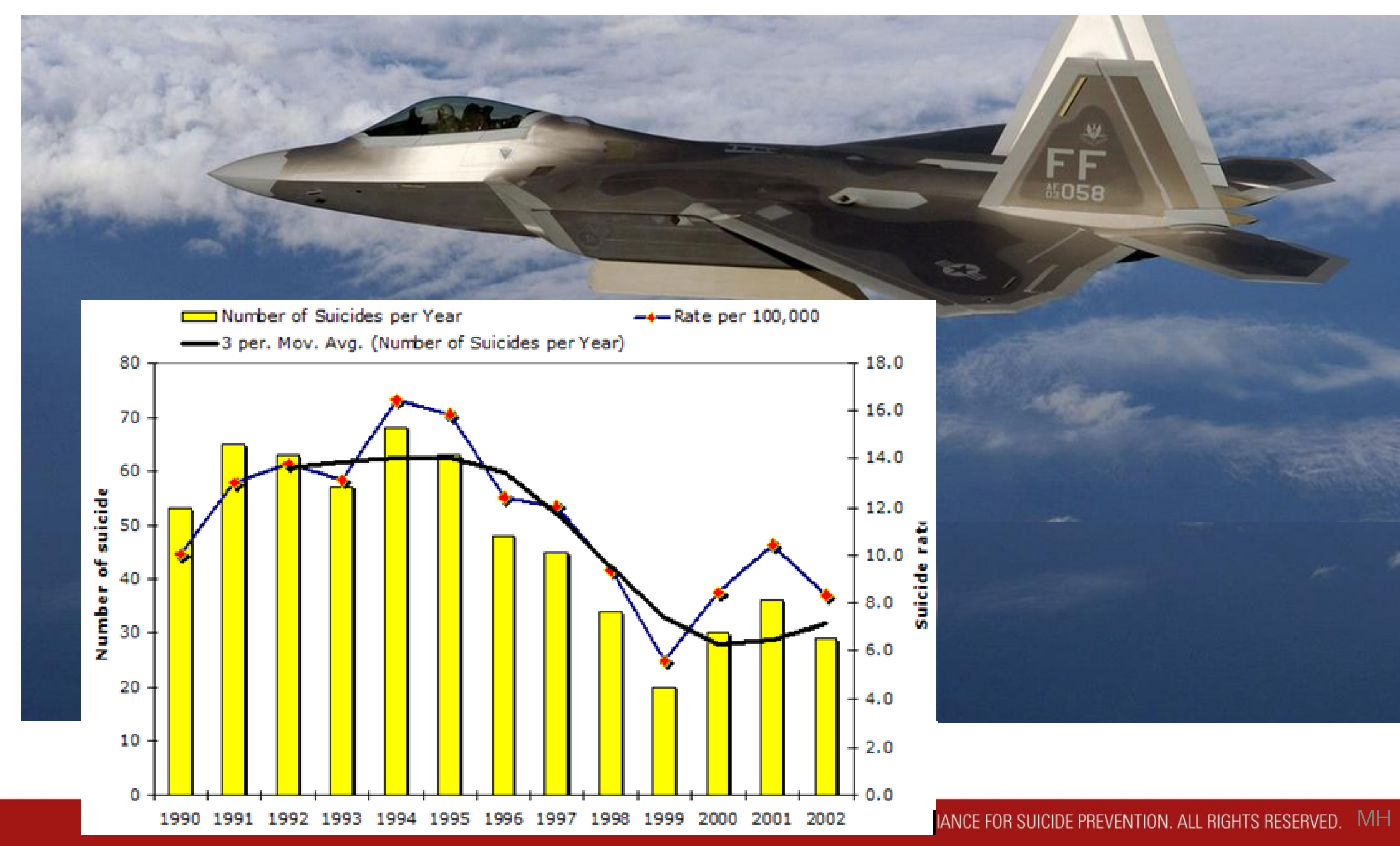


International Efforts

- England—Reduction in suicides in communities that implemented recommendations
- Largest reductions in when 24 hr community crisis care, proactive outreach available
- Follow-up within 7 days of IPU discharge
- Taiwan—Follow-up after suicide attempts led to 63% reduction in suicides.



The Air Force Reduced Suicide



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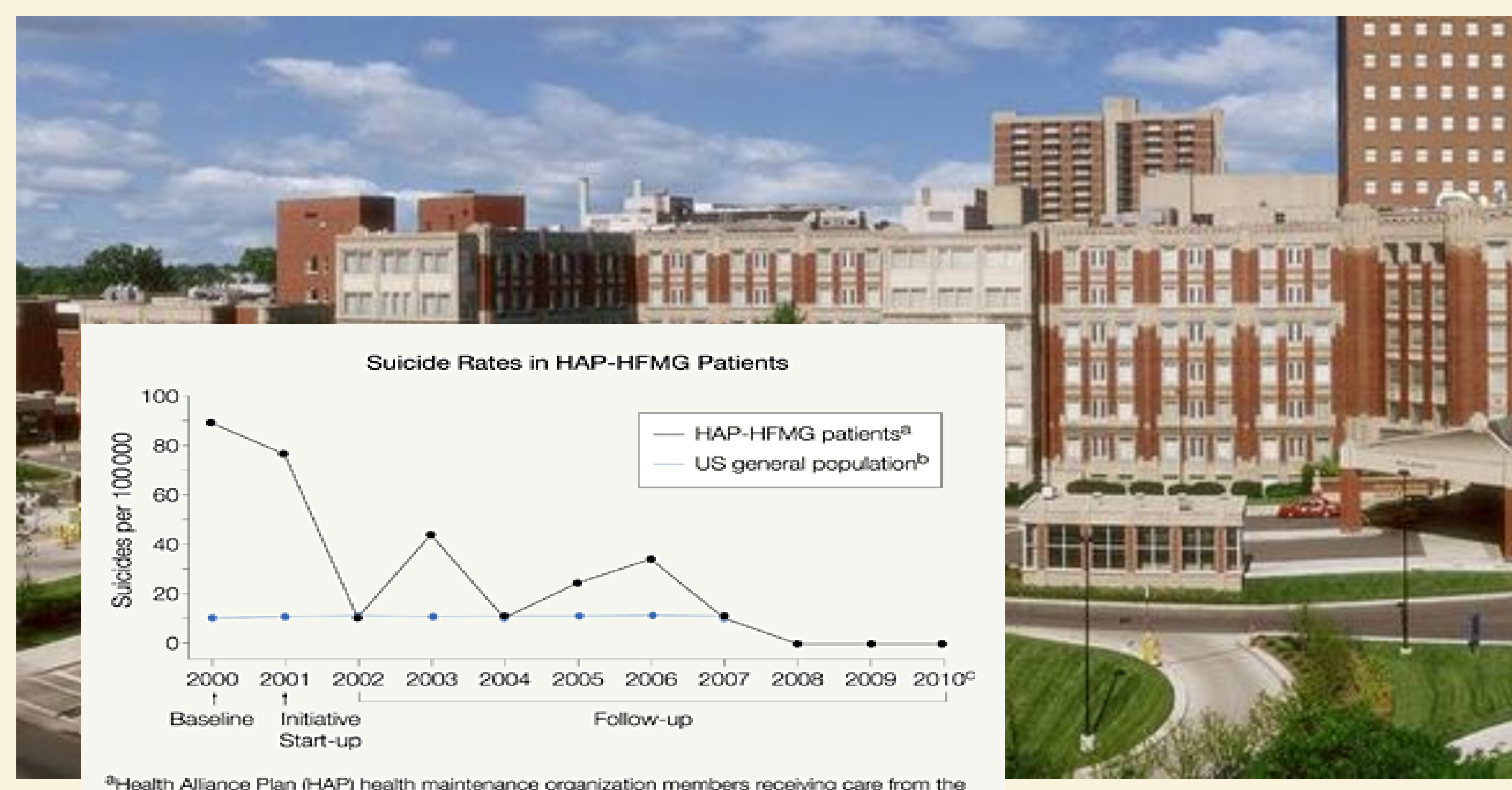
Henry Ford Health System Also Reduced Suicide



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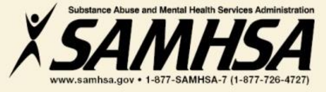
Suicide Prevention Resource Center

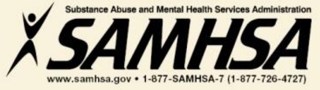
The nation's first and only federally funded suicide prevention resource center

- Advances the goals and objectives of the National Strategy for Suicide Prevention
- Staffing and Coordination for the National Action Alliance for Suicide Prevention
- "Charting the Future of Suicide Prevention"
- Prevention Support for GLS grantees
- Best Practices Registry for Suicide Prevention
- Primary Care Toolkit
- Training Institute
- Partners with American Association of Suicidology, American Foundation for Suicide Prevention, Suicide Prevention Action Network

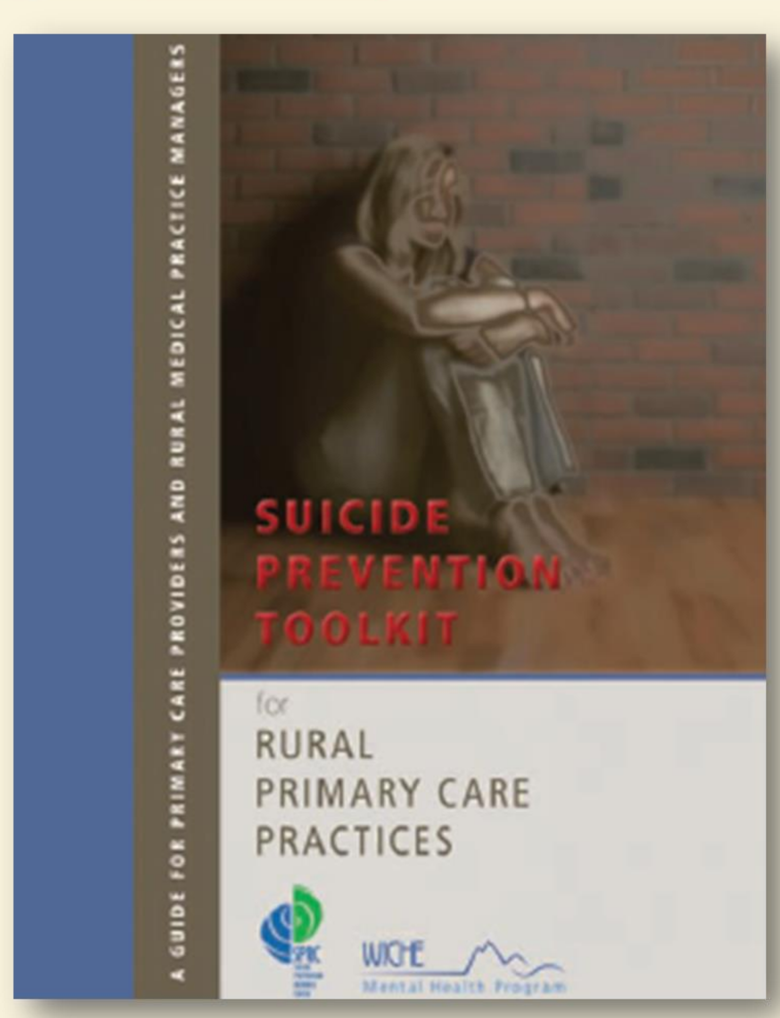


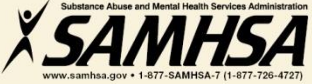
Suicide Prevention Resources for Older Americans

- *Promoting Mental Health and Preventing Suicide : A Toolkit for Senior Living Communities*
- *SPRC Older Adult Suicide Prevention Resource Sheet*
- *SAMHSA/ACL-Older Americans Behavioral Health-Issue Brief #4-Preventing Suicide in Older Adults*



Suicide Prevention Toolkit





Resources: Online Toolkit

The Public-Private Partnership Advancing the National Strategy for Suicide Prevention

Zero Suicide in Health Care | Zero Suicide Advisory Group

Identifying and Assessing Suicide Risk Level

Screening for suicide risk should be a universal part of primary care, hospital and emergency department care, behavioral health care, and crisis response intervention. Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, means availability, presence of acute risk factors, history of suicide attempts, and level of risk.

Screening

General Medical Settings

The primary care setting is presents an excellent opportunity for suicide prevention. The Western Interstate Commission for Higher Education (WICHE), in partnership with the Suicide Prevention Resource Center (SPRC), offers a comprehensive toolkit for primary care practices.

Up to 76 percent of Americans who die by suicide had contact with their primary care provider in the month prior to their death.

Physicians and nurses may be concerned about asking patients about suicidal thoughts and behavior of without resources to help them respond to identified risk. It is essential that primary care practices and hospitals have access to behavioral health support for patients that have positive responses to suicide screens. Such support can be forged from local mental health providers or could be provided by telephone or online by crisis service organizations. State and local government health and mental health organizations can help provide the impetus for forging critical local relationships.

Recently, Medicare added procedure codes for a 15-minute screen for depression for Medicare patients. Such a screen could cover the first two questions below, and we recommend adding a third direct question about suicide:

Zero Suicide Tool Kit

- About the Toolkit
- Zero Suicide Culture
- Pathway to Care
- Competent Workforce
- Suicide Risk Level
- Evidence-based Care
- Contact After Care

Quick Links

- Assessment Tools
- Clinical Decision Support
- Columbia-Suicide Severity Rating Scale
- Driving Suicides to Zero
- Is Your Patient Suicidal?
- Primary Care Tooklit
- Screening Tools

Get Started

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New Research has led to New Resources

Safety Planning

Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

WICHE

Western Interstate Commission for Higher Education

SPRC

URL: http://www.sprc.org/library/SafetyPlanningGuide.pdf

Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. ______
2. ______
3. ______

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. ______
2. ______
3. ______

Step 3: People and social settings that provide distraction:

1. Name______ Phone______
2. Name______ Phone______
3. Place______ 4. Place______

Step 4: People whom I can ask for help:

1. Name______ Phone______
2. Name______ Phone______
3. Name______ Phone______

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name______ Phone______
   Clinician Pager or Emergency Contact # ______
2. Clinician Name______ Phone______
   Clinician Pager or Emergency Contact # ______
3. Local Urgent Care Services______
   Urgent Care Services Address______
   Urgent Care Services Phone______
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. ______
2. ______

The one thing that is most important to me and worth living for is:

______

WICHE Mental Health Program

SPRC

http://www.sprc.org/library/SafetyPlanTemplate.pdf

Suicide Assessment Five-step Evaluation Triage

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide www.sprc.org/library/jcsafetygoals.pdf
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf

ACKNOWLEDGEMENTS

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National Suicide Prevention Lifeline
1.800.273.TALK (8255)

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www.sprc.org

www.mentalhealthscreening.org

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1 IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2 IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3 CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4 DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5 DOCUMENT
Assessment of risk, rationale, intervention and follow-up

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

Suicide Assessment Five-step Evaluation Triage

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Current/past psychiatric diagnoses:** especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. Co-morbidity and recent onset of illness increase risk
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ **Family history:** of suicide, attempts or Axis 1 psychiatric diagnoses requiring hospitalization
- ✓ **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- ✓ Access to firearms

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
- ✓ **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

* ***Homicide Inquiry:*** *when indicated, esp. postpartum, and in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- ✓ Assessment of risk level is based on clinical judgment, after completing steps 1-3
- ✓ Reassess as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

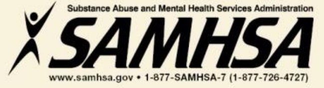
(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT: Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan

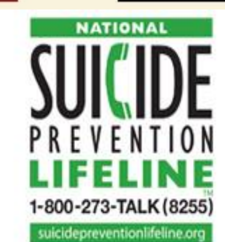
TIP 50

TIP 50: *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*

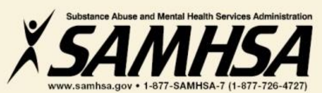
- High prevalence of suicidal thoughts and suicide attempts among persons with SA problems who are in treatment.
- TIP 50 helps
  - SA counselors work with adult clients who may be suicidal
  - Clinical supervisors and administrators support the work of SA counselors
- Free copies: http://store.samhsa.gov/product/SMA09-4381
- Training video: SAMHSA YouTube channel
- SPRC Webinar: http://www.sprc.org/traininginstitute/disc_series/disc_22.asp

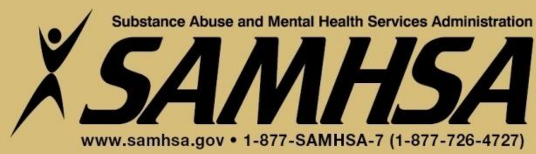


National Suicide Prevention Lifeline
1-800-273-TALK



- Answered over 1,000,000 calls in 2013
- 165 local crisis centers
- Developed risk assessment standards and guidelines for callers at imminent risk based on evaluation findings
- Press "1" for veterans and active duty military
- Initiating 24 hour chat service





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The Friendship Line

Charis Stiles MSW, Friendship Line Manager

NCOA Older Adult Suicide Webinar- September 29, 2014

Friendship Line

1-800-971-0016

- Serves adults 60 +, their caregivers, or younger adults with disabilities.
- The only AAS accredited crisis hotline and dual “warmline” for older adults in the nation.
- Offer 24/7 crisis intervention.
- Began in 1973 to address unmet needs of suicidal older adults.
- Primarily funded through San Francisco Department of Adult and Aging Services, and CA Mental Health Services Act

Theoretical Orientation

"Connections are what bind us to life."
- Founder Dr. Patrick Arbore.

- Broad view of suicide prevention, offering intervention earlier than many other crisis centers.
- Our focus is on lessening loneliness, building connections, and providing opportunities for older adults to feel valued, in addition to active suicide intervention.
- We utilize active listening and motivational interviewing with the intention of building bonds and helping callers continue to find meaning throughout the lifespan.

Common FL Caller Issues

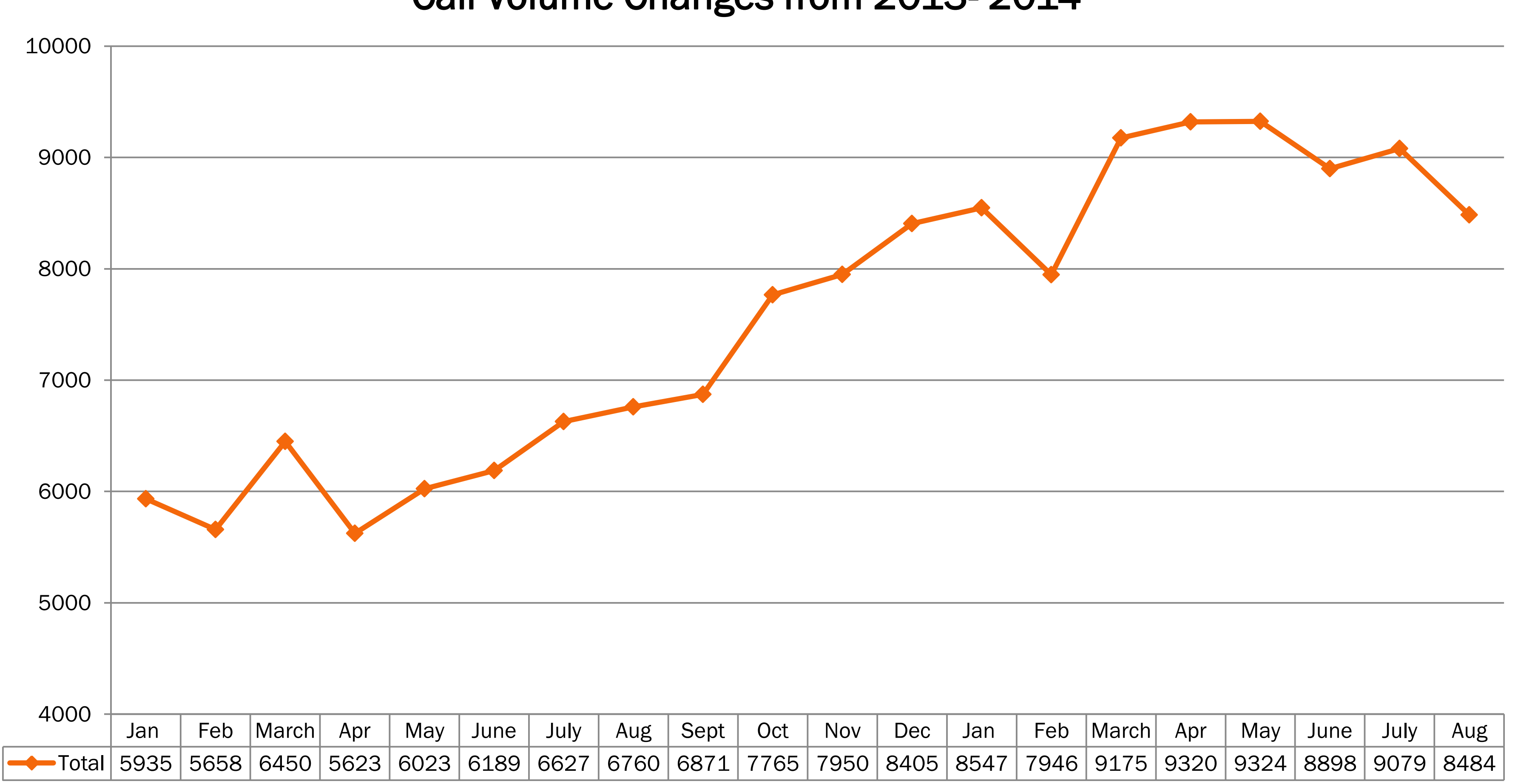
Friendship Line callers commonly are..

- Dealing with depression or anxiety.
- Lonely, isolated.
- Experiencing PTSD.
- Going through a major life change or transition.
- Grieving a loss.
- Coping with major health issues, financial issues, or housing issues.
- Feeling hopeless and worry about becoming “a burden”.

Friendship Line Staff and Volunteers

- Staff includes:
  - Four shift lead supervisors (MFT or MSW- level)
  - FL Coordinator
  - Volunteer Coordinator
  - FL Manager and Director
- Volunteers:
  - 60-90 volunteers including overnight counselors
  - Many volunteers are psychology, gerontology, social work, or counseling graduate students.
  - Initial 24 hour training, followed by 16 hours of observations and monitored shifts. Additional group supervisions and trainings offered on a monthly basis.

Call Volume Increases



	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July	Aug
Total	5935	5658	6450	5623	6023	6189	6627	6760	6871	7765	7950	8405	8547	7946	9175	9320	9324	8898	9079	8484

July 2014 Call Volume

Call In - Emotional Support	3,324
Call Out - Emotional Support	3,448
Medication Reminder *	1,067
Information & Referral	63
Check In	436
Total Calls	**9,079**

Overview of FL Services: Call In Service

- Callers are welcome to call in at any time.
- We operate 24/7 so we are available for crises or for support anytime needed.
- Limited to one call a day, unless in crisis.
- Volunteers assess for loneliness and suicidal ideation with each call in.

Emotional Support Call-Out

- This service targets older adults who may be lonely, bereaved, frail, isolated, depressed, and/or suicidal.
- Call-out clients can receive calls as often as once a day.
- This continual emotional support goes a long way in suicide prevention, offering ongoing connection and support.
- We're able to effectively monitor their emotional well-being and notice changes in mood that may signal a risk.
  - This includes regular re-assessments for loneliness, suicidal ideation, and depression.

- ***Many clients who call in with passive or active suicidal ideation become call out clients as a form of intervention!***

Check-In Service

- Daily check-ins provided to older or disabled adults who are concerned about their health and/or safety.
- Typically, these clients live alone and want an assurance system in place in case anything were to happen to them.
- Brief phone call letting us know they’re okay.
- If we do not hear from them, we have an agreement with the client to call their emergency contact.

Grief Services

- Saturday morning drop-in group
  - 10:30-12 every Saturday morning
  - Free!
- 8 week “basic” Traumatic Loss Group
  - Fee associated
  - 10-12 Saturdays
- Options available for graduates of the 8 week basic group!
- Individual counseling provided in the office.
- *Provided in San Francisco office.*

Elder Abuse and Neglect

- We work closely with local APS and law enforcement to report incidences of elder abuse and neglect.
  - Work closely with Elder Abuse Prevention program at Institute on Aging
  - Work with APS and law enforcement across the county!
- All volunteers are trained in elder abuse reporting and are mandated reporters.
- On average, we make 5 APS reports per month.

Example of Caller and Intervention

- MK was a 63 year old male living in rural TX calling in with suicidal ideation.
  - Mother recently died in the past 2 years.
  - Recent dx of bipolar disorder
  - Works graveyard shift as a janitor.
  - Past suicidal attempt 5 years ago.
- Overnight counselor talked with MK for an hour about his experiences of isolation, disconnectedness, grief, and hopelessness.
  - Goal of call was active intervention while providing meaningful connection and working relationship with MK.
- Connected MK with local resource for mental health services and MK became a daily call out before his graveyard shift.

Thank You!

Friendship Line

1-800-971-0016

- Charis Stiles, Friendship Line Manager
- 415-750-4138
- cstiles@ioaging.org

- Patrick Arbore, Friendship Line Director and Founder
- 415-750-4133
- parbore@ioaging.org

OLDER ADULT GATEKEEPER TRAININGS

Presented by Samaritans of Merrimack Valley

A Program of Family Services of the Merrimack Valley

Older Adult Gatekeeper Trainings

- 1999 Surgeon General's Report
- 1999 MA Coalition for Suicide Prevention (MCSP)
- 2006 Northeast Coalition for Suicide Prevention (NCSP)
- 2006 Suicide Prevention Training for Gatekeepers of Older Adults (8 hour) developed and funded by Department of Public Health (DPH)
- 2007 MA state legislature allocates $1.25 million for suicide prevention
- 2008 Suicide and Aging-A Gatekeeper Workshop (4 hours) developed and funded by DPH
- FY 2015 Legislature approved $4 million for suicide prevention

Suicide Prevention Training for Gatekeepers of Older Adults (8 hours)

- Created in 2006
- First presentation August 11, 2006
- Added to the Best Practice Registry of the Suicide Prevention Resource Center in January 2011 – currently one of two approved elder gatekeeper trainings in the US
- Approved for 6.5 CEUs for social workers and LMHCs
- As of September 2014:
  - 129 trainings
  - 67 locations
  - 1608 participants trained

Suicide Prevention Training for Gatekeepers of Older Adults (8 hours)

ELEMENTS OF THE TRAINING

- Quiz and comfort scale given at beginning and end of training session
- Interactive discussions
- Role playing and training video
- Vignettes
- Handouts
- Evaluation surveys
- Self-care

Suicide Prevention Training for Gatekeepers of Older Adults (8 hours)

WORKSHOP OVERVIEW

MORNING SESSION or DAY ONE SESSION

Session 1 – The process of aging and impact of mental health problems

Session 2 – Understanding suicide risk and mental health problems

Suicide Prevention Training for Gatekeepers of Older Adults (8 hours)

WORKSHOP OVERVIEW

AFTERNOON or DAY 2 SESSION

Session 3 – Working with older adults at risk of suicide

Session 4 – The process of planning immediate and ongoing support

Session 5 – Self-care and summary of the workshop

Suicide & Aging – A Gatekeeper Workshop (4 hours)

- Created 2010
- 37 trainings held
- 308 participants
- Added to the Best Practice Registry of the Suicide Prevention Resource Center in March 2013 – currently one of two approved elder gatekeeper trainings in the US
- Approved for 3.5 CEUs for social workers

Suicide & Aging – A Gatekeeper Workshop (4 hours)

- The aging process - positive/negative changes in older age, concerns of older adults and common attitudes towards aging … "ageism?"
- Suicidal issues with older adults - gatekeeper attributes & needs
- Suicidal risk and protective factors
- Warning signs
- How to speak to older adults at risk
- Self-care

Suicide & Aging - A Gatekeeper Workshop (4 hours)

SUICIDE QUIZ

- 14 questions about suicide prevention in general, ranging from statistical data to truths about suicide
- Given at the beginning of the presentation and reviewed at the end of the presentation
- Given as a tool for knowledge gained

Older Adult Gatekeeper Trainings

GATEKEEPER LOG

- Initials of older adult _______

- What signs or symptoms did you see that prompted you to become concerned about the older adult?

- What was the intervention?
  - I talked with the older adult.
  - I talked with my supervisor.
  - I made a referral.
  - Other (please explain) ____

- If a referral was made, to whom was it made?
  - Staff medical doctor.
  - Staff psychiatrist.
  - Staff social worker.
  - Mental health emergency services.
  - Outpatient mental health agency.
  - Other (please explain) ____

- What was the result of the referral?
  - The older adult is receiving counseling.
  - The older adult has begun medication.
  - The older adult was psychiatrically hospitalized.
  - The older adult was medically hospitalized.
  - Other (please explain) ____

Older Adult Gatekeeper Trainings

COMFORT SCALE

- How comfortable are you saying the word "suicide?"

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

- How comfortable are you talking with an older adult about suicide?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

- How comfortable are you talking with an older adult about mental health disorders, particularly depression?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

- How comfortable are you notifying others that someone may be at risk for suicide?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Older Adult Gatekeeper Trainings

Person expresses suicidal ideation

Direct Statements
I've decided to kill myself
I wish I were dead
I'm going to commit suicide
I'm going to end it all
If (such and such) doesn't happen I'll kill myself

Indirect Statements
I'm tired of life
What's the point of going on
My family is better off without me
Who cares if I'm dead anyway
Soon I won't be around
Soon you won't have to worry about me anymore
You're going to regret how you treated me

Behavioral Clues
Stockpiling pills
Putting affairs in order
Making a will
Making funeral plans
Giving away possessions
Relapse into substance use after period of recovery

Situational Clues
Sudden rejection by a loved one
Recent unwanted move
Death of a spouse
Diagnosis of terminal illness
Sudden unexpected loss of freedom

Question: Ask the person if they are thinking of suicide

YES

Person has a suicide plan

Person has
- **Access to lethal means,**
- **Poor social support**
- **Poor judgment**

Immediately notify PSS who will take control of the situation. Maintain contact with client until then.

Person does NOT have a suicide plan or intent

Person
- **Does NOT have access to lethal means**
- **DOES have good social support**
- **DOES have good judgment**

Listen
Give the person HOPE: I want you to live
PERSUADE:
Will you go with me to see a counselor?
Will you let me help you make an appointment ?
Will you promise me you'll stay alive until we can get you some help?
CONSULT:
Immediately discuss case with Green Button or PSS

Older Adult Gatekeeper Trainings

- Bibliography
- American Association of Suicidology data
- Local suicide statistics
- Local psychiatric emergency services
- Area mental health agencies
- Area nursing services
- Area Councils on Aging
- Statewide geriatric/medical psychiatric hospitals
- Help line number, websites and recommended reading

Older Adult Gatekeeper Trainings

- Debbie Helms - Samaritans of Merrimack Valley, Supervisor, 978-327-6671 - dhelms@FSMV.org

- Mary Quinn – Samaritans Training Coordinator, 978-327-6672 – mquinn@FSMV.org

- Samaritans website: www.stop-suicide.org

- Family Services website: www.fsmv.org

- Crisis help lines: 978-327-6607; 866-912-4763; 877-870-4673

THANK YOU FOR YOUR ATTENTION!