Suicide Prevention Among Older Adults

September 29, 2016

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Suicide Among Older Adults
Prevalence, Risk Factors, and Prevention

Phantane J. Sprowls, MPA
Office of Nutrition and Health Promotion Programs
Administration on Aging
Administration for Community Living
“Never never never never give up.”
– Winston Churchill
Population Projection by Age in the U.S.¹

<table>
<thead>
<tr>
<th>Year</th>
<th>Population in Millions</th>
<th>Population 65+ as a percentage of the U.S. population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>40</td>
<td>10%</td>
</tr>
<tr>
<td>2020</td>
<td>45</td>
<td>12%</td>
</tr>
<tr>
<td>2025</td>
<td>50</td>
<td>14%</td>
</tr>
<tr>
<td>2030</td>
<td>55</td>
<td>16%</td>
</tr>
<tr>
<td>2035</td>
<td>60</td>
<td>18%</td>
</tr>
<tr>
<td>2040</td>
<td>65</td>
<td>20%</td>
</tr>
<tr>
<td>2045</td>
<td>70</td>
<td>22%</td>
</tr>
<tr>
<td>2050</td>
<td>75</td>
<td>24%</td>
</tr>
<tr>
<td>2055</td>
<td>78</td>
<td>25%</td>
</tr>
<tr>
<td>2060</td>
<td>80</td>
<td>26%</td>
</tr>
</tbody>
</table>

¹ Source: Bureau of the Census.
Suicide among older adults
By Race, Age, and Gender, 2014

Suicide Rate Per 100,000

- White Men
- Black Men
- White Women
- Black Women

Age (Years)

Suicide Rate Per 100,000

60-64
65-69
70-74
75-79
80-84
85+
Suicide Rates in the U.S.³
By Age, 2004-2014

Suicide Rate per 100,000

Year


Suicide Rate per 100,000

20-34
35-49
50-64
65-79
80+

¹ Source: National Center for Health Statistics, National Vital Statistics System (NVSS), Mortality.</ref>
Means of committing suicide

Under Age 50
- Firearms
- Suffocation
- Fall/Jump
- Poisoning
- Cut/Pierce
- Other

Age 50+
- Firearms
- Suffocation
- Fall/Jump
- Poisoning
- Cut/Pierce
- Other
Risk Factors

- Depression
- Prior suicide attempts
- Marked feelings of hopelessness
- Co-morbid general medical conditions that significantly limit functioning or life expectancy
- Pain and declining role function (e.g., loss of independence or sense of purpose)
- Social isolation
- Family discord or losses (e.g., recent death of a loved one)
- Inflexible personality or marked difficulty adapting to change
- Access to lethal means (e.g., firearms)
- Alcohol or medication misuse or abuse
- Impulsivity in the context of cognitive impairment
What can we all do to help?
Local and Community Level Opportunities

• Provide education on factors associated with increased suicide risk and protective factors
• Implement depression screenings
• Provide education on suicide prevention, “hot lines,” and local crisis team referral
• Limit access to means of suicide, such as firearms.
State Level Opportunities

• Influence
  • Communicating ideas, gaining acceptance, motivating others to back and implement ideas in support of suicide prevention

• Objective oriented
  • Keeping the interests of suicide prevention initiatives and advocacy at the forefront

• People
  • Ensuring the right people/partners are present within your leadership structure to continue to move the needle with suicide prevention efforts

• Funding and Delivery systems
  • Directed federal or state funding and developing and leveraging delivery systems
State Opportunities con’t...State Plans

• All states have a State Plan on Aging
  • More than 10 currently include suicide prevention as part of their State Plan on Aging
  • All states address behavioral and/or mental health in some capacity
• All states have Mental Health & Substance Abuse Prevention/Treatment Plans
Older Adult Behavioral Health Coalitions

Membership:

- State employees (aging, public health, mental health and/or substance abuse prevention/treatment)
- Local organizations (AAAs, senior centers, community mental health centers, hospitals, home health, adult day, adult protective services, Alzheimer’s Association, long-term care providers)
- Managed/integrated care entities
- Consumers and families
- Students
Older Adult Behavioral Health Coalitions con’t…

- **Activities:** networking; resource coordination; systems planning; education; training; conferences; advocacy; policy analysis

- **Funding Sources:** government; no source; philanthropy; sponsoring organizations; membership dues

- **National Coalition on Mental Health and Aging**
  - Website: [http://www.ncmha.org/](http://www.ncmha.org/)
Recent ACL collaboration in support of Behavioral Health and Suicide Prevention

SAMHSA in collaboration with ACL developed training to help Aging and Disability Resource Centers (ADRC) staff better meet the needs of older adults with behavioral health issues.

- Goal is to enhance training for staff at an ADRC/No Wrong Door System
- Products: Resource Guide and Training Modules

Course Modules

- MODULE 1: Recognizing and Responding to Older Adult Behavioral Health Issues
- MODULE 2: Suicidal Thoughts and Behaviors
- MODULE 3: Navigating Medicaid Behavioral Health
- MODULE 4: Self-Care for Staff
For more information:
U.S. Department of Health and Human Services
Administration for Community Living
Washington, DC
Email: phantane.sprowls@acl.gov
Web: http://www.acl.gov/
References


Suicide Prevention Among Older Adults

Richard McKeon Ph.D.
Chief, Suicide Prevention Branch, SAMHSA

Suicide Prevention and Older Adults Webinar
September 29th, 2016
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
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
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...
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 Toolkit
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 Assessment Five-step Evaluation Triage

RESOURCES
- Download this card and additional resources at www.sprc.org or at www.stopssuicide.org
- SAFE-T draws upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psych.org/psych_pract/treatgg/pg/SuicidalBehavior_05-15-06.pdf

ACKNOWLEDGEMENTS
- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57732. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

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: anxiety, impulsivity, hopelessness, irritability, 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 I psychiatric diagnoses requiring hospitalization
- Precipitants/stressors: triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated, Ongoing medical illness (e.g., 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
  - Plans: timing, location, lethality, availability, preparatory acts
  - Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), non-suicidal self-injurious actions
  - Intent: extent to which the patient (i) expects to carry out the plan and (ii) 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

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

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

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. Formulate instructions, if relevant; follow up plan
• Answered over 1,500,000 calls in 2015
• 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
Older Americans Suicide Prevention Toolkits

Promoting Mental Health and Preventing Suicide: A Toolkit for Senior Living Communities

PROMOTING EMOTIONAL HEALTH AND PREVENTING SUICIDE
A Toolkit for Senior Centers

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

2015
Why Are Such Toolkits Important?

Statistics are Alarming

- Depression is not a normal part of aging
- Normal thoughts about death are different from suicidal thoughts
- It is important to reduce stigma associated with mental health disorders
There is Hope and Help

Protective Factors

- Appropriate assessment and care for physical and behavioral health issues
- Social connectedness
- Sense of purpose or meaning
- Resilience around change
Framework for the Toolkits

• Whole Population- Promote the emotional health of all older adults
• At Risk-Recognize and respond to individuals at risk
• Crisis Response-Respond to a suicide attempt or death

(Langford, L. 2008. A Framework for Mental Health Promotion and Suicide Prevention in Senior Living Communities)
Audience for the Toolkit

• Senior Center staff and volunteers

• Community service providers for older adults (e.g., meals on wheels, transportation, home care)

• Behavioral health professionals
The Role of Senior Centers & Their Partners in Addressing Suicide

1. Provide activities that increase the emotional well-being of all participants

2. Identify and get help for those individuals at risk of suicide

3. Respond to a suicide death or attempt
Activities that increase the emotional well-being of all their participants
Identifying and getting help for individuals at risk of suicide

- Train staff and volunteers
- Refer to mental health providers
- Conduct screening
- Provide counseling
Providing Support after a Suicide

✓ Postvention protocols
✓ Community support meetings
✓ Mental health counseling
Resources in Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers

TOOLS AND FACT SHEETS

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### Tool 2: Assessment Checklist

#### Promoting Emotional Health and Preventing Suicide among Older Adults

<table>
<thead>
<tr>
<th>Questions</th>
<th>Review This Section of the Toolkit</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each question, circle the answer that best matches your current situation.</td>
<td>If you answered &quot;No&quot; or &quot;Don't Know,&quot; consider taking the steps and using the tools and resources in the toolkit section listed below.</td>
</tr>
</tbody>
</table>

#### Getting Started

<table>
<thead>
<tr>
<th>Do your staff members and volunteers know what factors may increase the risk of suicide among older adults?</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
<th>Getting Started section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a list of the behavioral health contacts in your community?</td>
<td>Yes</td>
<td>No</td>
<td>Don't Know</td>
<td></td>
</tr>
</tbody>
</table>

#### Promote Emotional Health

<table>
<thead>
<tr>
<th>Do you offer a variety of activities that promote intellectual, creative, spiritual, and physical well-being?</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
<th>Strategy 1: Provide Activities and Programs That Increase Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you offer programs designed to promote social networks and community building?</td>
<td>Yes</td>
<td>No</td>
<td>Don't Know</td>
<td>Strategy 1: Support the Development of Social Connections</td>
</tr>
</tbody>
</table>

#### Recognize and Respond to Suicide Risk

<table>
<thead>
<tr>
<th>Have your staff and volunteers been trained?</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
<th>Strategy 2: Recognize the Warning Signs of</th>
</tr>
</thead>
</table>
Information Form for Behavioral Health Resources

Name of Organization/Program: ____________________________________________________________

Contact Person: _________________________________________________________ Phone Number: ____________________________

E-Mail: ____________________________

1. Do you currently provide services for older adults (ages 65+) with:
   Mental health issues ___ Yes ___ No
   Substance use problems ___ Yes ___ No

2. Are you able to take new clients that we would refer to you? ___ Yes ___ No

3. Do you accept health insurance? ___ Yes ___ No
   If yes, check all that apply: ___ Medicare ___ Medicaid ___ Private insurance ___ Other

4. What counseling and/or treatment programs do you provide?

5. What support groups do you provide?

6. Would you be available for consultation with our senior center staff about behavioral health issues?

7. What services could you provide at our senior center, for example:
   ___ Screening
   ___ Counseling
   ___ Support groups
   ___ Speakers/training/classes for: ___ Staff ___ Participants ___ Other (please describe):
Fact Sheets

- Scope of the problem
- Risk and protective factors
- Warning signs of suicide
- Depression
- Alcohol and medication misuse

Fact Sheet 2: Know the Warning Signs of Suicide

Have you ever heard someone make these statements? Have you thought them yourself?

- "They’ll be better off without me."
- "Don’t worry. I won’t be here to bother you much longer."
- "I can’t deal with it any more. Life is too hard."
- "I no longer want to live."
- "Death seems like the only way out."

Do either of the following descriptions sound like your neighbor, a friend, or yourself?

- The person has been drinking more than usual. He or she doesn’t think life has any purpose now that his or her spouse is gone. He or she tells family or other people that he or she plans to be dead within weeks. He or she stops coming to exercise class. He or she seems asleep or takes naps all day. He or she reports feeling hopeless and that nothing in life will ever improve.

Know the warning signs of suicide.

The following three warning signs suggest that a person could be at immediate risk of suicide:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

Other behaviors that may also indicate a serious risk—especially if the behavior is new, has increased, and/or seems related to a painful event, loss, or change:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting3 symptomatic or agitated, behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about wanting revenge
- Displaying extreme mood swings
For more information

• **Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers:**

• **Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities:**

• **Suicide Prevention Resource Center**
  [www.sprc.org](http://www.sprc.org)
Richard McKeon, Ph.D., M.P.H.
Branch Chief, Suicide Prevention, SAMHSA
240-276-1873
Richard.mckeon@samhsa.hhs.gov
Evidence-based depression and suicide prevention programs for older adults

Lesley Steinman, MSW, MPH
National Council on Aging
September 29, 2016
Overview

• Program to Encourage Active, Rewarding Lives (PEARLS)
  • Program Overview
  • Evidence
  • Implementation
  • Suicide / self-harm protocols
• Suicide prevention for older adults
• Resources
• Q&A
PEARLS Birth Story

• Late-life depression is often unrecognized and un/undertreated
• Older adults with social isolation, medical comorbidity, and physical impairment are more likely to be depressed / less able to seek appropriate care for depression.
• **The PEARLS RCT study aimed to** collaborate with existing aging service agencies to determine the effectiveness of a home-based program of detecting and managing minor depression or dysthymia among older adults.
  • Aging and Long-Term Care Administration (ALTSA)
  • Seattle-King County Area Agency on Aging
  • Local community organizations – Senior Services, low-income senior housing
  • CDC-funded Prevention Research Center (UW Health Promotion Research Center)
What is PEARLS?...for providers

Depression Care Management

• Active screening for depression
• Measurement-based outcomes
• Trained depression care manager
  • Brief, evidence-based interventions
  • Education / self-management support
• Psychiatrist role re-defined
• 6 – 8 hour long sessions over a 4 – 5 month period
What is PEARLS?...for participants

Jennifer and Jack

- Stroke support group
- Respite care
- Rebuilding Together
- Minivan
- Swimming
- “PEARLS helped me to sort out all of my stuff.”
- “I liked how Paul came to our house to help me figure out how to do the things I used to do, just do them differently.”
What makes PEARLS unique?

- Participant-driven
- Outside traditional mental health settings
- Home-based
- Multiple chronic conditions
- Developed with and utilizes existing service-provision programs
- Team-based approach
- Aims to improve quality of life as well as reducing depressive symptoms
PEARLS RCT’s

2000 – 2003: 138 frail, homebound elders with minor depression
- 4-5 chronic conditions
- 42% racial/ethnic minority, low-income

2008 – 2010: 80 all-age adults with epilepsy and comorbid depression
- 70% with major depression
- 23% racial/ethnic minority

Significant improvement in depressive symptoms and other outcomes
PEARLS study with older adults

6 month results
Ciechanowski, P et al
JAMA 2004; 291:1569-1577

- ≥50% drop on HSCL-20: Usual Care 8%, Intervention 54%
- % achieving remission: Usual Care 10%, Intervention 44%
- % reporting any hospitalizations: Usual Care 34%, Intervention 22%
PEARLS study with all-age adults with epilepsy

18 month results for suicidal ideation

PEARLS Implementation

- Implementation Toolkit
- Technical Assistance
- Training
- Recognition
- Research and evaluation
PEARLS includes a suicide/self-harm protocol

Agency may already have a procedure in place

• If not, need to develop one

Depressed people sometimes become suicidal

All staff, especially PEARLS counselor and supervisor, need to know what to do

Identify resources within your agency and outside

This discussion is a brief overview – NOT an exhaustive plan
Key elements in a written protocol

Trigger

• “Yes” answer to question 9 on PHQ-9 (thoughts of death and thoughts of self-harm)
• Current suicidal plan or intent, or recent suicide attempt

Assessment

• PEARLS counselor needs to know how to do an initial suicide assessment
• Ideation vs Plan vs Intent
• Low → Moderate → High Risk
# Assessing risk

<table>
<thead>
<tr>
<th>Thoughts / Behaviors</th>
<th>Risk Level</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts of death only (<strong>Ideation</strong>)</td>
<td>Low risk</td>
<td>• With this much stress, have you thought of hurting yourself?</td>
</tr>
<tr>
<td>• No plan</td>
<td></td>
<td>• Have you ever tried to kill yourself?</td>
</tr>
<tr>
<td>• No behaviors (eg, previous attempt)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts of suicide or self-harm (<strong>Intent</strong>)</td>
<td>Moderate risk</td>
<td>• Assess for frequency, duration, and intensity of thoughts</td>
</tr>
<tr>
<td>• Limited intent (<strong>Intent</strong>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• May have had a previous attempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts of suicide more definite (<strong>Intent</strong>)</td>
<td>High risk</td>
<td>• Do you have a plan? How, when, where?</td>
</tr>
<tr>
<td>• Plan in place</td>
<td></td>
<td>• Do you have the means (drugs, gun, etc.)?</td>
</tr>
<tr>
<td>• Have the means to implement the plan</td>
<td></td>
<td>• Do you have a timeline?</td>
</tr>
<tr>
<td>• Preparatory/rehearsal behavior (<strong>Action</strong>)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Action Steps for PEARLS Counselor

Consultation

Develop a safety plan with the client

Has the client informed other providers (primary care, mental health, home health) about these suicidal thoughts?

• If no, request permission to release this information to those providers

Provide emergency numbers for your area

Take more definite steps if warranted – take the client to the emergency room, call the police, etc.

Document all activities and steps taken in client’s record
Sample Suicide Plan

Protocol for Handling Client Statements of Self-Harm

This information is provided to supplement and not replace your agency’s existing procedures for dealing with potential self-harm. This protocol was referred to during discussion of the PHQ-9—if a client responded “Yes” (i.e., endorsing a non-zero rating) to question 9 on the questionnaire. Follow this protocol immediately if a client responds “Yes” to that question. The procedure outlines a systematic approach to be used by the PEARLS counselor for dealing with clients that have:

- thoughts of death and thoughts of self-harm (answering “Yes” to Q9 in eligibility interview), or
- current suicidal plan/intent or a recent suicide attempt (may need to prompt for information).

Procedure

1. Ask the client immediately if they:
   a) have a plan of how they may harm themselves;
   b) intend to harm themselves; and
   c) have had any recent attempts.

2. If they answer “yes” to any of the above, ask the client if they have recently told a health care and/or mental health provider about their thoughts.

3a. If the client has informed a provider, give the client emergency numbers and ask that they notify their provider or contact one of the emergency numbers if they need help in the future. After the interview, notify the supervising psychiatrist and your agency supervisor of the client’s current mental state.

3b. If the client has not informed a provider, request permission to release this information to their primary care physician or other involved provider (e.g., psychiatrist, counselor, etc.).
   a) If client consents, contact the primary care and/or other provider(s) immediately.
   b) If client does not consent, provide them with emergency numbers and ask that they notify their provider or contact one of the emergency numbers should they need help in the future. Immediately after the interview, contact the PEARLS supervising psychiatrist and your agency supervisor to discuss the situation.

4. If you feel the client is an imminent, significant risk to themselves or others, and you do not feel that the client will make a call for help, immediate action can be taken without the client’s consent. Call the emergency contact numbers (Crisis line or 911), and take other actions that may be required to protect the client (order of contact depends on the urgency of the situation).
Effective suicide prevention programs

• A Systematic Review of Elderly Suicide Prevention Programs (LaPierre, 2011)

• 19 scientific studies / 11 interventions
  • Primary care-based collaborative care (IMPACT, PROSPECT)
  • Community-based outreach (Japan)
  • Phone counseling
  • Clinical Treatment (pharmacotherapy + IPT)
Effective suicide prevention programs (continued)

- Most studies focused on reduction of risk factors
  - Depression screening
  - Depression treatment
  - Decreasing isolation

- Two studies focused on strengthening protective factors
  - CBT workshop for adapting to retirement
  - IPT focused on improving social functioning and skills

- Strongest evidence exists for women and for targeting suicide risk factors

- Gaps – older men, people who are not seeking services, different outcome measures suicide prevention outcome measures
Resources

• Western Interstate Commission for Higher Education
  – www.wiche.edu/mentalhealth/
  – Pocket Guide for Professionals for Assessment and Intervention
  – Safety Planning Guide for Clinicians

• Local crisis clinic, psychiatrists, etc.

• National Suicide Hotline 800-273-8255

• Forefront Suicide Prevention Training
  – www.intheforefront.org/training
  – Assessing and Managing Suicide Risk Training
  – safeTalk Training
Resources

The Joint Commission:
• Infographic: https://www.jointcommission.org/assets/1/6/SEA_56_Suicide_Infographic_2_10_16_FINAL.pdf
• Sentinel Event Alert: https://www.jointcommission.org/sea_issue_56/
• Webinar Recording: https://www.jointcommission.org/webinar_replay_evaluating_responding_to_suicide_risk_tools_practices/

Detecting and treating suicide ideation in all settings
1. Detecting Suicide Ideation in Non-acute or Acute Care Settings
2. Taking Immediate Action and Safety Planning
3. Behavioral Health Treatment and Discharge
4. Education and Documentation
Partners

PEARLS participants

Aging and Disability Services
Area Agency on Aging for Seattle and King County
Advocacy. Action. Answers on Aging

Catholic Community Services
Catholic Housing Services of Western Washington

Senior Services is now Sound Generations

Washington State Department of Social & Health Services
Aging and Long Term Support Administration

Edmonds Senior Center
edmondsssc.org

Evidence-Based Leadership Council

Area Agency on Aging of Tarrant County

National Council on Aging

Florida Health Networks

Wellness Solutions in your Neighborhood

Health Promotion Research Center
A CDC Prevention Research Center

Jewish Family Service of St. Paul:
Life Enrichment Action Program (LEAP)
Thank you!

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Questions & Answers

Type your question into the chat box on the lower left-hand side of your screen.

For reference, the recording of this webinar will be available shortly on www.ncoa.org/cha.