Suicide Prevention

Funded by SAMHSA in collaboration with AoA
Welcome and Overview

Introductions & Welcome

• Stephen Bartels, MD
  • Scientific Co-Director, Older Americans Technical Assistance Center
  • Centers for Health and Aging, Dartmouth College
Presenters

• **Kimberly Van Orden, PhD**— University of Rochester School of Medicine

• **Richard McKeon, PhD** — Substance Abuse and Mental Health Services Administration (SAMHSA)

• **Elder Community Care**
  • **Steve Corso, MSW, LICSW** — BayPath Elder Services

    • **Lynn Kerner, MSW, LICSW** — Advocates, Inc.

    • **Eileen Davis** — The Samaritans
Suicide in Older Adults: Who is at risk and what can we do about it?

Suicide Prevention Webinar
January 16, 2013

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Rochester, NY USA

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CSPS Fellow

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Disclosures

- Conflicts of interest - none

Collaborators

- Eric Caine, MD
- Kenneth Conner, PhD
- Paul Duberstein, PHD
- Deborah King, PhD
- Alisa O’Riley, PhD
- Carol Podgorski, PhD
- Thomas Richardson, PhD
- Adam Simning, PhD
- Xin Tu, PhD

Yeates Conwell, MD
Kimberly Van Orden, PhD
“My work is done. Why wait?”

George Eastman
March 14, 1932
Age 77
PREVALENCE OF LATE-LIFE SUICIDE
Significance

- Older adults are the most rapidly growing segment of the population.
Population aged 80 or over: world, 1950-2050 (Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Population in Millions</th>
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<tbody>
<tr>
<td>1950</td>
<td>14.5</td>
</tr>
<tr>
<td>1975</td>
<td>31.8</td>
</tr>
<tr>
<td>2009</td>
<td>101.9</td>
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<tr>
<td>2025</td>
<td>160.8</td>
</tr>
<tr>
<td>2050</td>
<td>394.7</td>
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</table>
Significance

- Older adults are the most rapidly growing segment of the population.
- Older adults have higher rates of suicide than other segments of the population.
Suicide Rates by Age, Race, and Gender
U.S. -- 2007

Suicide Rate Per 100K

Age (Years)

White Male
Black Male
White Female
Black Female
Worldwide Suicide Rates, WHO

Distribution of suicide rates (per 100,000) by gender and age, 2000

<table>
<thead>
<tr>
<th>Age group</th>
<th>Males</th>
<th>Females</th>
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<tbody>
<tr>
<td>5-14</td>
<td>1.5</td>
<td>0.4</td>
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<tr>
<td>15-24</td>
<td>22.0</td>
<td>4.9</td>
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<tr>
<td>25-34</td>
<td>30.1</td>
<td>6.3</td>
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<tr>
<td>35-44</td>
<td>37.5</td>
<td>7.7</td>
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<tr>
<td>45-54</td>
<td>43.6</td>
<td>9.6</td>
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<tr>
<td>55-64</td>
<td>42.1</td>
<td>10.6</td>
</tr>
<tr>
<td>65-74</td>
<td>41.0</td>
<td>12.1</td>
</tr>
<tr>
<td>75+</td>
<td>50.0</td>
<td>15.8</td>
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</tbody>
</table>
LETHALITY OF LATE LIFE SUICIDE

• Older people are
  – more frail (more likely to die)
  – more isolated (less likely to be rescued)
  – more planful and determined
ATTEMPTED : COMPLETED SUICIDE

General population

Deaths
Hospitalizations
Emergency Dept visits

Older adults

Deaths

1 2 4
Self-inflicted injury among all persons by age and sex – United States, 2007
METHODS OF SUICIDE IN THE U.S

Total

Age > 65

- FIREARMS
- Hanging, Strangulation, suffocation
- Solid and liquid poisons
- Gas Poisons
- Jump from high place
- All other methods
LETHALITY OF LATE LIFE SUICIDE

• Older people are
  – more frail (more likely to die)
  – more isolated (less likely to be rescued)
  – more planful and determined

• Implying
  – interventions must be aggressive
  – primary and secondary prevention are key
As the largest and most rapidly segment of the population enters the stage of life with highest risk for suicide, we should expect the total number (and proportion) of late life suicides to increase dramatically in coming decades.

WHAT CAN WE DO ABOUT IT?
DOMAINS OF SUICIDE RISK IN LATER LIFE

Social
- loss
- isolation
- dependency

Psychiatric
- depression
- other

Psychological
- personality
- coping

Medical
- illness
- treatment

Biological
- aging
- environment
DOMAINS OF SUICIDE RISK IN LATER LIFE

Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986
# RISK FACTOR: Psychiatric Dx

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<tbody>
<tr>
<td>Any Axis I dx</td>
<td>--</td>
<td>43.9</td>
<td>113.1</td>
<td>56.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Any mood d/o</td>
<td>4.0</td>
<td>184.6</td>
<td>63.1</td>
<td>56.0</td>
<td>59.2</td>
</tr>
<tr>
<td>Maj dep episode</td>
<td>--</td>
<td>184.6</td>
<td>28.6</td>
<td>14.0</td>
<td>36.3</td>
</tr>
<tr>
<td>Subst use d/o</td>
<td>ns</td>
<td>4.4</td>
<td>43.1</td>
<td>3.0</td>
<td>ns</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>--</td>
<td>--</td>
<td>3.6</td>
<td>3.0</td>
<td>ns</td>
</tr>
<tr>
<td>Schiz spectrum</td>
<td>ns</td>
<td>--</td>
<td>10.7</td>
<td>ns</td>
<td>&gt;1</td>
</tr>
<tr>
<td>Dementia/del</td>
<td>0.2</td>
<td>--</td>
<td>ns</td>
<td>ns</td>
<td>ns</td>
</tr>
</tbody>
</table>

ns = not significant
DOMAINS OF SUICIDE RISK IN LATER LIFE

Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986
DOMAINS OF SUICIDE RISK IN LATER LIFE

Social
Psychiatric
Psychological - personality - coping
Medical
Biological

Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986
Personality Traits In Later Life Completed Suicides

- High Neuroticism
  - anxious
  - angry
  - sad
  - fearful
  - self-conscious

- Low Openness to Experience
  - follow routine
  - prefer familiar to the novel
  - constricted range of intellectual interests
  - blunted affective and hedonic responses
DOMAINS OF SUICIDE RISK IN LATER LIFE

Social
Psychiatric
Psychological
Biological
Medical - illness treatment

Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986
Suicide and Medical Illness

- Cancer: 1.73 (1.16-2.58)
- Prostate disease (not CA): 1.70 (1.16-2.49)
- COPD (for married): 1.86 (1.22-2.83)
- CHF: 1.36 (1.00 - 1.85)
- COPD: 1.30 (1.06 - 1.58)
- Seizure disorder: 2.41 (1.42 - 4.07)
- Pain - moderate: 1.24 (1.04 - 1.47)
  - severe: 4.07 (2.51 - 6.59)

Quan, et al., *Soc Psychiatry Psychiatr Epidemiol* 2002; 37:190-197

Juurlink et al., *Arch Intern Med* 2004;164:1179-1184
Comorbidity and Suicide Risk

Juurlink et al., Arch Intern Med 2004;164:1179-1184
DOMAINS OF SUICIDE RISK IN LATER LIFE

Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986
CONNECTEDNESS AND SUICIDE IN OLDER ADULTS

- Family discord and social isolation (Beautrais, 2002; Rubenowitz et al, 2001; Duberstein et al, 2004; Harwood et al, 2006)
- Having no confidantes (Miller, 1977; Turvey et al, 2002)
- Living alone (Barraclough, 1971)
- Not participating in community organizations or having hobbies (Rubenowitz et al, 2001, Duberstein et al, 2004)
- Bereavement (Erlangsen et al, 2004; Conwell et al, 1990)
RISK FACTORS FOR SUICIDE AMONG OLDER ADULTS

- Depression – major depression, other
- Prior suicide attempts
- Co-morbid general medical conditions
- Often with pain and role function decline
- Social dependency or isolation
- Family discord, losses
- Personality inflexibility, rigid coping
- Access to lethal means
Assessment and PREVENTION FRAMEWORK

**HOW** DO WE ASSESS RISK and PREVENT SUICIDE IN ELDERS?

(Approaches to Prevention)
Developmental Process of Late Life Suicide

- Peri-suicidal state
- Depression, hopelessness
- ↑ Symptoms, ↓ Resiliency
- Role Changes, Medical Illnesses, Acute & Chronic Stressors
- Personality Factors, Social Ecology, Cultural Values & Perceptions

- "Distal"
- RISK FACTORS
- "Proximal"

- Selective
- Indicated
- Universal

Caine & Conwell, 2001
Institute of Medicine Terminology: “LEVELS” OF PREVENTIVE INTERVENTION

“Indicated” – symptomatic and ‘marked’ high risk individuals – interventions to prevent full-blown disorders or adverse outcomes.

“Selective” – high-risk groups, though not all members bear risks – prevention through reducing risks.

“Universal” – focused on the entire population as the target – prevention through reducing risk and enhancing health.
INDICATED PREVENTION

- Symptomatic and ‘marked’ high risk individuals – interventions to prevent full-blown disorders or adverse outcomes.
SCREENING TOOLS
Why we use screening tools

1. The goal of suicide risk assessment is NOT a prediction about 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. Take action for any endorsement of suicidal ideation, but not the same action for every level of risk.
How to screen for suicidal thoughts?

- Ask. Screening does not create SI.

- Suicidal thoughts:
  - Are a symptom of depression (but can occur in adults w/out depression)
  - Should always be taken seriously although they are not always an indication that someone would actually die by suicide
  - Are thought of in terms of “passive” (e.g., thoughts of being better of dead) and “active” (i.e., thoughts of taking action towards hurting self)
  - Can be assessed with the PHQ-9, GDS, and other tools.
Mood Scale (PHQ)

I am now going to ask you some questions regarding your emotional health.

In the past two weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Following Up

- If any positive response, FOLLOW-UP
  - 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, FOLLOW-UP further

- There are routinized screeners designed to be used to follow-up the PHQ-9 suicide item.
  - Option: the *P4 Screener for Assessing Suicide Risk*
Past suicide attempt

Suicide plan

Probability (perceived)

Preventive factors

What we do

- **Low risk:**
  - Express concern
  - Get “buy in” to inform PCP
  - Urge they remove means
  - Consult supervisor within 48 hours
  - Coping card

- **Moderate risk:**
  - All of the above, but consult supervisor that day

- **High risk:**
  - Call supervisor now, with client present
  - Consider emergency services (ED, mobile crisis, 911)
Engaging older adults
# Last Primary Care Provider Contact in Suicides

<table>
<thead>
<tr>
<th>Study</th>
<th>Age</th>
<th>N</th>
<th>1 week</th>
<th>1 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Miller (1976)</td>
<td>≥ 60</td>
<td>30</td>
<td>33</td>
<td>77</td>
</tr>
<tr>
<td>• Barraclough (1971)</td>
<td>≥ 65</td>
<td>30</td>
<td>47</td>
<td>70</td>
</tr>
<tr>
<td>• Clark (1991)</td>
<td>≥ 65</td>
<td>54</td>
<td>41</td>
<td>70</td>
</tr>
<tr>
<td>• Cattell &amp; Jolley (1995)</td>
<td>≥ 65</td>
<td>100</td>
<td>19</td>
<td>43</td>
</tr>
<tr>
<td>• Conwell et al (1994)</td>
<td>55-74</td>
<td>24</td>
<td>25</td>
<td>42</td>
</tr>
<tr>
<td>• Conwell et al (1994)</td>
<td>75+</td>
<td>20</td>
<td>35</td>
<td>75</td>
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</table>
RISK FACTOR: Firearm Access

<table>
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<tr>
<th></th>
<th>SC</th>
<th>NC</th>
<th>OR</th>
<th>95% CI</th>
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<tbody>
<tr>
<td>(%(N) with)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- guns in home</td>
<td>62.7 (52)</td>
<td>41.3 (33)</td>
<td>2.3</td>
<td>1.2-4.8</td>
</tr>
<tr>
<td>- handgun</td>
<td>36.1 (30)</td>
<td>18.8 (15)</td>
<td>2.4</td>
<td>1.2-5.6</td>
</tr>
<tr>
<td>- long gun only</td>
<td>26.5 (22)</td>
<td>22.5 (18)</td>
<td>1.3</td>
<td>0.6-2.9</td>
</tr>
</tbody>
</table>

*Model adjusts for education, living arrangements, and mental disorders that developed prior to the last year.  
Interventions & Recommendations
Recommendations for INDICATED PREVENTION

1. Because of the close association between depression and suicide in older adults
   - detection and effective treatment of depression are key
2. Routine screening for depression
   - PHQ-9, GDS, or CES-D
3. Depression treatment is effective at treating depression
   - And is effective at reducing suicidal ideation in some, and maybe reducing suicide rates
4. Primary care most common venue
The IMPACT Study

N=1801 subjects >60 yrs with major depression or dysthymia
Randomized to -- collaborative care (depression care manager; n=906)
-- or care as usual (CAU; n=895)

Unutzer et al., JAGS 54:1150-6, 2006
The PROSPECT Study

- Primary outcome was suicide ideation
- Randomization at the *practice* level
- At baseline $\rightarrow$ 24 month f/u
  - SI in intervention: $74/214 = 35\% \rightarrow 14/124 = 11\%$
  - SI in CAU group: $43/182 = 24\% \rightarrow 16/109 = 15\%$
  - **ONLY** for those with major depression
  - **ONLY** for “active” suicidal ideation

Alexopoulos et al. (2009), *AJP*. 
Odds Ratios for Suicidality and Suicidal Behavior for Active Drug Relative to Placebo by Age

(Stone et al, BMJ, August 2008)
Recommendations: Behavioral Interventions

- Interpersonal Psychotherapy
  - PROSPECT
  - Work of Marnin Heisel: pre-post reductions in death & suicide ideation, as well as reductions in depression symptom severity (Heisel et al. 2009).
  - IPT is useful in preventing relapse and maintaining gains in social functioning among older adults with depression (Reynolds et al. 1999; Lenze et al. 2002)
  - There are also treatment manuals specifically describing the implementation of IPT with older adults (Hinrichsen and Clougherty 2006), including a modification for older adults with cognitive impairment (Miller 2009).

Alexopoulos et al. (2009), AJP.
Recommendations: Behavioral Interventions

- Problem Solving Therapy
  - IMPACT
  - Patricia Arean and Mark Hegel: PST-PC (Arean et al. 2008).
  - PST-PC: effective at treating Major Depression and Dysthymia (Arean et al. 2008), including depressive symptoms with comorbid executive dysfunction (Alexopoulos et al. 2003).
  - The delivery of PST by social service agencies has also been shown to be effective at treating Minor Depression in older adults (PEARLS; Ciechanowski et al. 2004).
An under-studied problem

- Only **two** randomized controlled trials (RCT’s) w/effects on suicide deaths.
  - Caring Letters\(^1\)
  - SUPRE-MISS\(^2\)
- Not with older adults

SELECTIVE PREVENTION

- *High-risk groups*, though not all members bear risks – prevention through reducing risks.
Tele-Help/Tele-Check Service for the Elderly

- 18,641 service users in Padua, Italy
- January 1, 1988 thru December 31, 1998
- Mean age = 80.0 years
- 84% women, 73% lived alone
- Suicides observed = 6
  expected = 20.9
  SMR = 28.8% (p<.0001)

Among women

DeLeo et al., Br J Psychiatry 181:226-229, 2002
UNIVERSAL PREVENTION

- Focused on the *entire population* as the target – prevention through reducing risk and enhancing health.
THE COAL GAS STORY

(Keitman, 1976)

Percentage of CO in domestic gas, United Kingdom 1955-74

Hawton, June 2001
OPTIMAL SUICIDE PREVENTION =
  Indicated
  +
  Selective
  +
  Universal

“MULTI-LAYERED SUICIDE PREVENTION”
All residents age ≥ 65 in Yasuzuka, Japan
  - Pre/post and comparable town reference cohort

Intervention – 7 yrs
  - Mental health education workshops
  - Annual, voluntary screening of depression
  - 2-stage screening and referral to general practitioner for treatment with psychiatric consultation available

Results:
  - 64% ↓ in suicide risk for women, Nonsignificant for men
    - No change for men or women in reference region
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Study Details</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
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<tr>
<td><strong>ALL AGES</strong></td>
<td></td>
<td></td>
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<tr>
<td>Rutz et al. (1992)</td>
<td>Gotland Study</td>
<td>↔</td>
<td>↓</td>
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<td>Hegerl et al. (2006)</td>
<td>Nuremberg</td>
<td>↓</td>
<td>↓</td>
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<tr>
<td>Szanto et al. (in press)</td>
<td>Hungary</td>
<td>↔</td>
<td>↓</td>
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<td><strong>OLDER ADULTS</strong></td>
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<tr>
<td>DeLeo et al. (2002)</td>
<td>Telehelp/Telecheck</td>
<td>↔</td>
<td>↓</td>
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<tr>
<td>Oyama et al. (2004)</td>
<td>Joboji</td>
<td>↓</td>
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<td>Oyama et al. (2005)</td>
<td>Yuri town</td>
<td>↔</td>
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<td>Oyama et al. (2006a)</td>
<td>Yasuzuka</td>
<td>↔</td>
<td>↓</td>
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<tr>
<td>Oyama et al. (2006b)</td>
<td>Matsudai</td>
<td>↔</td>
<td>↓</td>
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<tr>
<td>Helpful Review Articles</td>
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Thank you

Contact information:

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National Resources for Suicide Prevention

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

Older American TCE Suicide Prevention Webinar
January 16, 2013
TOUGH REALITIES

- ~36,000 Americans die by suicide each year
- 1.1 million (0.05 percent) Americans (18 & older) attempted suicide in the past year
- 2.2 million (1 percent) Americans (18 & older) made a plan in the past year
- 8.4 million (3.7 percent) Americans (18 & older) had serious thoughts of suicide in the past year
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...
Individuals discharged from an inpatient unit continue to be at risk for suicide

- ~10% of individuals who died by suicide had been discharged from an ED within previous 60 days
- ~ 8.6 percent hospitalized for suicidality are predicted to eventually die by suicide
US Suicide Prevention Milestones

1996
UN Guidelines for National Strategy

1997
Congressional Resolution passed

1998
Reno Conference

1999
Surgeon General's Call to Action to Prevent Suicide

2000
$9 million grant for crisis line

2001
National Strategy for Suicide Prevention

2002
- $9 million for SPRC
- Reducing Suicide: A National Imperative by IOM

2003
PNFC Report on Mental Health

2004
- $9 million grant for crisis line
- Garrett Lee Smith Memorial Act signed

2005
- SPRC Reauthorized
- First Garrett Lee Smith Memorial Act grants

2006
- Suicide Prevention included in SAMHSA Priority Matrix
- Federal Work Group on Suicide Prevention formed

2007
- $14.5 million grant for crisis line
- Joshua Omvig Veterans Suicide Prevention Act signed

2008
- Action Alliance for Suicide Prevention explored
- Mental Health Parity signed

2010
Action Alliance for Suicide Prevention Launched
SPRC Reauthorized
National Strategy for Suicide Prevention
National Strategy for Suicide Prevention

Strategic Directions within the National Strategy for Suicide Prevention

- Strategic Direction 1: Healthy & Empowered Individuals, Families, & Communities
- Strategic Direction 2: Clinical & Community Prevention Services
- Strategic Direction 3: Preventing Suicidal Behaviors
- Strategic Direction 4: Surveillance, Research, & Evaluation

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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

**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

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

SPRC Executive Secretary Project Coordinator(s)
EXCOM Representation

- **Public**
  - Defense
  - Education
  - Health and Human Services
  - Former Federal legislator
  - Interior
  - Justice
  - Labor
  - State government official
  - VA
  - National Council for Suicide Prevention
  - Older adult services
  - Organized labor
  - Primary care
  - Social media
  - SPRC
  - Traditional media
  - Youth advocacy

- **Private**
  - Behavioral health/substance abuse
  - Business
  - Faith leader/interfaith
  - Hospitals
  - Insurance
  - Clinical
  - Consumer of mental health services
  - Philanthropy
  - Research
  - Suicide attempt survivor
  - Suicide loss survivor

- **Others**
  - Consumer of mental health services
  - Philanthropy
  - Research
  - Suicide attempt survivor
  - Suicide loss survivor
Priority 1: Update/implement the Surgeon General’s NSSP by 2012

Priority 2: Public awareness and education

Priority 3: Focus on suicide prevention among high-risk populations

3 categories of Task Forces have been developed:

- Infrastructure: To support suicide prevention for all populations
- High Risk Populations: Showing increasing or disproportionately high rates of deaths by suicide or attempts (e.g. AI/AN)
- Interventions: Specific suicide prevention domains or settings (e.g. quality clinical care, faith communities, clinical workforce preparedness)
ACTION ALLIANCE RECOMMENDS
3 PRIORITY AREAS FOR CMS CONSIDERATION

→ **Issue One:** Too many missed opportunities to save lives in primary care settings

→ **Issue Two:** Millions of Americans still lack access to evidence-based care and BH professionals that can reduce suicidal behavior

→ **Issue Three:** Too many discharged from EDs/inpatient units following suicide crisis at significantly elevated risk yet 50 percent referred to care following discharge do not actually receive outpatient treatment
National Suicide Prevention Lifeline
1-800-273-TALK

- Answered over 700,000 calls in 2011
- More than 3 million total
- 152 local crisis centers
- In response to evaluation findings, created the Crisis Center Follow-up Grants
- Developed risk assessment standards and guidelines for callers at imminent risk
Crisis Center Follow-up Evaluation

- 43% of suicidal callers experienced some recurrence of suicidal ideation within several weeks following the initial call.
- Upon follow up, only **22.5% of the suicidal callers had been seen by the behavioral healthcare system to which they had been referred and an additional 12.6% had an appointment scheduled but had not yet been seen.**
- Led to grants to Lifeline crisis centers to follow up suicidal callers.
- When asked to what extent the counselor’s call stopped them from killing themselves, **53.7%** indicated a lot, and **25.1%** indicated a little.
- When asked to what extent the counselor call has kept them safe, **60.8%** indicated a lot, and **29.3%** indicated a little.
- **59.8%** reported that just getting or anticipating the call(s)/knowing someone cared was helpful to them.
Veterans and Suicide

• SAMHSA/VA partnership
• 800-273-TALK “press one”
• Veteran’s Crisis Line received 13,250 calls per month
  – 70% of whom identified themselves as veterans, service members, or their friends and family members.
• 7,000 emergency rescues of veterans attempting suicide.
• One in five suicides is by a veteran.
  – 18 veteran suicides each day, 1 in 3 in VHA
  – 950 suicide attempts each month
  – Suicide rate for veterans age 18-29 who use VA healthcare services are lower than those who do not per VA
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 Assessment Five-step Evaluation Triage

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

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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
   Determines 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 I 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 (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.
   ✓ 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/lack of plan to be lethal vs. self-injurious, Explore ambivalence reasons to live 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 diagnoses with severe symptomatology, crisis precipitating event, protective factors not present</td>
<td>Potentially lethal suicide attempt or persistent plan with strong intent or suicide reenactment</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, low 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>

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). timeframe instructions, if relevant: follow-up plan.

This chart is designed to represent a range of risk levels and interventions, not actual discrimination.
SPARK Toolkits

Suicide Prevention Assessment and Resource Toolkits

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

• Preventing Suicide: A Toolkit for High Schools
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](http://store.samhsa.gov/product/SMA09-4381)
• Training video: SAMHSA YouTube channel
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Suicide Prevention Resource Center
National Action Alliance for Suicide Prevention
The Genesis of ECC

- Unmet need among community older adults
- Myths and stigma perpetuated the problem
- Lack of access to services
- Services were not person-centered
- Services were fragmented
- There was a need for community-based comprehensive coordinated services
- Community Foundation Planning Grant
Attributes of a Successful Inter-Agency Team

- Common Goals / Shared Vision
- Complimentary Strengths and Assets
- Personality and Organizational Culture Fit
- Agency and Staff Commitment
- Flexibility
- Boundaries
- Champion
- Champion
Key Ingredients of the Model

- Multi-agency
- Business Associate Agreements
- Outreach to home-bound older adults
- Aging services as entry point
- Aging services offers in-home depression screening
- Mobile assessment and counseling
- Telecheck
- 24-hour crisis team
Process Outcomes
SAMHSA Grant: 2008-2011

- 62% of referrals to mental health came from BayPath (aging) programs
- ~700 consultations to referral sources
- 585 referred to mental health services
- >400 received 1+ in-home visit
  - Avg. 5 mental health home visits/person
- >2,400 Outbound Telecheck calls
  - 71 Telecheck recipients
Decreased Depression
SAMHSA Grant: 2008-2011

PHQ-9 scores in minimal range:
pre: 26.3%, post: 53.8% \( p < .001 \)
Selected Outcomes by Telecheck Participation

Client Functioning, Met Criteria (n=95)

Socially Connected, Met Criteria (n=96)

Suicide/death Ideation, Met Criteria (n=63)
Samaritans

- Suicide prevention agency
- Use non-judgmental, active listening
- Provide emotional support and validation
- Telecheck volunteers receive additional training and are over age 60
Special thanks to Martin Harris, PhD, the University of Tasmania Department of Rural Health, and the Australian Government, Department of Health & Ageing for permission to use and adapt these TeleCheck forms.
Telecheck Domains

Physical

- Health: ☑ ..*hospitalized for stroke*..
- Mobility: ☑ ......*uses walker*.......... 
- Sleep: ☐ ................................................................
- Medication: ................................................................
- Other: ☐ ..................................................................
Telecheck Domains

Emotional

- Grief/Loss:  □  ........................................
- Transitions:  □  ........................................
- Age issues:  □  ........................................
- Relationships:  ........................................
- Suicide History:  …2 attempts in early 30s
Anatomy of a Call

- Introduction & Name exchange
- Info from “Domains” used as prompts for new clients
- On-going follow-up
- Closing remarks, wind-down
- Ask if client would like a future call
Collaboration to form a Safety Net
Please send questions via WebEx Chat
Older Americans Behavioral Health Webinar and Issue Briefs Series are available on AoA, NCOA, NASUAD and NASMHPD websites.

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