Suicide Prevention and Older Adults

Speakers:

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SUICIDE PREVENTION IN LATER LIFE

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Disclosures

- Conflicts of interest - none

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K23MH096936 NIMH Kimberly Van Orden, PhD

and many more…….
“My work is done. Why wait?”

George Eastman
March 14, 1932
Age 77
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.
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>
</tr>
</thead>
<tbody>
<tr>
<td>5-14</td>
<td>1.5</td>
<td>0.4</td>
</tr>
<tr>
<td>15-24</td>
<td>22.0</td>
<td>4.9</td>
</tr>
<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>43.8</td>
<td>9.6</td>
</tr>
<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>
</tr>
</tbody>
</table>

World Health Organization, 2002
Suicide rates among all persons by age and sex--United States, 2010

Source: CDC vital statistics
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.
- Suicidal behavior is more lethal in later life than at other points in the life course.
Self-inflicted injury among all persons by age and sex – United States, 2007

Rate per 100,000 population

Age Group in years


Source: CDC WISQARS NEISS
ATTEMPTED : COMPLETED SUICIDE

General population

1
5
30

Deaths

Hospitalizations

Emergency Dept visits

Older adults

1
2
4

Deaths

1

Hospitalizations

2

Emergency Dept visits

4
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
METHODS OF SUICIDE IN THE U.S.

Total

Age > 65

- **FIREARMS**
- **Hanging, Strangulation, suffocation**
- **Solid & 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 (indicated)
  - More distal prevention is key (selective and universal)
As the largest and most rapidly growing 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?
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
What to look for: Risk factors

Axis I
- psychopathology

Axis II
- personality, coping style

Axis III
- physical health

Axis IV
- social context

Axis V
- functioning
## RISK FACTOR: Psychiatric Dx in case/control studies of suicide in later life

<table>
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<tr>
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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>28.6</td>
<td>14.0</td>
<td></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*
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
## 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

![Graph showing the estimated relative risk of suicide associated with the number of illnesses. The x-axis represents the number of illnesses (0-7), and the y-axis represents the estimated relative risk of suicide. The graph includes a table with the number of cases and controls for each number of illnesses.](image_url)
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)
Axis I
- psychopathology

Axis II
- personality, coping style

Axis III
- physical health

Axis IV
- social context

Axis V
- functioning

Elderly man with chronic back pain and anxious, neurotic personality style.

Elderly widower with rigid, constricted coping, macular degeneration, and depression, learns he can no longer drive.

Recently bereaved older woman, disabled and homebound by arthritis, with no social network on which to call for support.
PREVENTION FRAMEWORK

**HOW** DO WE PREVENT SUICIDE IN ELDERS?

(Approaches to Prevention)
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**

- Because of the close association between depression and suicide in older adults
  - detection and effective treatment of depression are key

- Routine screening for depression
  - PHQ-9, GDS, CES-D

- Depression treatment is effective
  - Including at reducing suicidal ideation and maybe suicide rates

- Aging services’ coordination with primary care and mental health care is essential
Delivery system reform

INTEGRATED CARE NETWORKS

Community

Primary Care Service System (PCMH)

Mental Health Services

Aging Services Network (ASN)
Delivery system reform

INTEGRATED CARE NETWORKS

Primary Care Service System (PCMH)

Mental Health Services

Aging Services Network (ASN)

Community
Healthy Ideas
Identifying Depression, Empowering Activities for Seniors

- An evidence-based program that integrates depression detection & management into existing care management services
  - Depression screening
  - Psychoeducation (incl caregivers)
  - Linkage to primary care & mental health
  - Behavioral activation

http://careforelders.org/default.aspx/Menu ItemID/492/MenuGroup/.htm

Proven Impact

Healthy IDEAS is a national model with measurable results and demonstrated benefits for older adults, service providers and community mental/behavioral health practitioners.

FOR OLDER ADULTS:
- Fewer symptoms of depression
- Decreased physical pain
- Better ability to recognize and self-treat symptoms
- Improved well-being through achievement of personal goals

FOR SERVICE PROVIDERS:
- Expanded capacity to address depression
- Better communication and stronger partnerships with mental health providers
- Opportunity to deliver a proven, successful program that addresses critical client needs
- Improved staff knowledge and confidence in helping clients

FOR COMMUNITY MENTAL/BEHAVIORAL HEALTH PARTNERS:
- Increased opportunity to work with diverse populations of older adults
- Strengthened connections to community agencies
- Greater opportunity to reach and help underserved older adults

Why Healthy IDEAS?

Healthy IDEAS brings together community service providers, the mental/behavioral health community and healthcare practitioners to provide a low-cost, practical way for addressing depression among older people.

Healthy IDEAS is a proven program that can be flexibly integrated into the regular routines of existing staff. Special training and detailed tools to deliver the program are available at minimal cost. Healthy IDEAS can be used with older adults of any age, race or economic status.

Healthy IDEAS also offers an opportunity to create or strengthen partnerships between public and private service providers, funding organizations, and academic institutions to achieve meaningful and significant benefits for older adults and their families.

Recognition

The U.S. Administration on Aging has designated Healthy IDEAS as an evidence-based program and recommends it for nationwide replication. Healthy IDEAS has also received a Substance Abuse and Mental Health Services Administration (SAMHSA) Science to Service Implementation Award in the mental health category.

How it Works

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is an evidence-based program that integrates depression awareness and management into existing case management services provided to older adults.

HEALTHY IDEAS IMPROVES QUALITY OF LIFE BY:
- Screening for symptoms of depression and assessing their severity
- Educating older adults and caregivers about depression
- Linking older adults to primary care and mental health providers
- Empowering older adults to manage their depression through a behavioral activation approach that encourages involvement in meaningful activities

“Healthy IDEAS was the answer to our prayers. We knew we wanted to address depression and this was an evidence-based intervention with proven results. Healthy IDEAS fits well into our case management program and really helped reduce our clients’ depression and pain.”

PROGRAM DIRECTOR, Sheltering Arms Senior Services, Houston, TX
“Open Door”

- Brief, individualized intervention to identify & address barriers to engagement in MH treatment for older adults whose depression was detected by aging services.
  - Major Depression 51%
  - Suicide ideation 29%

Open Door

5 steps in Open Door:

1. Recommend referral for MH treatment
2. Conduct barriers assessment
3. Define personal goal (that could be achieved with MH care)
4. Provide education about depression treatment options
5. Address barriers to accessing care.
### Abbreviations:
PE, psychoeducation; PST, problem-solving therapy; MI, motivational interviewing.

### Table 1: Examples of Open Door intervention

<table>
<thead>
<tr>
<th>Psychologic barrier</th>
<th>Open Door intervention activity</th>
<th>Source of technique (PST, MI, or PE)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal stigma concern:</td>
<td>Validate concern (stigma is real!)</td>
<td>MI – reflective listening and empathy</td>
<td>Support</td>
</tr>
<tr>
<td>“My neighbor will not include me if she thinks I’m crazy.”</td>
<td>Define clear options</td>
<td>PST – brainstorming</td>
<td>More hope</td>
</tr>
<tr>
<td></td>
<td>Emphasize personal choice</td>
<td>MI – collaboration</td>
<td>Less helplessness</td>
</tr>
<tr>
<td></td>
<td>Review pros and cons of each option</td>
<td>PST – identify pros and cons and compare</td>
<td>Action plan</td>
</tr>
<tr>
<td>Treatment efficacy concerns:</td>
<td>Identify hopeless as symptoms of depression</td>
<td>PE – education about depression</td>
<td>Increase in knowledge</td>
</tr>
<tr>
<td>“What’s talking going to do? Nothing can change.”</td>
<td>Identify what she wishes to change</td>
<td>PST – identify a goal</td>
<td>Increased motivation</td>
</tr>
<tr>
<td></td>
<td>Link goal with treatment outcome</td>
<td>PE – review psychotherapy efficacy data and discuss the process of seeking care</td>
<td>Engagement</td>
</tr>
<tr>
<td>Attribution of depression symptoms:</td>
<td>Validate overlap of medical and psychologic symptoms</td>
<td>PE – depression symptom and medical symptom overlap</td>
<td>Increased knowledge</td>
</tr>
<tr>
<td>“It’s the diabetes and my age that cause my troubles”</td>
<td>Describe symptoms of depression</td>
<td>PE – information on depression</td>
<td>Increased perceived need for treatment</td>
</tr>
<tr>
<td></td>
<td>Review myths and potential for misattribution</td>
<td>PE – discuss myths and stereotypes</td>
<td></td>
</tr>
</tbody>
</table>
PEARLS
The Program to Encourage Active & Rewarding Lives for Seniors

- PEARLS is an evidence-based program designed to improve the detection and treatment of late-life depression within aging services.
  - Problem Solving Therapy, Activity Scheduling, plus collaborative depression care management by a multidisciplinary team

http://www.pearlsprogram.org
PEARLS
% with at least a 50% reduction in depression severity score at 6 month f/u

Usual Care, n=66  PEARLS, n= 72

SPECTRUM OF ASN DEPRESSION CARE

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Sever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness complexity (severity; med comorbidity)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

ASN CAU

Augmented ASN CAU (E.g., PEARLS)

Collaborative Care Management (ASN + MH + PC)
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

- Among women

DeLeo et al., Br J Psychiatry 181:226-229, 2002
Elder Community Care can provide:

- Comprehensive mental health/substance abuse assessment
- In-home counseling
- Telephone call befriending service (TeleConnect)
- In-home personal monitoring system (TeleHelp)
- Access to 24 hour emergency response
- Medication management by a psychiatric nurse practitioner.
- Referral to community resources and services

http://www.eldercommunitycare.org/
While there are other organizations that respond to the needs of people who may be contemplating suicide, none provides the type of services that IOA’s Friendship Line offers to respond to the public health problem of suicide among the elderly. Knowing that older people do not contact traditional suicide prevention centers on a regular basis even if they are considering suicide, we created the only program nationwide that reaches out to lonely, depressed, isolated, frail and/or suicidal older adults, encouraging conversations rather than confrontation with depressed older people.

Traditional suicide prevention Hot Lines state that they serve the needs of all community members across the life-span. However, we are the only one that specializes in the needs of those individual 60 years of age and older. Not only do we receive calls to our 24-hour Friendship Line, the only accredited crisis line in the country for seniors and adults with disabilities, but we also make on-going outreach calls to lonely older adults.

National - 800.971.0016
Local - 415.752.3778
THE SENIOR CONNECTION (TSC)

U01 CE001942-01

- **OBJECTIVE:** To examine whether linking socially disconnected seniors with peer supports is effective in reducing risk for suicide.

- **DESIGN**
  - Sample: Primary care patients ≥60 yrs who self-identify as lonely or a burden on others
  - RCT comparing
    - CAU (n=200)
    - TSC (n=200) – peer companion
TSC Intervention – Anticipated Outcomes

- Reduced...
  - Loneliness, burdensomeness (psychological disconnectedness)
  - Depression, SI, worthlessness

- Improved ...
  - Structural connectedness
  - Physical health
  - Well-being
UNIVERSAL PREVENTION

- Focused on the *entire population* as the target – prevention through reducing risk and enhancing health.
QPR
Question, Persuade, Refer

- Considered a “best practice” intervention
  - by SAMHSA & Suicide Prevention Resource Center

- Target of intervention is *gatekeepers*

- 1 to 2 hour education program
  - Think CPR but for suicide prevention.

- Empirically shown to increase:
  - Knowledge and self-efficacy about helping identify and refer suicidal individuals, including older adults

Wyman et al., (2008); Matthieu et al. (2008); Cross et al. (2011)
QPR

1) Teaches the warning signs of a suicidal crisis.

2) Teaches how to respond:
   
   **Question the individual’s desire or intent regarding suicide**
   
   **Persuade the person to seek and accept help**
   
   **Refer the person to appropriate services**
QPR

- Developer is Paul Quinnett, PhD
- qinstitute@qwestoffice.net
- www.qprinstitute.com
Warning Signs of Acute Risk

- Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and or,

- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,

- Talking or writing about death, dying or suicide, when these actions are out of the ordinary.
Warning Signs
American Association of Suicidology

**IS**
- Ideation
- Substance Abuse

**PATH**
- Purposeless
- Agitation
- Trapped
- Hopelessness

**WARM**
- Withdrawal
- Anger
- Restlessness
- Mood changes
1-800-273-TALK

National Suicide Prevention Lifeline

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

Suicide Is Preventable.
Call the Lifeline at 1-800-273-TALK (8255).

With Help Comes Hope
OPTIMAL SUICIDE PREVENTION =

Indicated + Selective + Universal

“MULTI-LAYERED SUICIDE PREVENTION”
OPTIMAL SUICIDE PREVENTION =

Indicated – *detect and treat depression*

+ 

Selective – *optimize independent functioning, increase social connectedness*

+ 

Universal – *education to reduce ageism, gatekeeper programs*
Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities.

HHS Publication No. SMA 4515, CMHS-NSPL-0197. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

http://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515
Suicide in late-life is not an expected or “normal” response to the stresses of aging

**Risk**
- psychiatric illness
- social disconnectedness
- functional impairment
- physical illness
- pain

**Resiliency**
- Positive emotions
- Emotion regulation
- Closeness in relationships

Charles & Carstensen (2010) ; Gatz et al. 1996

Helpful Review Articles


Thank you

Contact information:

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Promoting Emotional Health and Preventing Suicide: Toolkits for Providers of Services for Older Adults

September 17, 2015

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Substance Abuse and Mental Health Services Administration
Rosalyn.blogier@samhsa.hhs.gov

Chris Miara, M.S., Senior Project Director,
Suicide Prevention Resource Center
cmiara@edc.org
Creating the Toolkits
Asbury Summit

It Takes a Community: A Summit on Opportunities for Mental Health Promotion and Suicide Prevention in Senior Living Communities

October 15-16, 2008

“It Takes a Community”
Report on the Summit on Opportunities for Mental Health Promotion and Suicide Prevention in Senior Living Communities

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*
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)