A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

www.samhsa.gov • 1-877-SAMHSA-7

Suicide Prevention

OLDER AMERICANS
Behavioral Health
Technical Assistance Center

Funded by SAMHSA
in collaboration with AoA

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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

Center for the Study and Prevention of Suicide

CSPS

Suicide in Older Adults: Who is at risk and what can we do about it?

Suicide Prevention Webinar

January 16, 2013

Yeates Conwell, MD
Professor of Psychiatry

Kimberly Van Orden, PhD
CSPS Fellow

University of Rochester School of Medicine
Rochester, NY USA

MEDICINE *of* THE HIGHEST ORDER

UNIVERSITY *of* ROCHESTER MEDICAL CENTER

Disclosures

Yeates Conwell, MD
Kimberly Van Orden, PhD

- 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

and many more……

“My work is done. Why wait?”

George Eastman

March 14, 1932

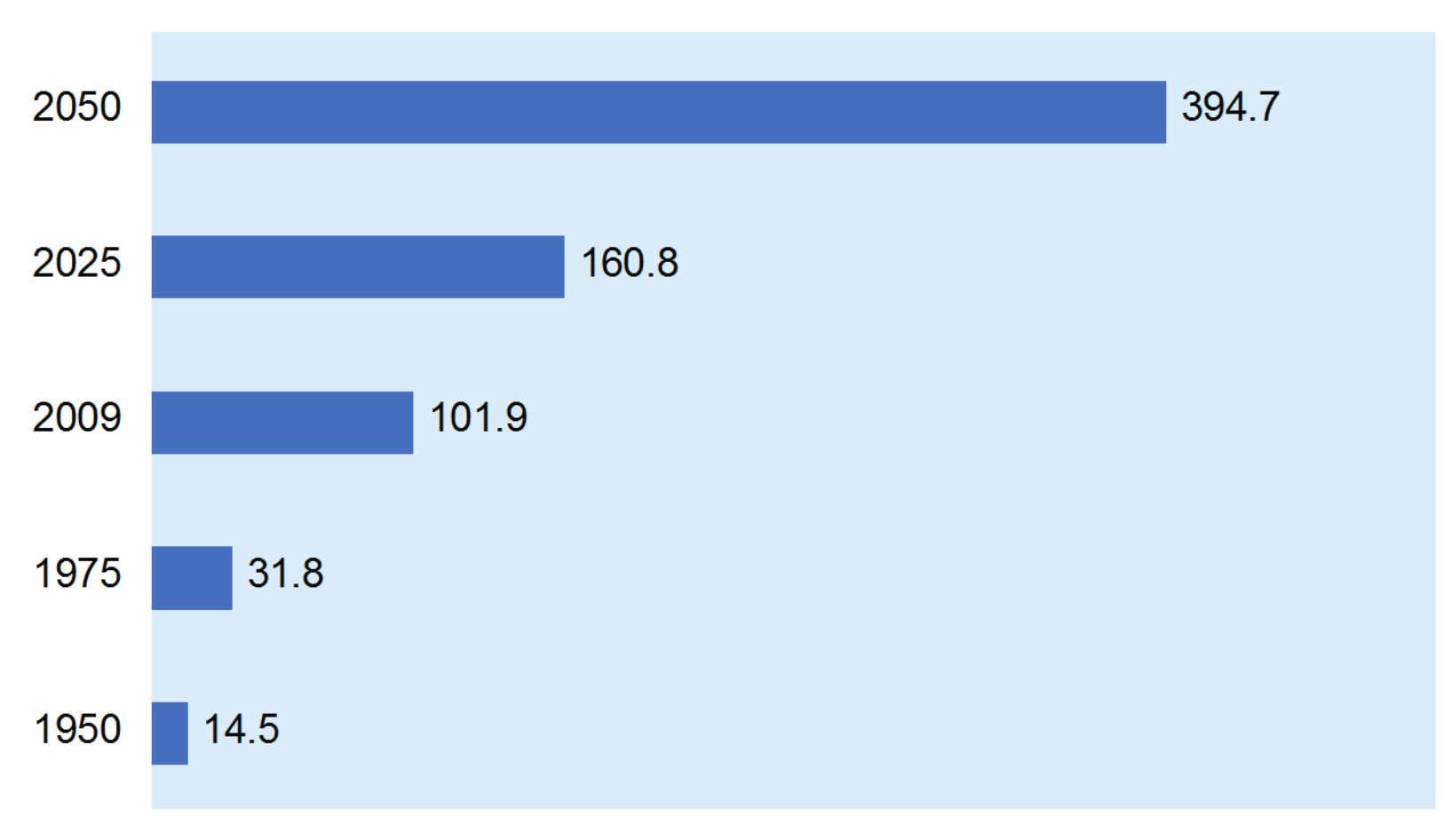
Age 77

PREVALENCE OF LATE-LIFE SUICIDE

Significance

- Older adults are the most rapidly growing segment of the population.

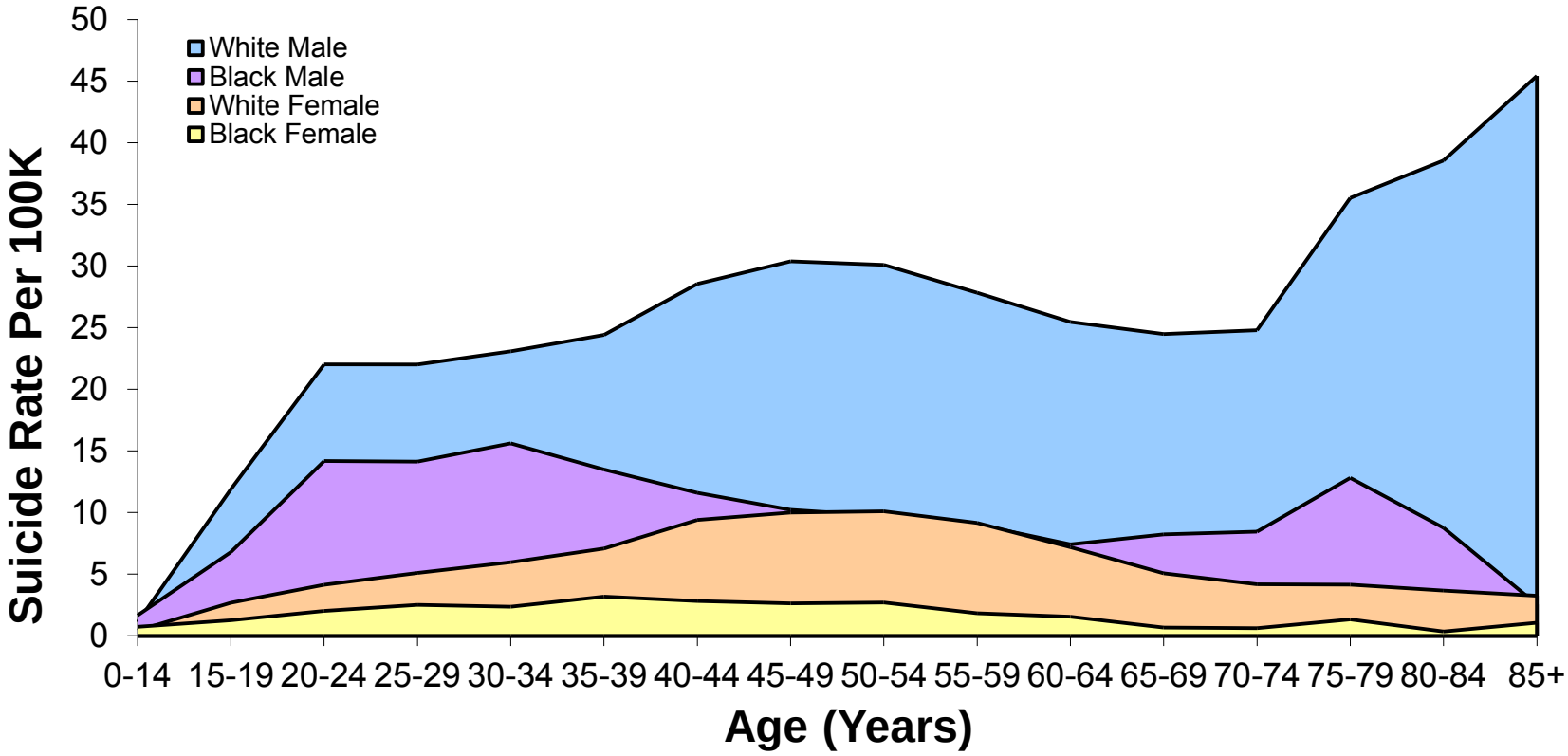
Population aged 80 or over: world, 1950-2050 (Millions)



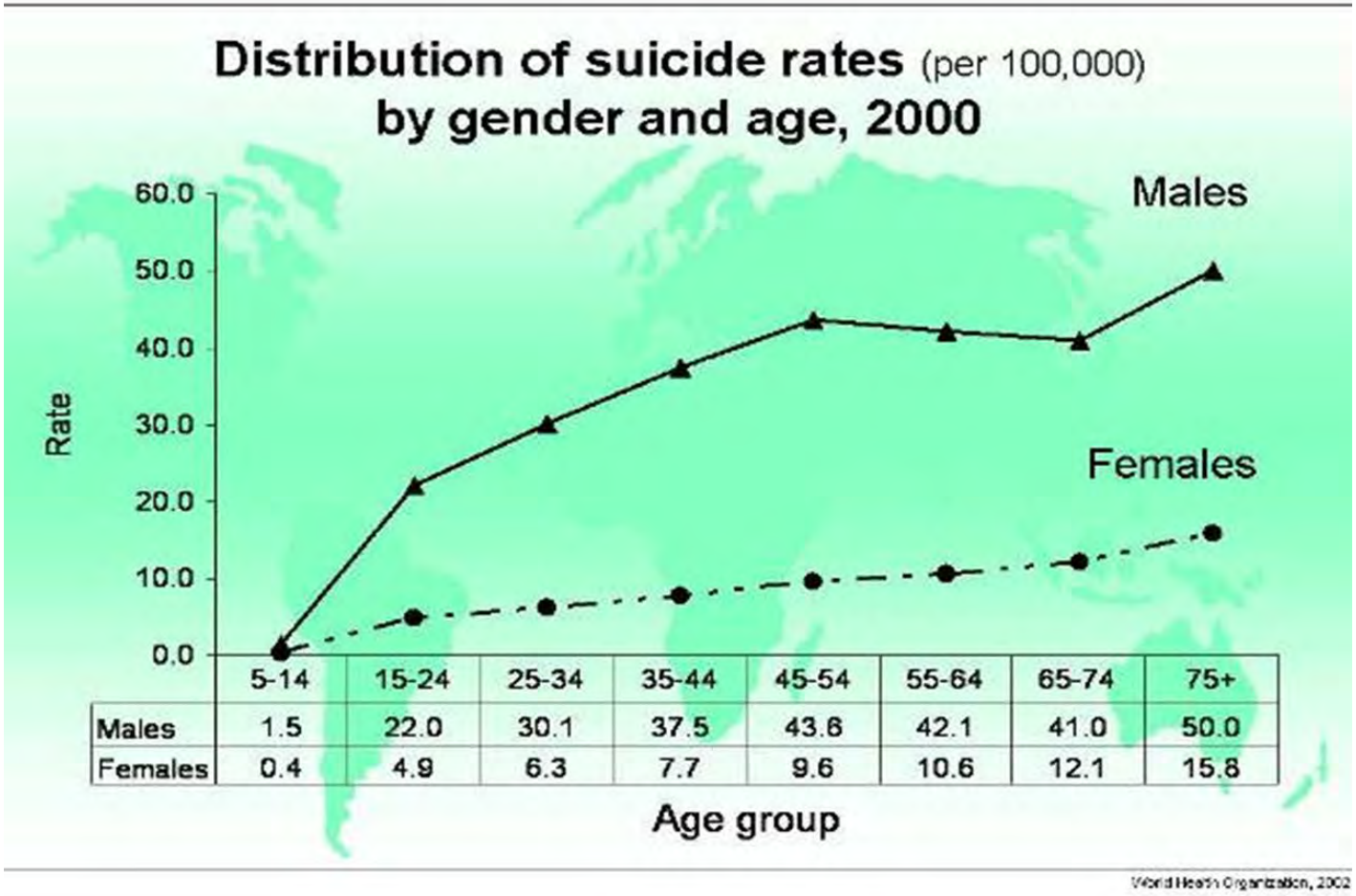
Significance

- 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



Worldwide Suicide Rates, WHO

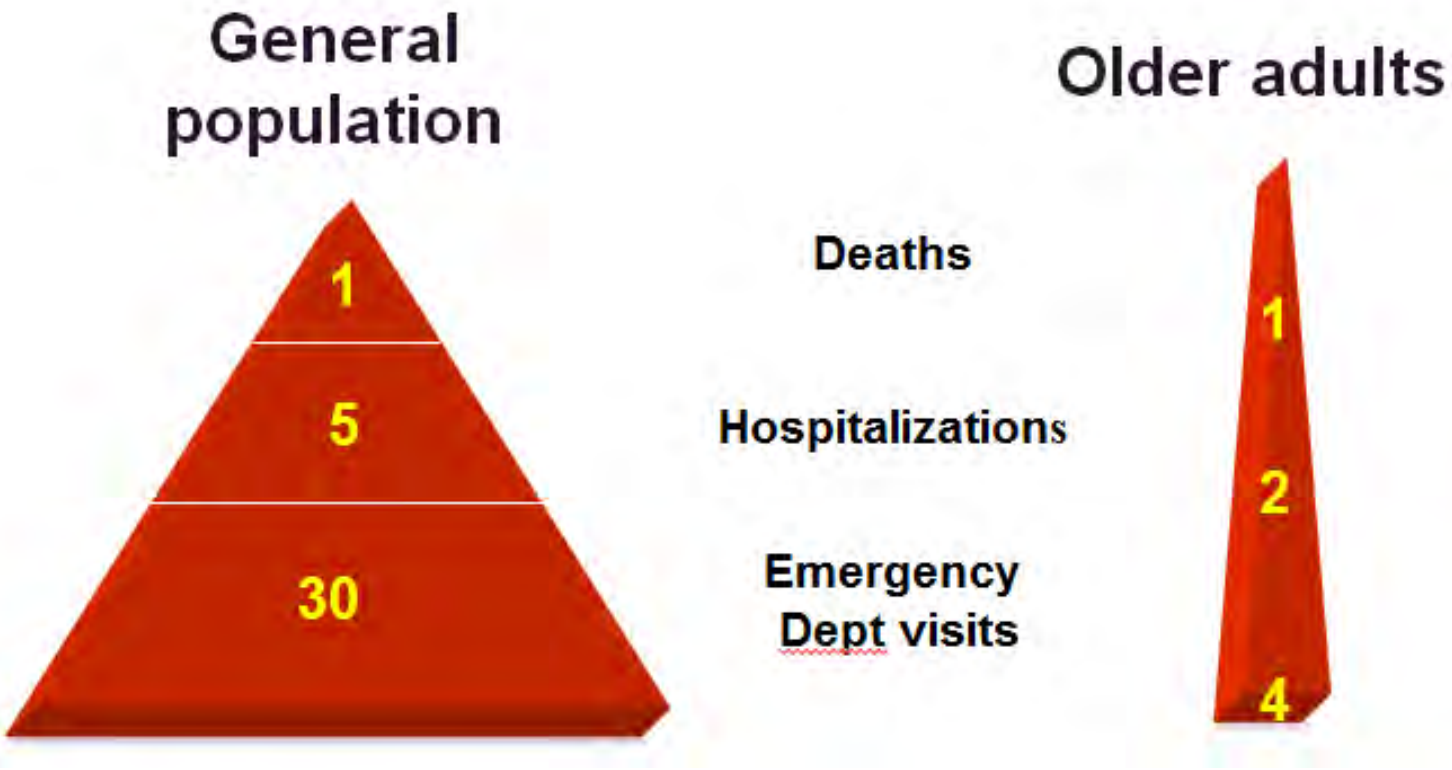


	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+
Males	1.5	22.0	30.1	37.5	43.6	42.1	41.0	50.0
Females	0.4	4.9	6.3	7.7	9.6	10.6	12.1	15.8

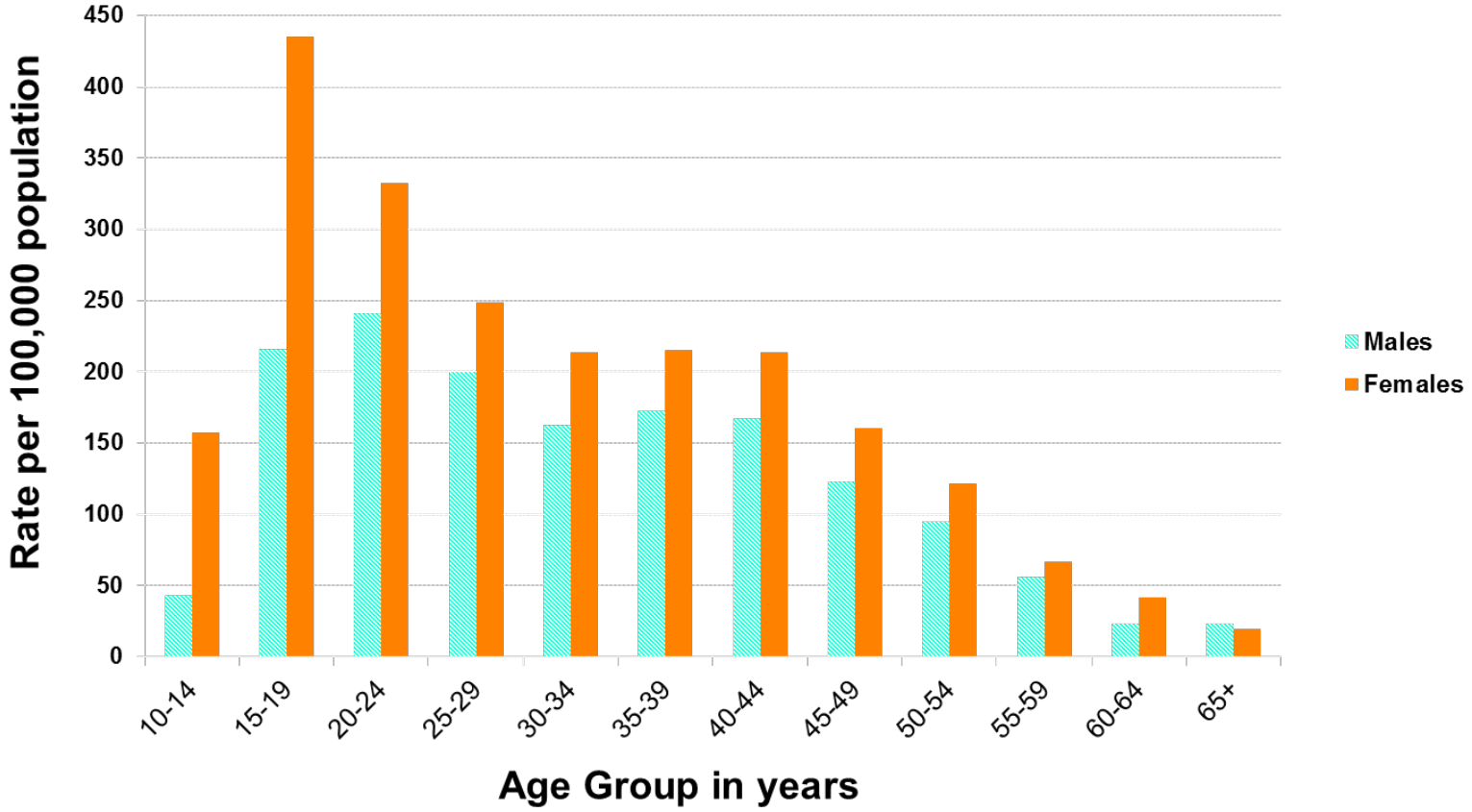
LETHALITY OF LATE LIFE SUICIDE

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

ATTEMPTED : COMPLETED SUICIDE

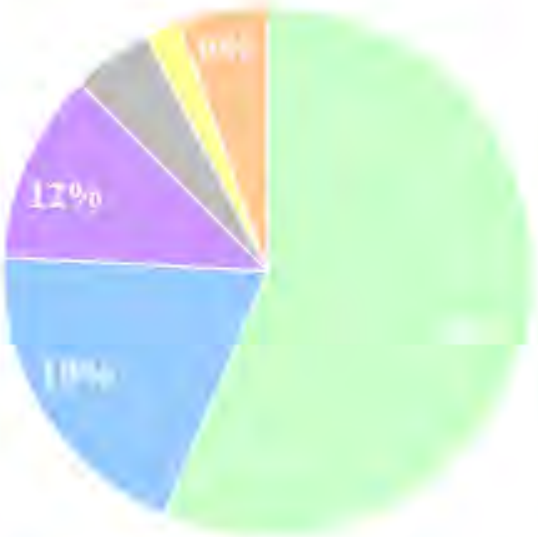


Self-inflicted injury among all persons by age and sex – United States, 2007



METHODS OF SUICIDE IN THE U.S

Total



- FIREARMS
- Hanging, Strangulation, suffocation
- Solid and liquid poisons
- Gas Poisons
- Jump from high place
- All other methods

Age > 65

LETHALITY OF LATE LIFE SUICIDE

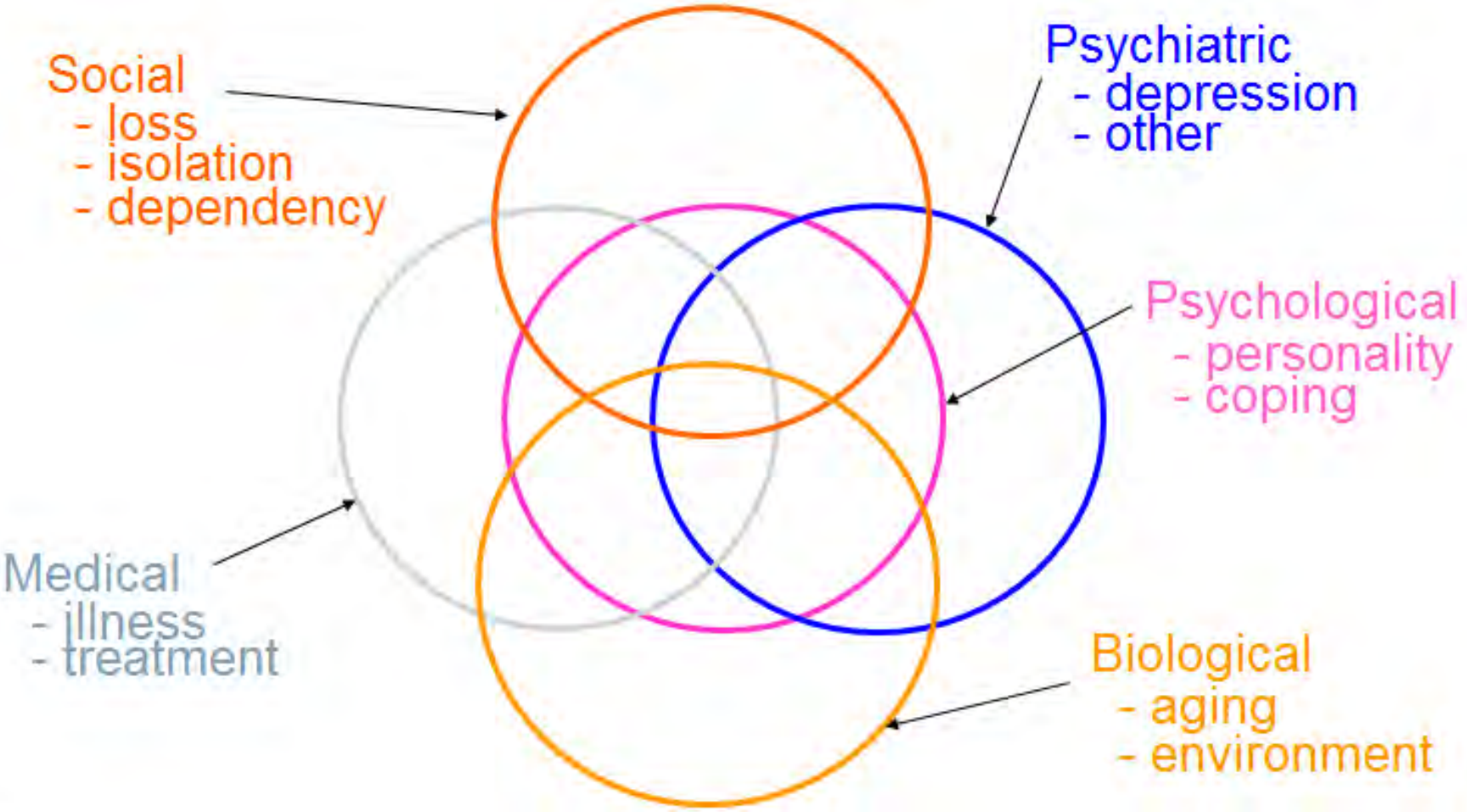
- Older people are
  - more frail (more likely to die)
  - more isolated (less likely to be rescued)
  - more planful and determined

- **Implying**
  - **interventions must be aggressive**
  - **primary and secondary prevention are key**

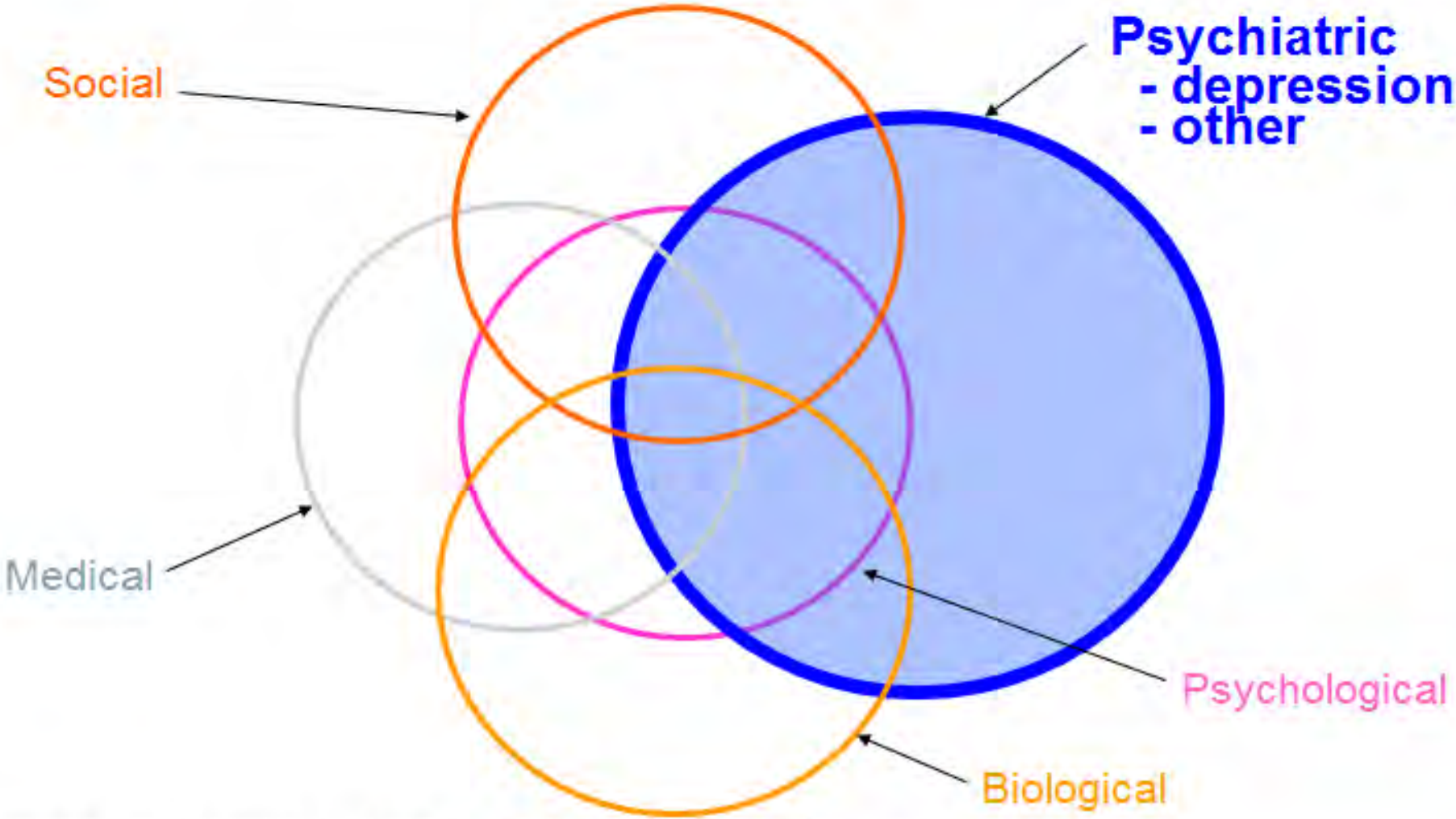
As the largest and most rapidly segment of the population enters the stage of life with highest risk for suicide, we should expect the total number (and proportion) of late life suicides to *increase dramatically* in coming decades.

WHAT CAN WE DO ABOUT IT?

DOMAINS OF SUICIDE RISK IN LATER LIFE



DOMAINS OF SUICIDE RISK IN LATER LIFE



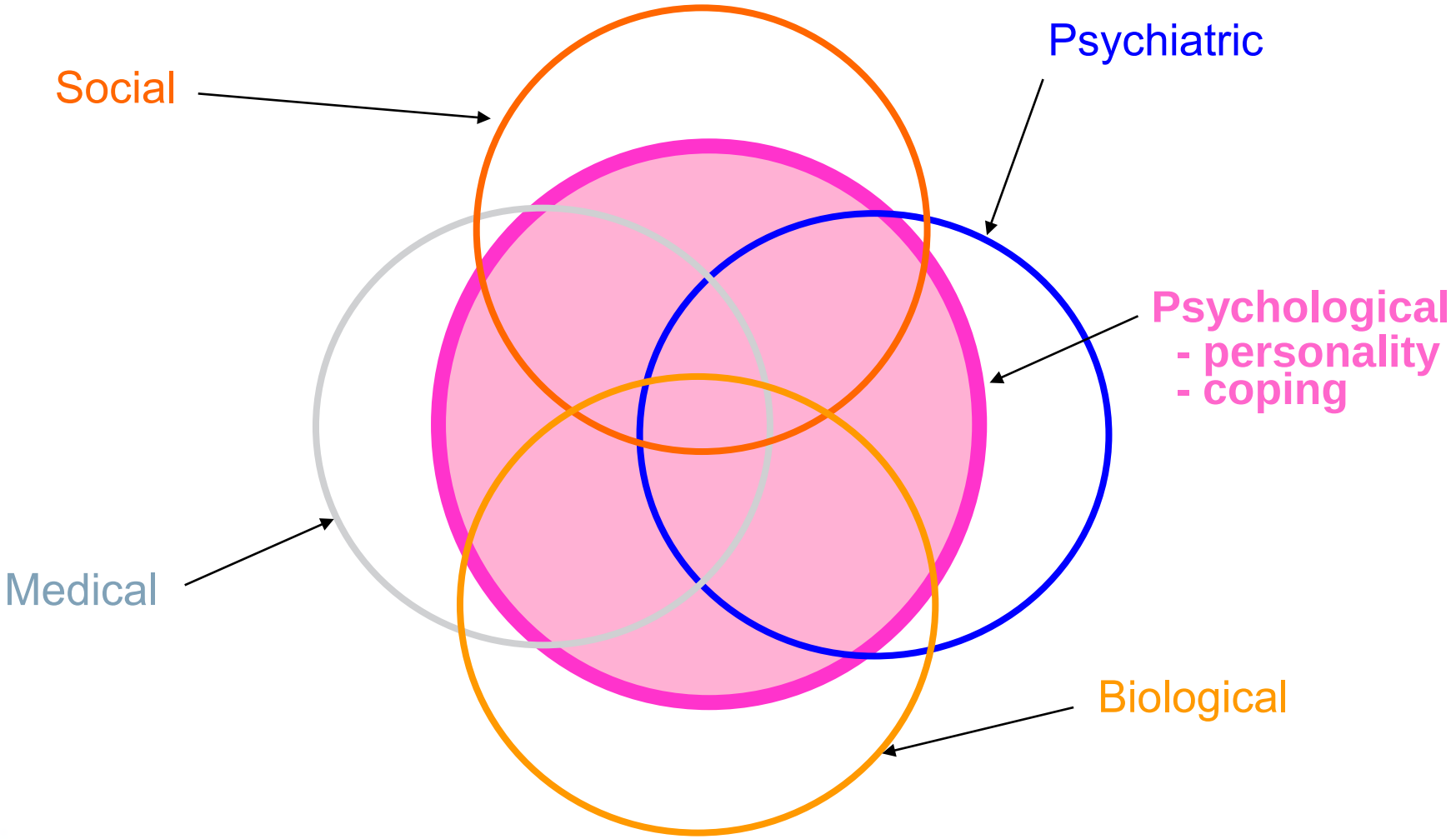
Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986

RISK FACTOR: Psychiatric Dx

Odds Ratio	Harwood et al 2001	Beautrais 2002	Waern et al 2002	Conwell et al 2003	Chiu et al 2004
Any Axis I dx	--	43.9	113.1	56.0	50.0
Any mood d/o	4.0	184.6	63.1	56.0	59.2
Maj dep episode	--		28.6	14.0	36.3
Subst use d/o	ns	4.4	43.1	3.0	ns
Anxiety disorder	--	--	3.6	3.0	ns
Schiz spectrum	ns	--	10.7	ns	>1
Dementia/del	0.2	--	ns	ns	ns

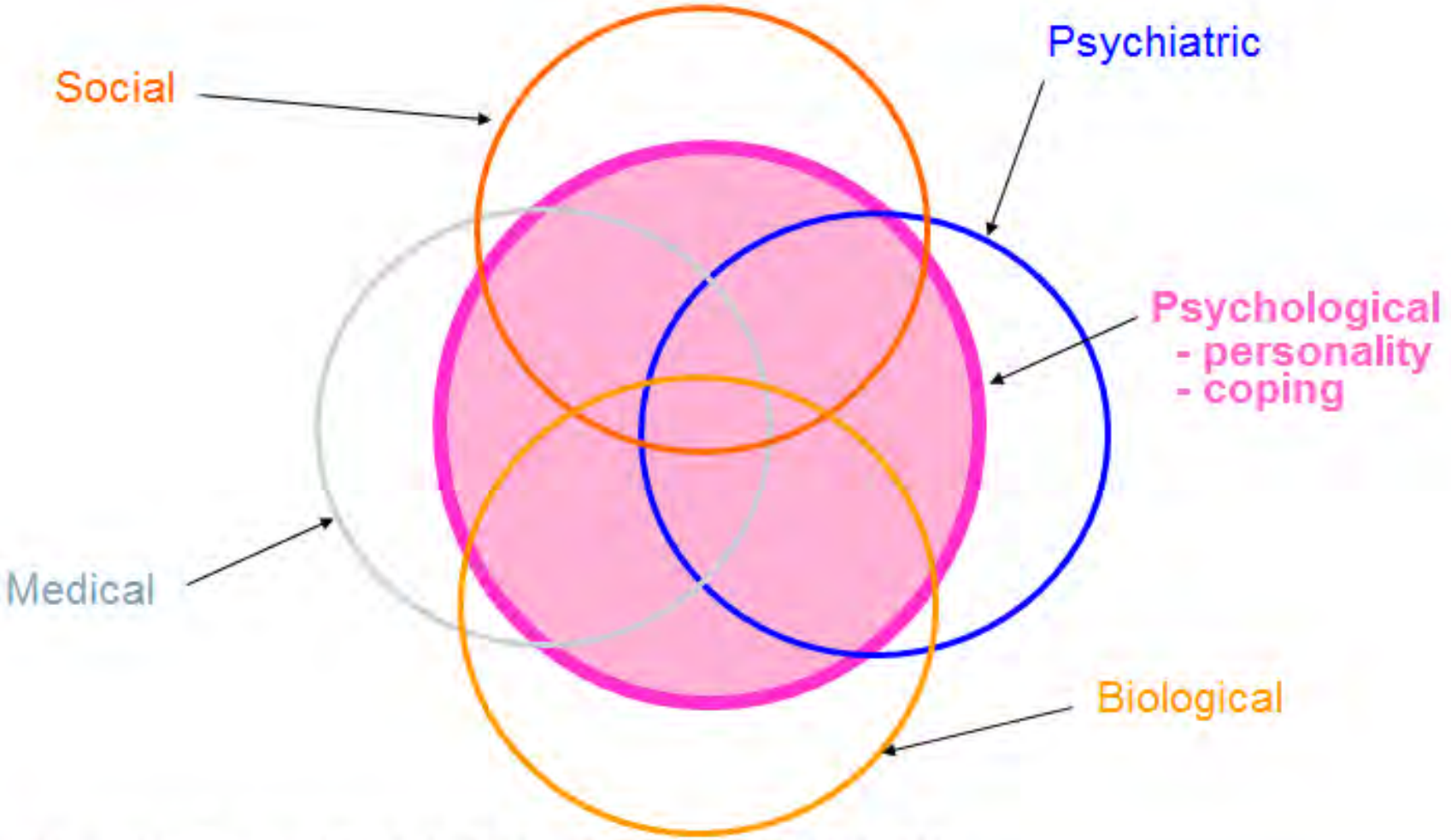
ns = not significant

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

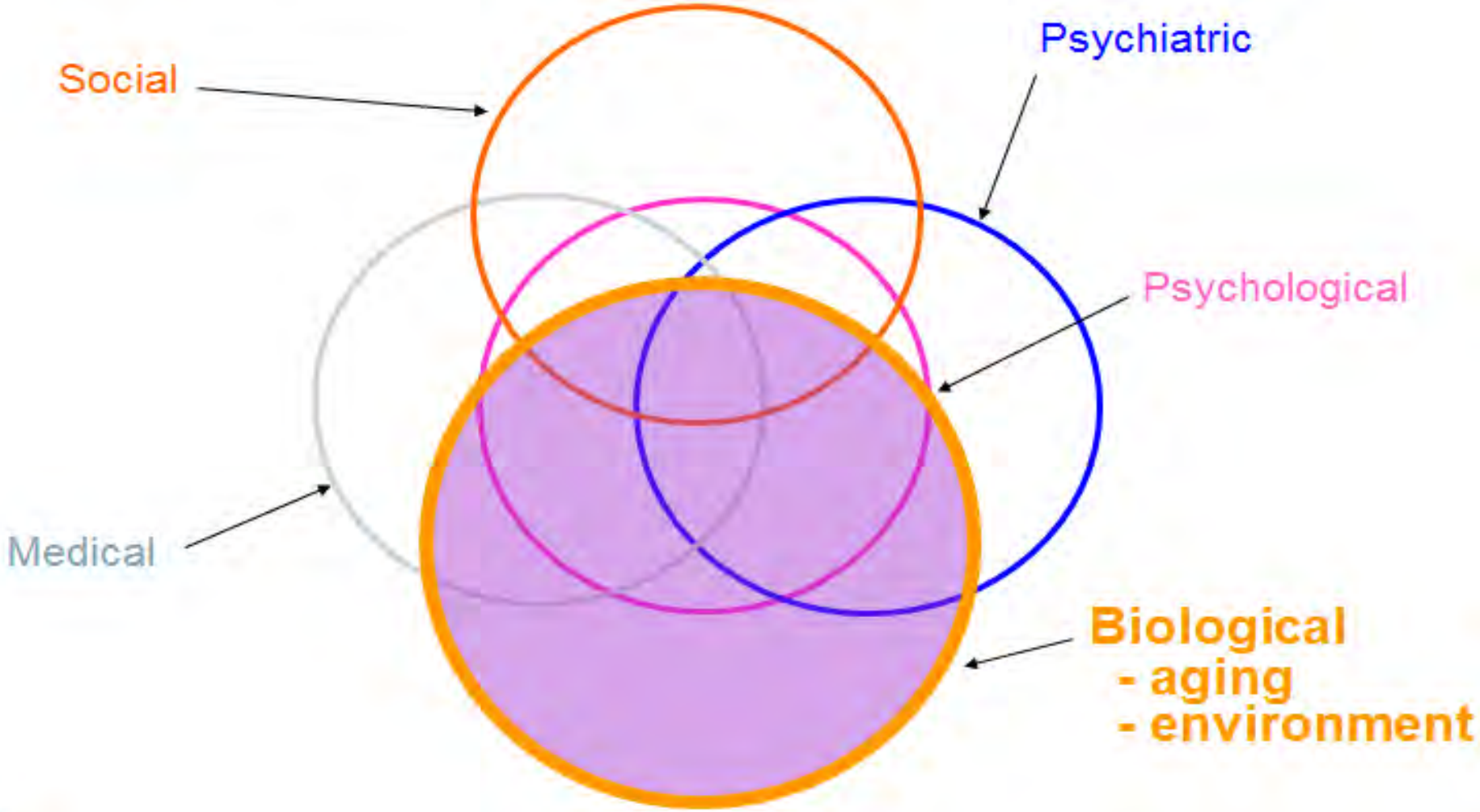


Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986

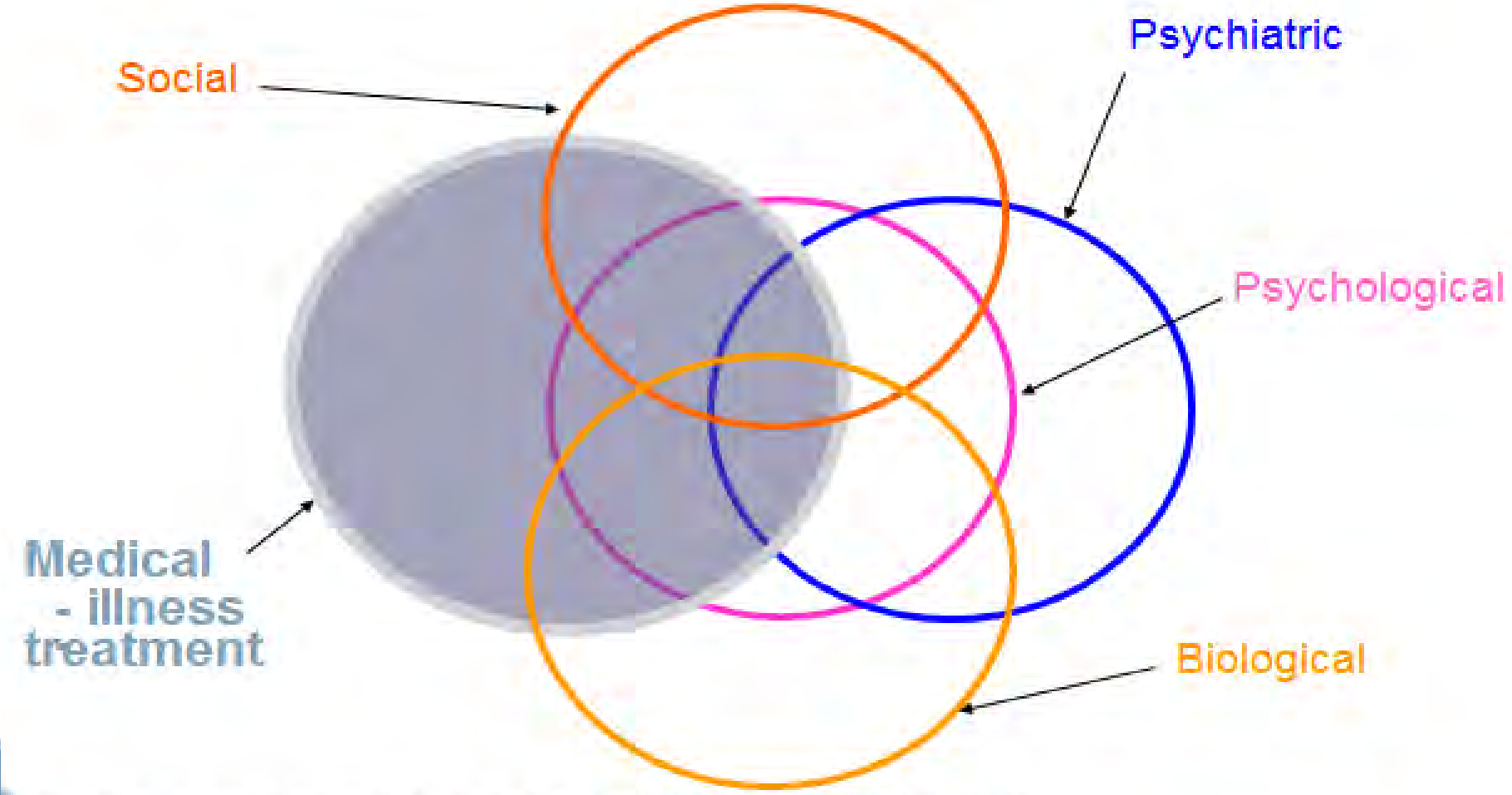
Personality Traits In Later Life Completed Suicides

- 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



DOMAINS OF SUICIDE RISK IN LATER LIFE



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

Suicide and Medical Illness

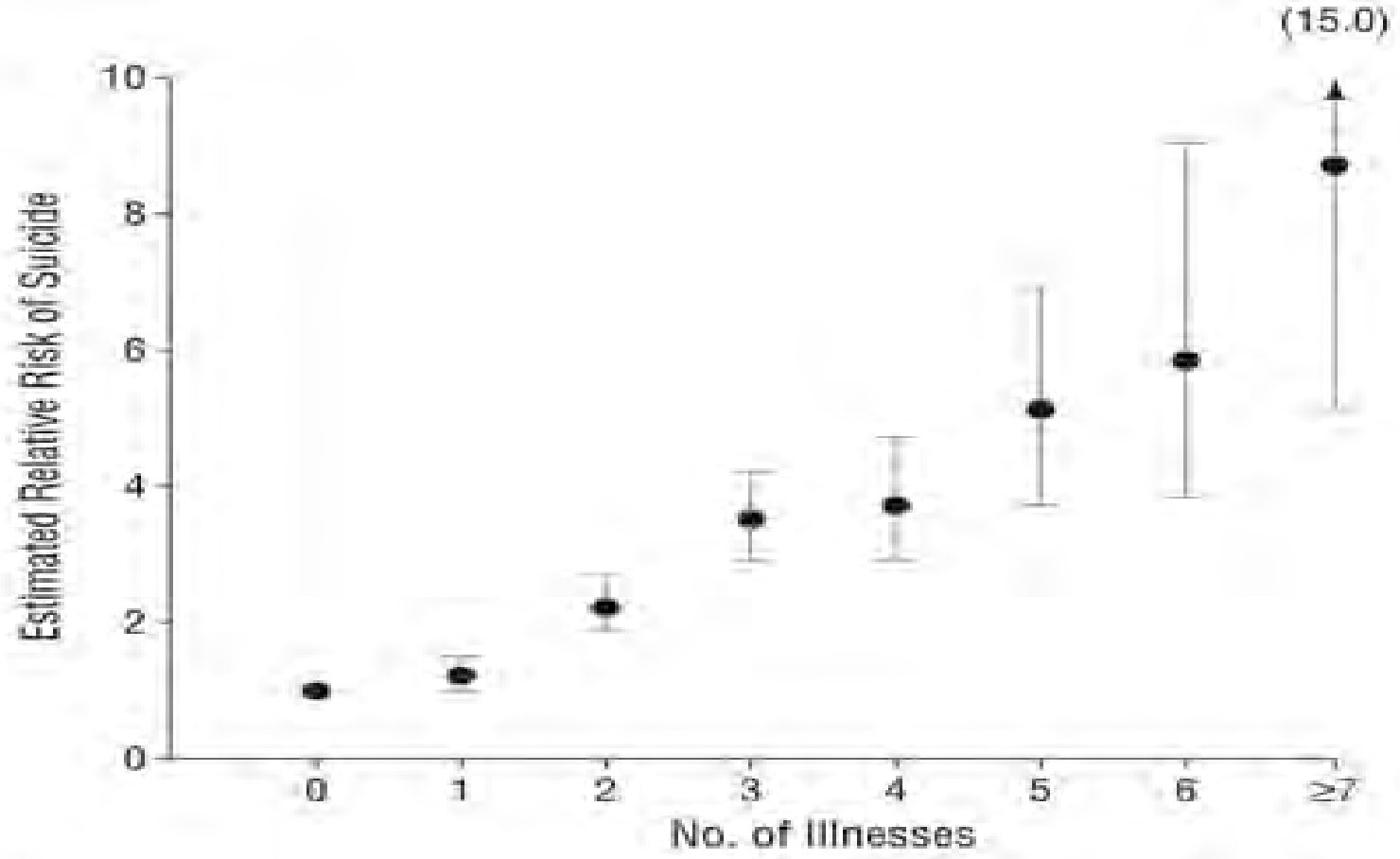
- Cancer 1.73 (1.16-2.58)
- Prostate disease (not CA) 1.70 (1.16-2.49)
- COPD (for married) 1.86 (1.22-2.83)

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

- 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)

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

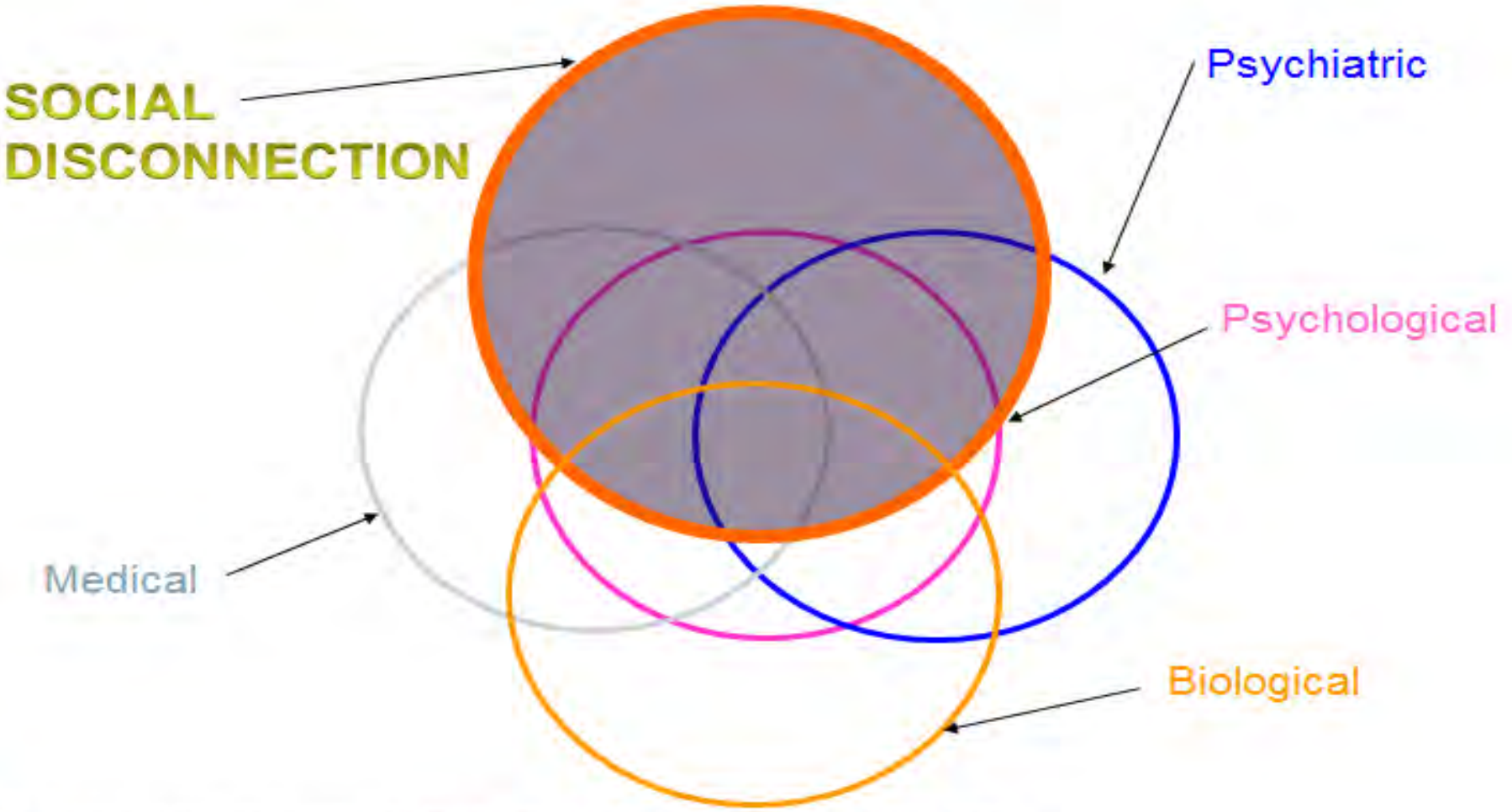
Comorbidity and Suicide Risk



									Total
No. of Cases	232	231	287	281	148	81	39	30	1329
No. of Controls	1766	1450	976	617	307	122	51	26	5315

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)
- Functional impairment/disability (Conwell et al, 2000, 2010; Duberstein et al, 2004, Waern et al, 2008)
- 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

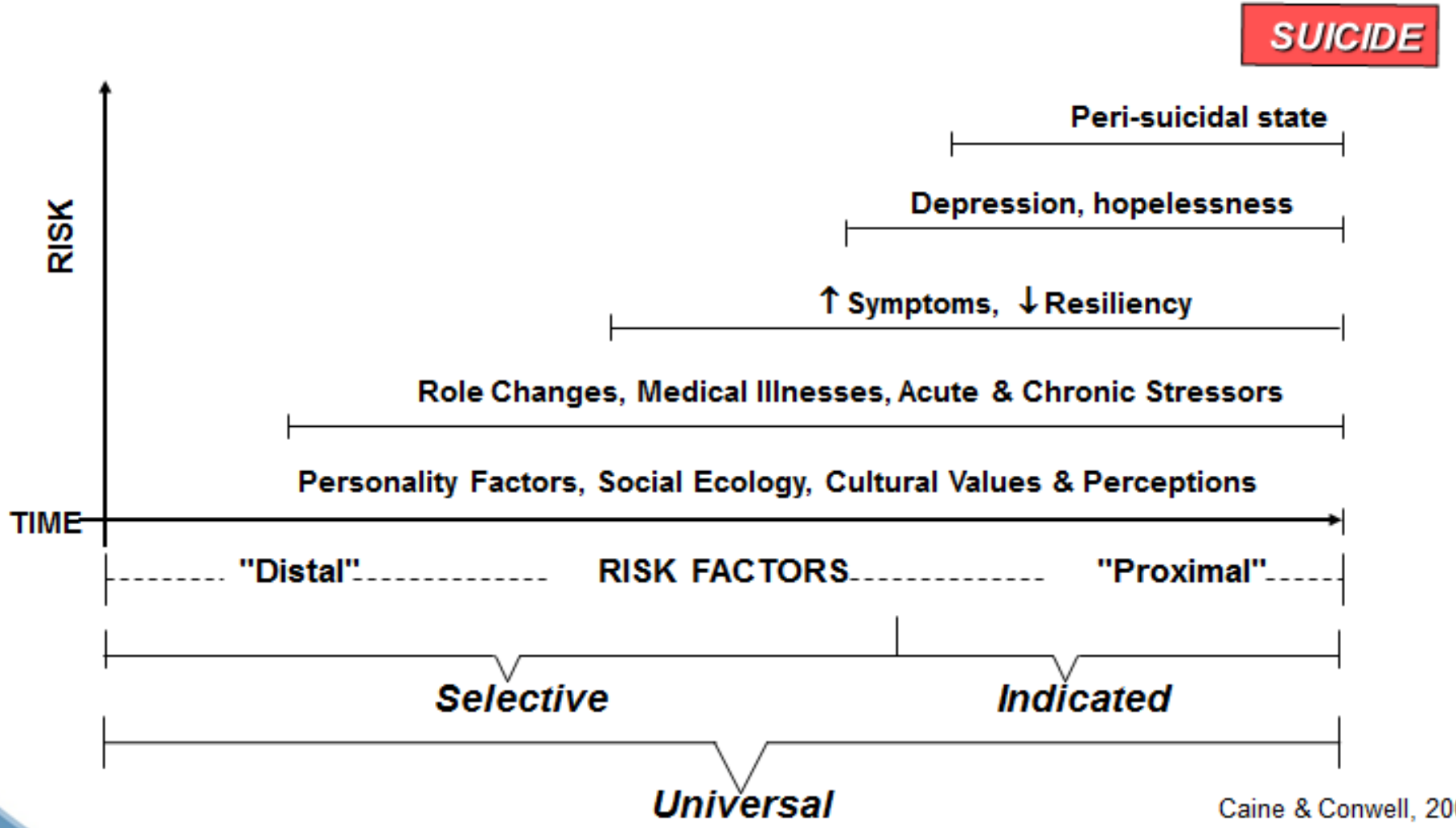
HOW DO WE ASSESS RISK

and PREVENT

SUICIDE IN ELDERS?

(Approaches to Prevention)

DEVELOPMENTAL PROCESS OF LATE LIFE SUICIDE



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)

Mood Scale (PHQ)

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

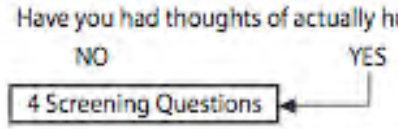
In the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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*

Figure 1. P4 Screener for Assessing Suicide Risk[a,b]



1. Have you ever attempted to harm yourself in the past?

NO YES

2. Have you thought about how you might actually hurt yourself?

NO YES → [How? _____]

3. There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?

a. Not at all likely _____
b. Somewhat likely _____
c. Very likely _____

4. Is there anything that would prevent or keep you from harming yourself?

NO YES → [What? _____]

	Shaded ("Risk") Response	
Risk Category	Items 1 and 2	Items 3 and 4
Minimal	Neither is shaded	Neither is shaded
Lower	At least 1 item is shaded	Neither is shaded
Higher		At least 1 item is shaded

[a]P4 is a mnemonic for the 4 screening questions: *past* suicide attempt, suicide *plan*, *probability* of completing suicide, and *preventive* factors. ©Copyright 2010 Kurt Kroenke, MD.

[b]Any individual who responds "yes" to a question about thoughts of self-harm is asked 4 additional questions—the 4 *P*'s on past history, plan, probability, and preventive factors. Shaded responses are those that are more concerning for suicidal ideation.

Past suicide attempt
Suicide **p**lan
Probability (perceived)
Preventive factors

Dube, P., Kurt, K., Bair, M. J., Theobald, D., & Williams, L. S. (2010). The p4 screener: evaluation of a brief measure for assessing potential suicide risk in 2 randomized effectiveness trials of primary care and oncology patients. Primary care companion to the Journal of clinical psychiatry, 12(6). doi: 10.4088/PCC.10m00978blu

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

Study	Age	N	% seen within 1 week	% seen within 1 month
• Miller (1976)	≥ 60	30	33	77
• Barraclough (1971)	≥ 65	30	47	70
• Clark (1991)	≥ 65	54	41	70
• Cattell & Jolley (1995)	≥ 65	100	19	43
• Conwell et al (1994)	55-74	24	25	42
	75+	20	35	75

RISK FACTOR: Firearm Access

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

*Model adjusts for education, living arrangements, and mental disorders that developed prior to the last year. (Conwell et al, AJGP 10:407-416, 2002)

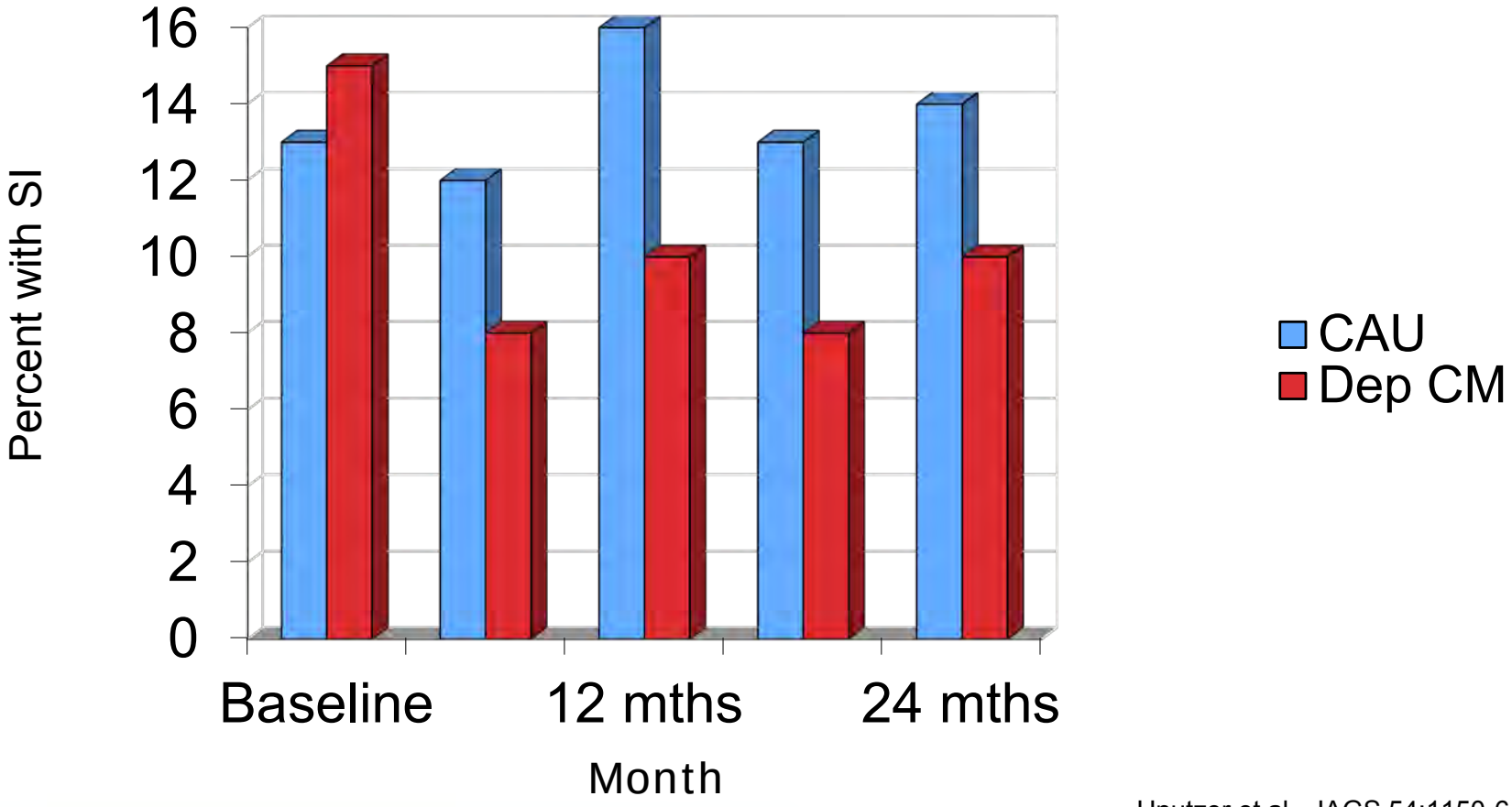
Interventions & Recommendations

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)



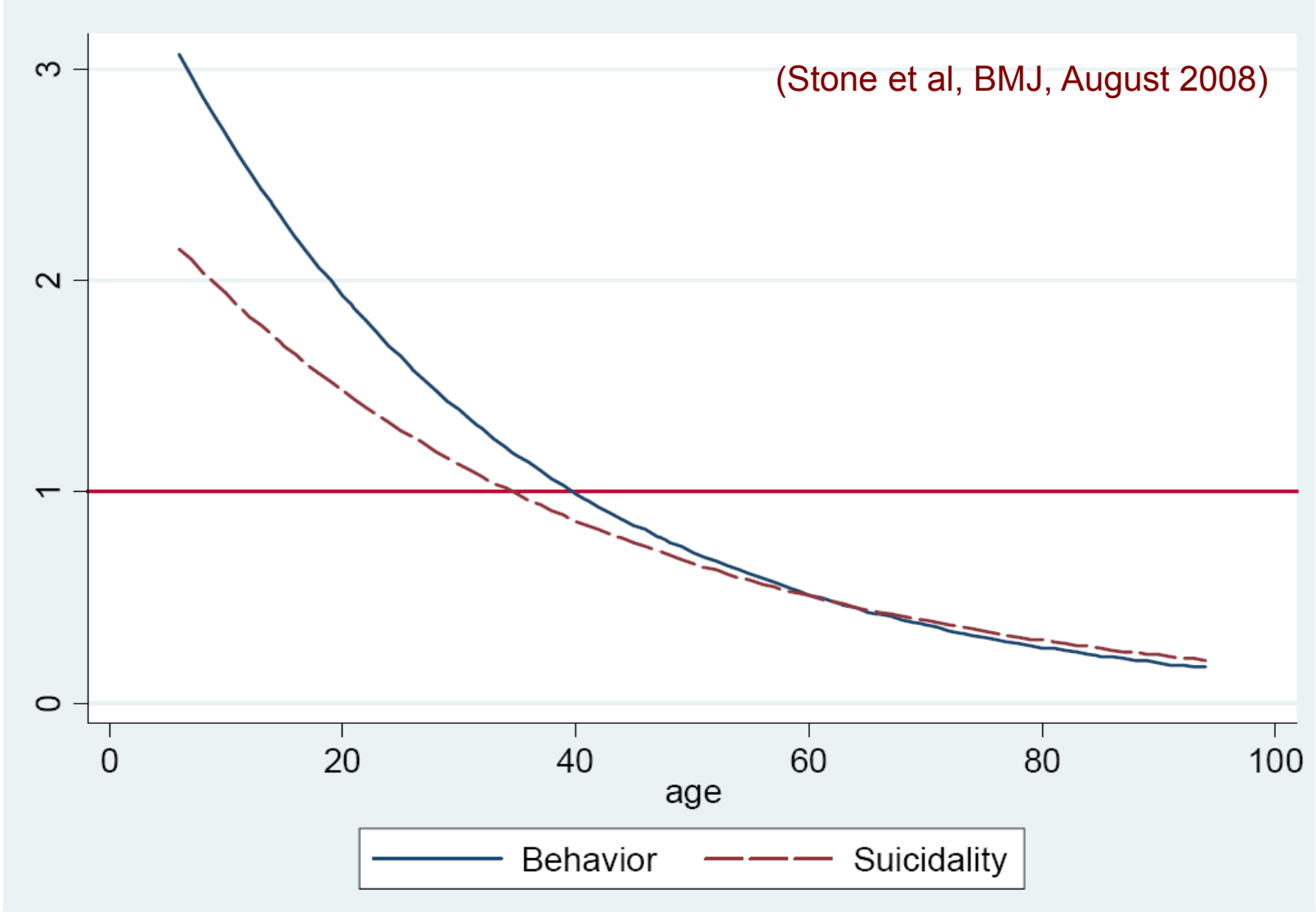
Unutzer et al., JAGS 54:1150-6, 2006

The PROSPECT Study

- Primary outcome was suicide ideation
- Randomization at the *practice* level
- At baseline → 24 month f/u
  - SI in intervention: 74/214 = 35% → 14/124 = 11%
  - SI in CAU group: 43/182 = 24% → 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



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).

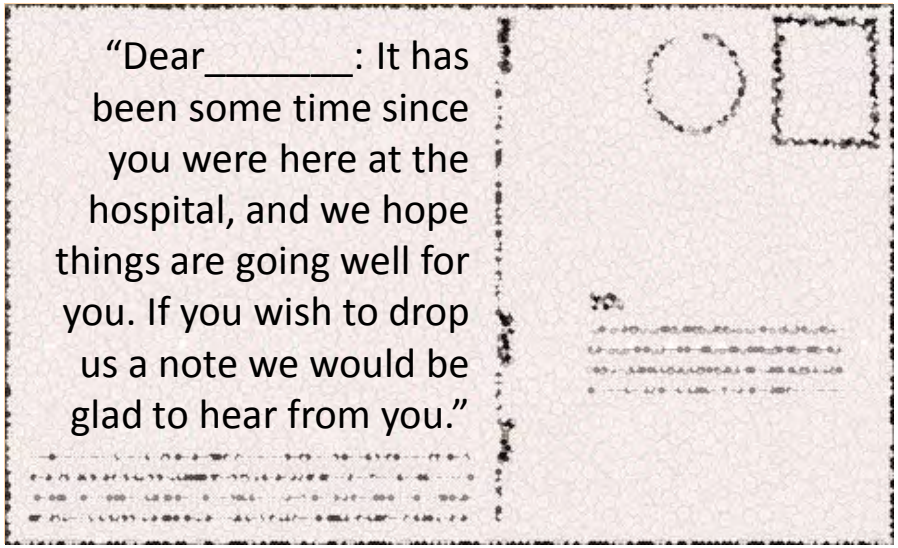
Alexopoulos et al. (2009), *AJP*.

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.
  - oCaring Letters[1]
  - oSUPRE-MISS[2]
- Not with older adults



[1] Motto JA, Bostrom AG. A randomized controlled trial of postcrisis suicide prevention. Psychiatric services 2001;52(6):828-33.
[1] Fleischmann A, Bertolote JM, Wasserman D, De Leo D, Bolhari J, Botega NJ, et al. Effectiveness of brief intervention and contact for suicide attempters: a randomized controlled trial in five countries. Bulletin of the World Health Organization 2008;86(9):703-9.

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*

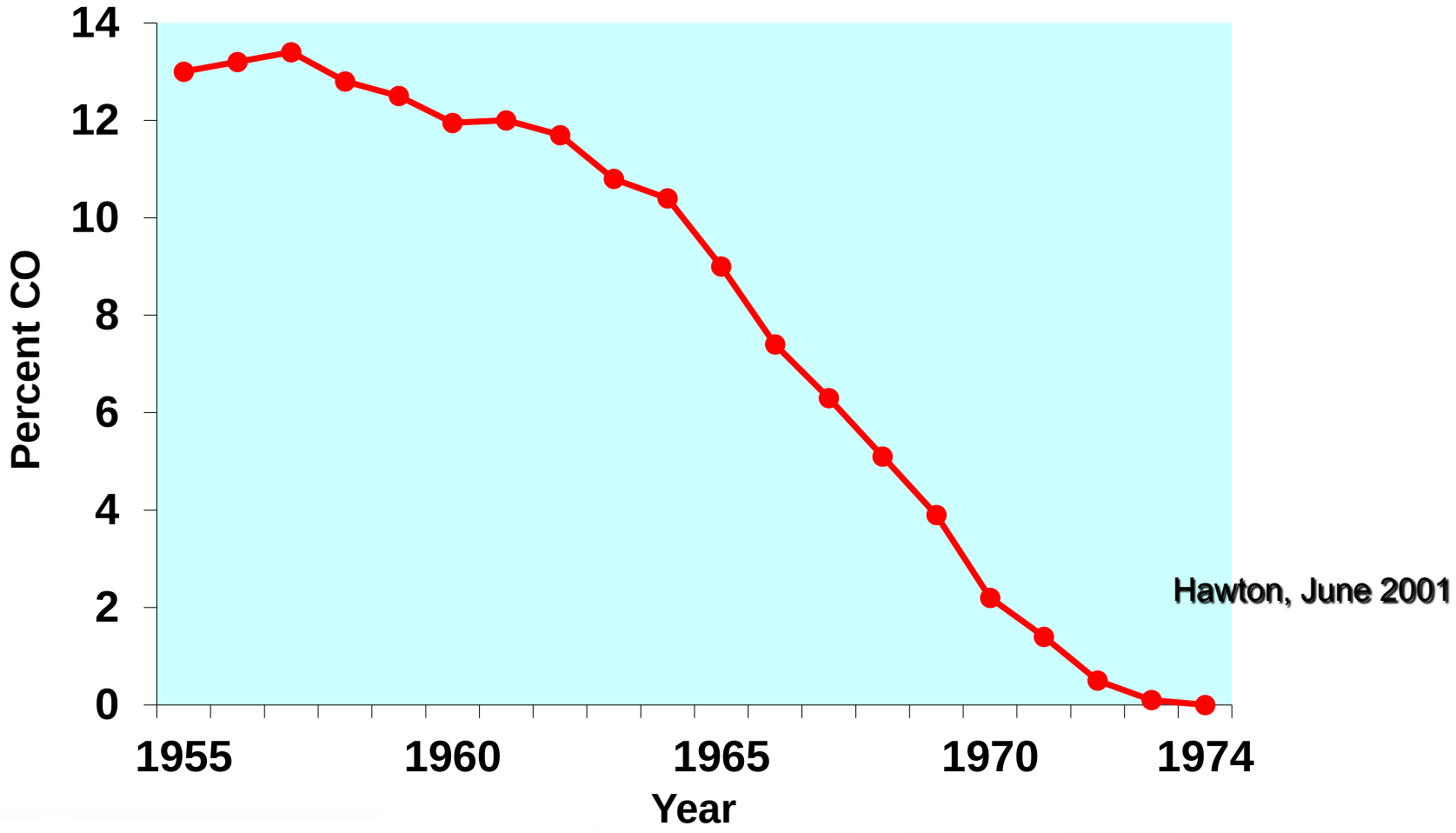
DeLeo et al., Br J Psychiatry 181:226-229, 2002

UNIVERSAL PREVENTION

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

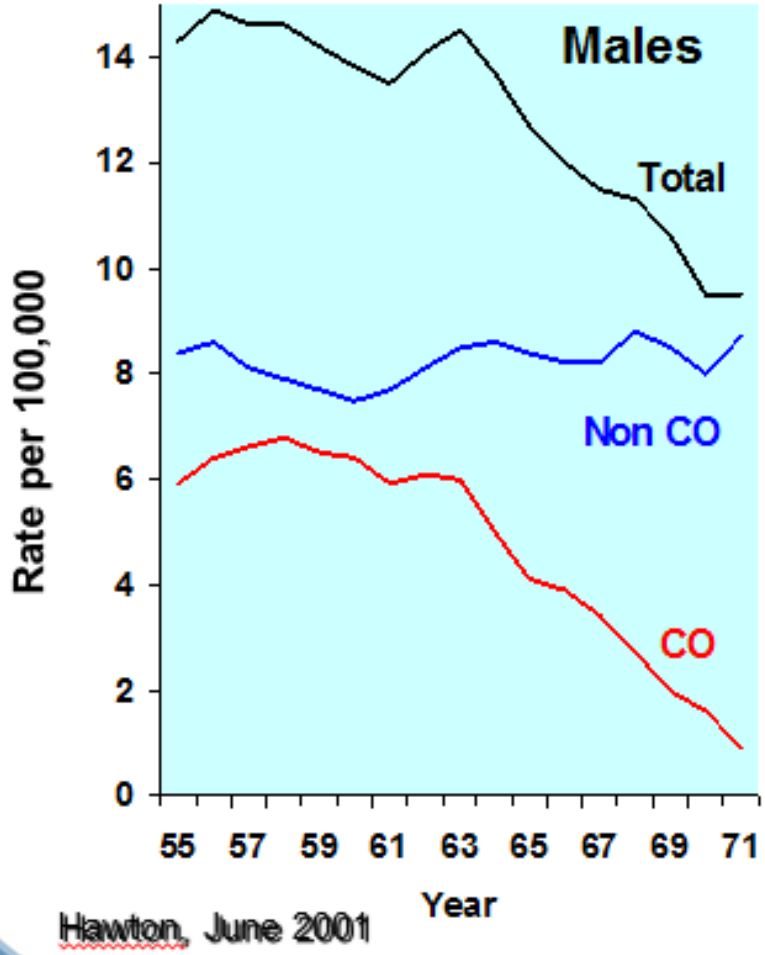
THE COAL GAS STORY (Kreitman, 1976)

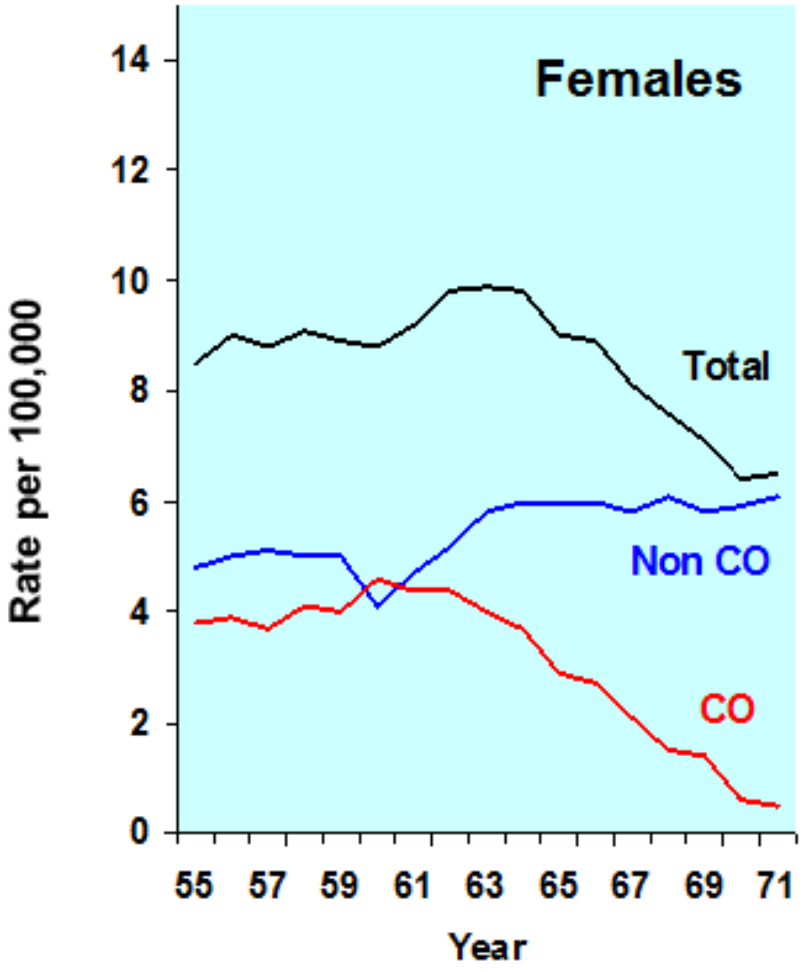
Percentage of CO in domestic gas, United Kingdom 1955-74



THE COAL GAS STORY

Suicide rates by mode of death: England & Wales





OPTIMAL SUICIDE PREVENTION =

Indicated

+

Selective

+

Universal

"MULTI-LAYERED SUICIDE PREVENTION"

OYAMA ET AL., Gerontologist 46:821-826, 2006

- 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

EFFECT OF MULITLAYERED PREVENTION INITIATIVES ON SUICIDE RATES

		MALE	FEMALE
ALL AGES			
Rutz et al. (1992)	Gotland Study	↔	↓
Hegerl et al. (2006)	Nuremberg	↓	↓
Szanto et al. (in press)	Hungary	↔	↓
OLDER ADULTS			
DeLeo et al. (2002)	Telehelp/Telecheck	↔	↓
Oyama et al. (2004)	Joboji	↓	↓
Oyama et al. (2005)	Yuri town	↔	↓
Oyama et al. (2006a)	Yasuzuka	↔	↓
Oyama et al. (2006b)	Matsudai	↔	↓

Helpful Review Articles

Conwell, Y., Van Orden, K., & Caine, E. D. (2011). **Suicide in older adults**. *The Psychiatric Clinics of North America, 34*(2), 451-468. doi: 10.1016/j.psc.2011.02.002. NIHMSID # 278215

Lapierre, S., Erlangsen, A., Waern, M., De Leo, D., Oyama, H., Scocco, P., . . . Quinnett, P. (2011). **A systematic review of elderly suicide prevention programs**. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 32*(2), 88-98.

Rudd, M. D., Berman, A. L., Joiner, T. E., Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., Van Orden, K. A.**,** & Witte, T. (2006). **Warning signs for suicide: theory, research, and clinical applications**. [Review]. *Suicide & Life-Threatening Behavior, 36*(3), 255-262. doi: 10.1521/suli.2006.36.3.255

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E., Jr. (2010). **The Interpersonal Theory of Suicide**. *Psychological Review, 117*(2), 575-600. NIHMSID # 301351.

Van Orden, K. A., Mellqvist Fässberg, M., Duberstein, P., Erlangsen, A., Lapierre, S., Bodner, E., Canetto, S. S., De Leo, D., Szanto, K., & Waern, M. (in press). **A systematic review of social factors and suicidal behavior in older adulthood**. *International Journal of Environmental Research and Public Health*. PMC in process

Erlangsen A, Nordentoft M, Conwell Y, Waern M, De Leo D, Lindner R, Oyama H, Sakashita T, Andersen-Ranberg K, Quinnett P, Draper B, Lapierre S; International Research Group on Suicide Among the Elderly. (2011). **Key considerations for preventing suicide in older adults: consensus opinions of an expert panel**. *Crisis*, 32(2):106-9.

Thank you

Contact information:

Yeates Conwell, MD
Kim VanOrden, PhD
University of Rochester Medical Center
300 Crittenden Boulevard
Rochester, NY 14642 USA

Yeates_Conwell@urmc.rochester.edu
Kimberly_vanorden@urmc.rochester.edu

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

National Resources for Suicide Prevention

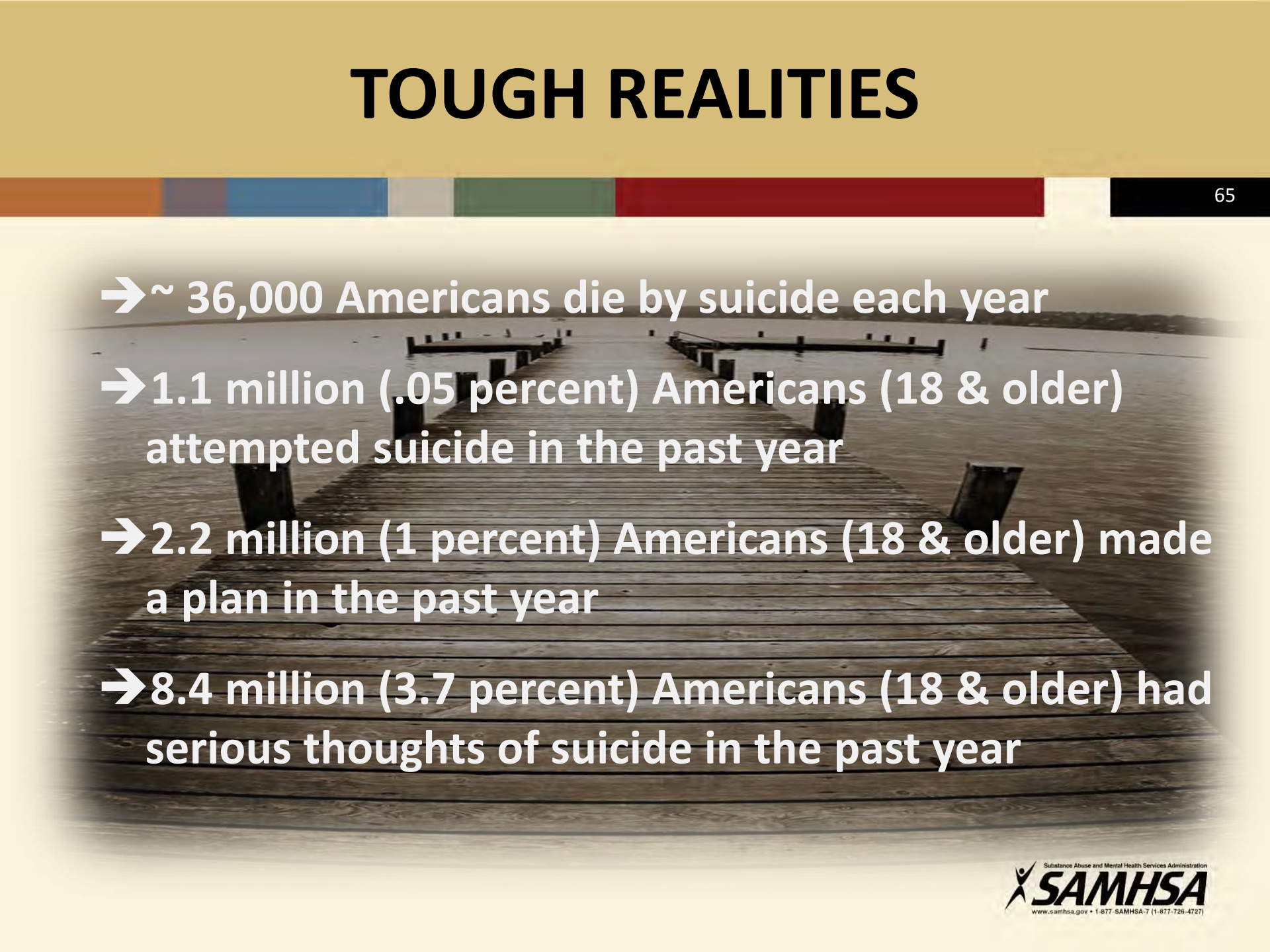
Richard McKeon Ph.D.

Chief, Suicide Prevention Branch , SAMHSA

Older American TCE Suicide Prevention Webinar
January 16, 2013

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

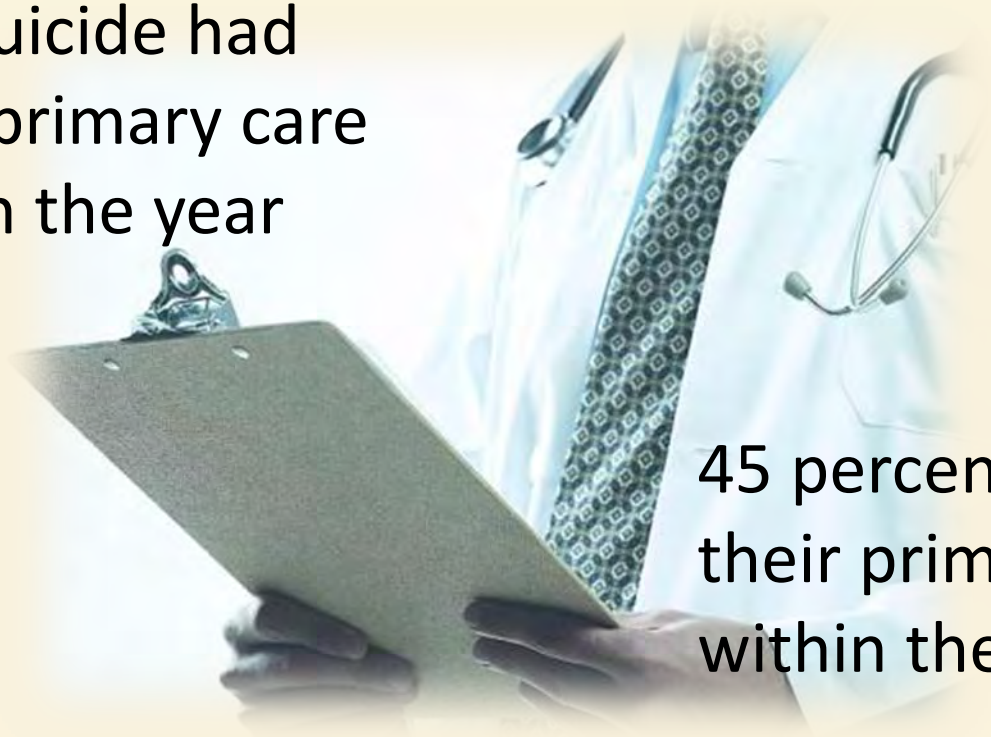
TOUGH REALITIES



- ~ 36,000 Americans die by suicide each year
- 1.1 million (.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

MISSED OPPORTUNITIES = LIVES LOST

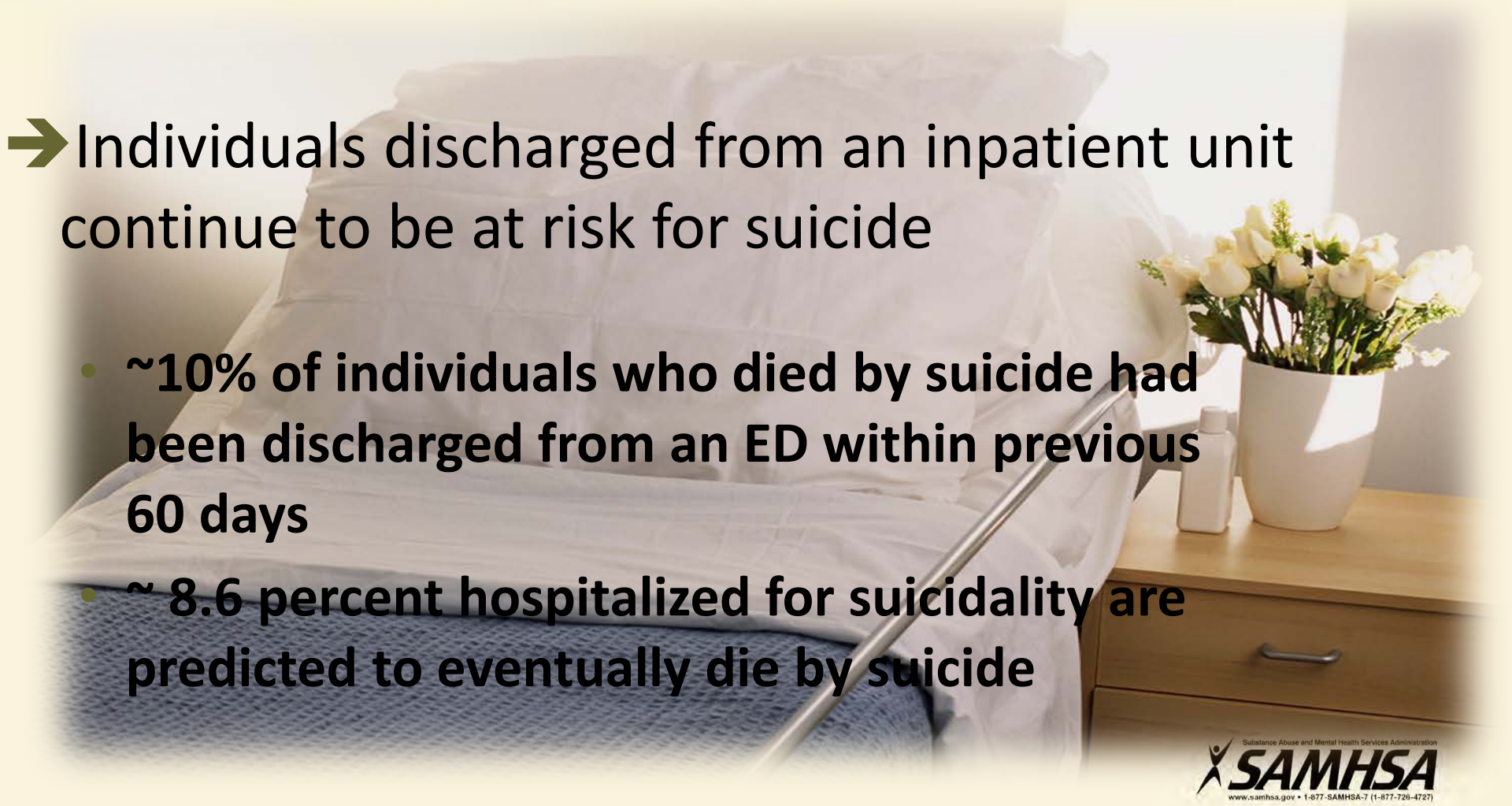
77 percent of individuals who die by suicide had visited their primary care doctor within the year



45 percent had visited their primary care doctor within the month

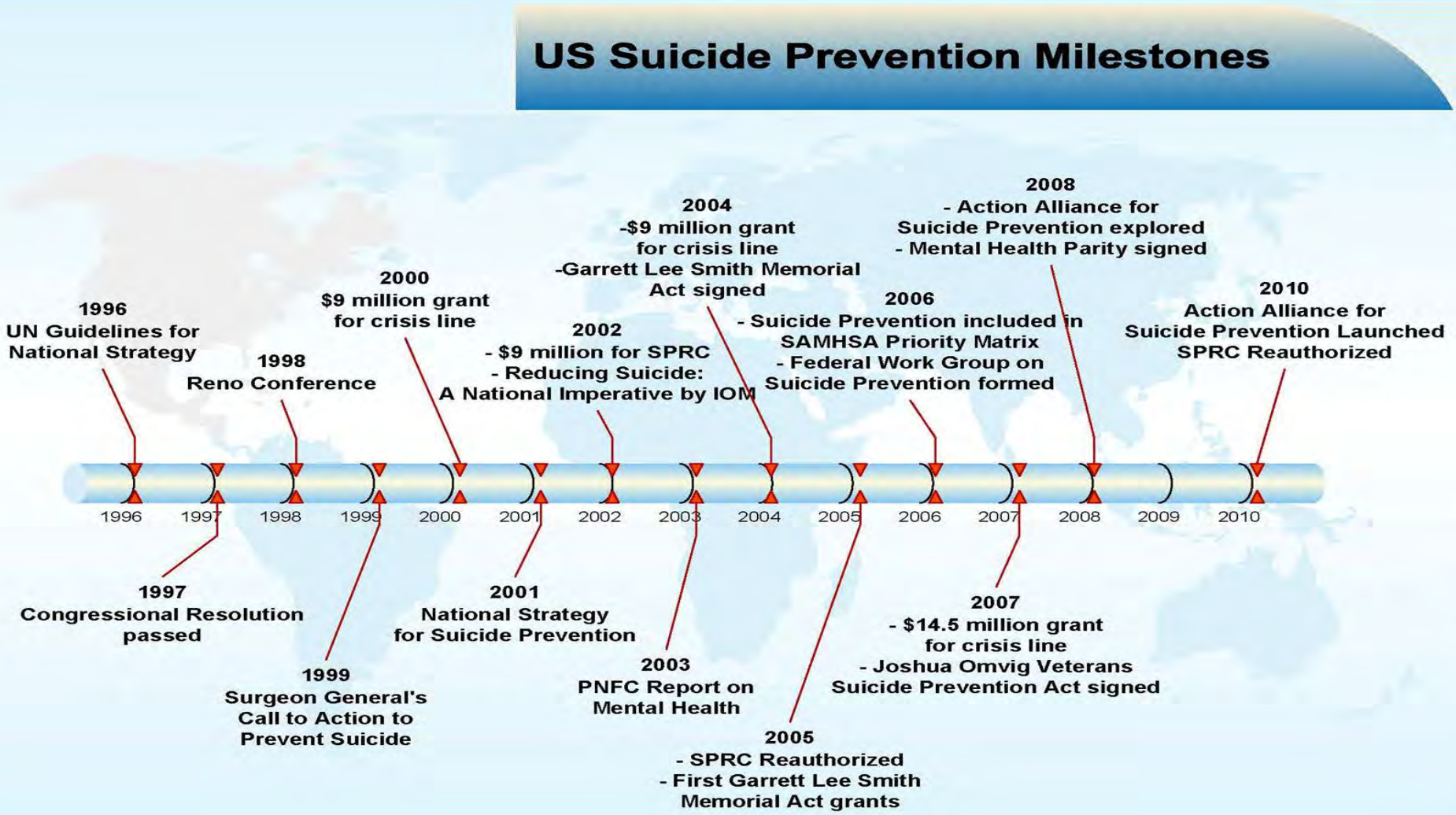
THE QUESTION OF SUICIDE WAS SELDOM RAISED...

MISSED OPPORTUNITIES = LIVES LOST

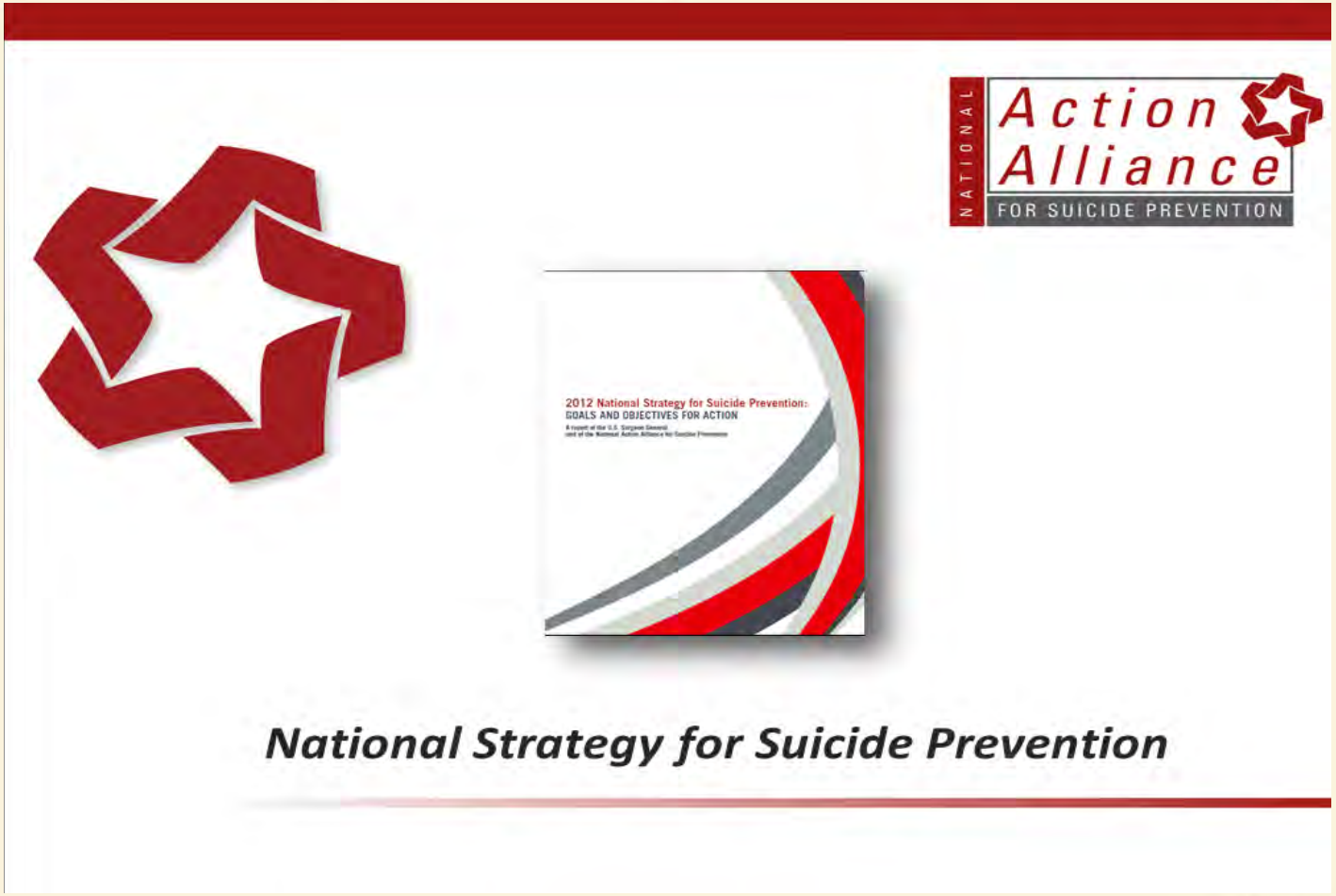


- Individuals discharged from an inpatient unit continue to be at risk for suicide
  - **~10% of individuals who died by suicide had been discharged from an ED within previous 60 days**
  - **~ 8.6 percent hospitalized for suicidality are predicted to eventually die by suicide**

US Suicide Prevention Milestones



National Strategy for Suicide Prevention

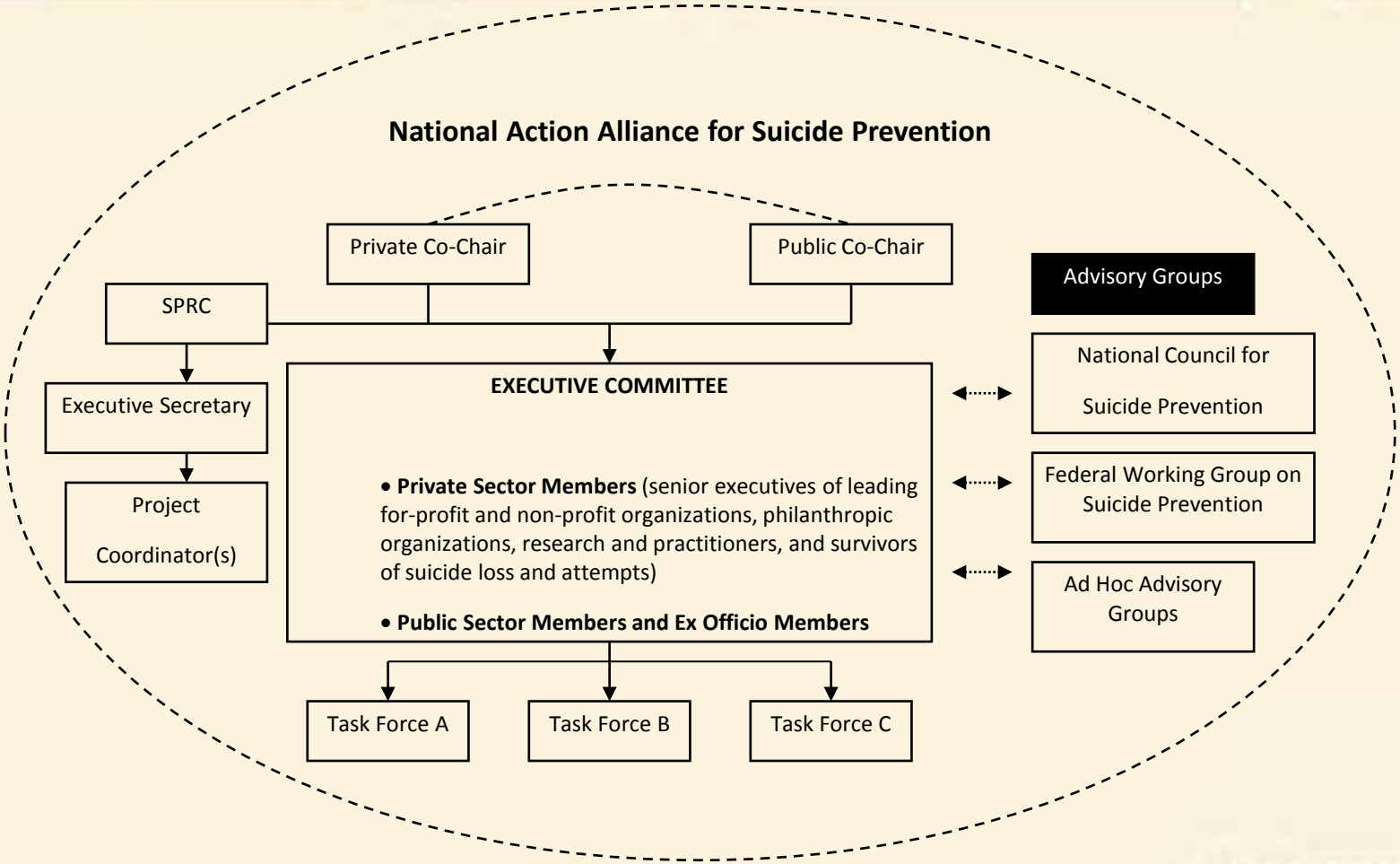


National Strategy for Suicide Prevention

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
- **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



Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

EXCOM Representation

- **Public**
  - Defense
  - Education
  - Health and Human Services
  - Former Federal legislator
  - Interior
  - Justice
  - Labor
  - State government official
  - VA
- **Private**
  - Behavioral health/substance abuse
  - Business
  - Faith leader/interfaith
  - Hospitals
  - Insurance
  - National Council for Suicide Prevention
  - Older adult services
  - Organized labor
  - Primary care
  - Social media
  - SPRC
  - Traditional media
  - Youth advocacy
- **Others**
  - Clinical
  - Consumer of mental health services
  - Philanthropy
  - Research
  - Suicide attempt survivor
  - Suicide loss survivor

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

- 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.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

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

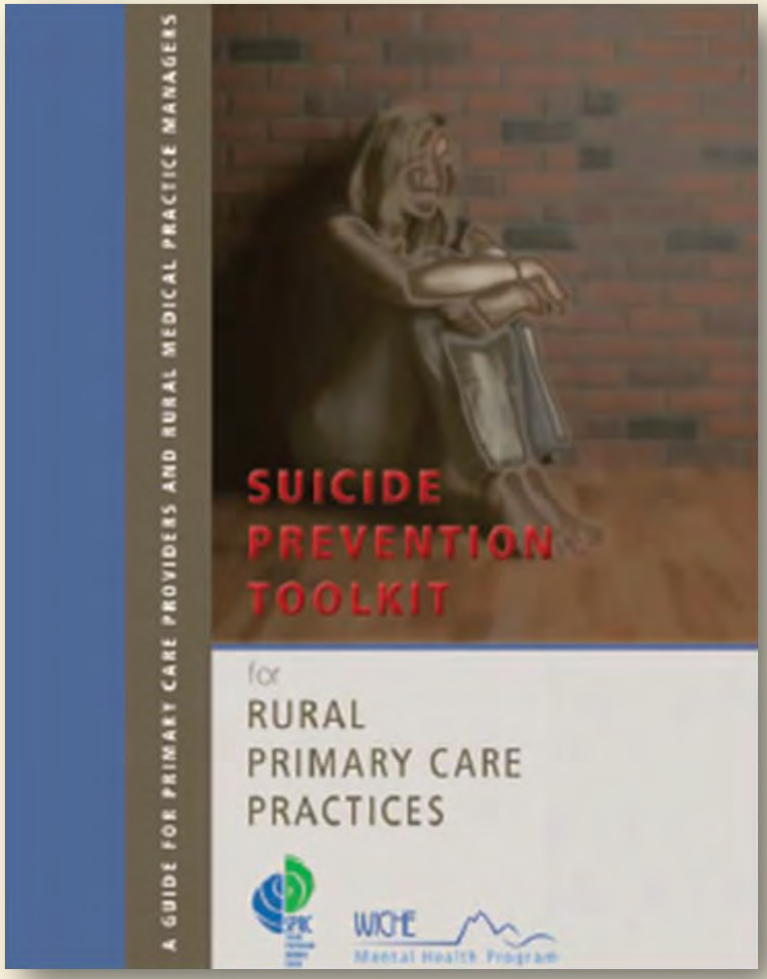
Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Suicide Prevention Resource Center

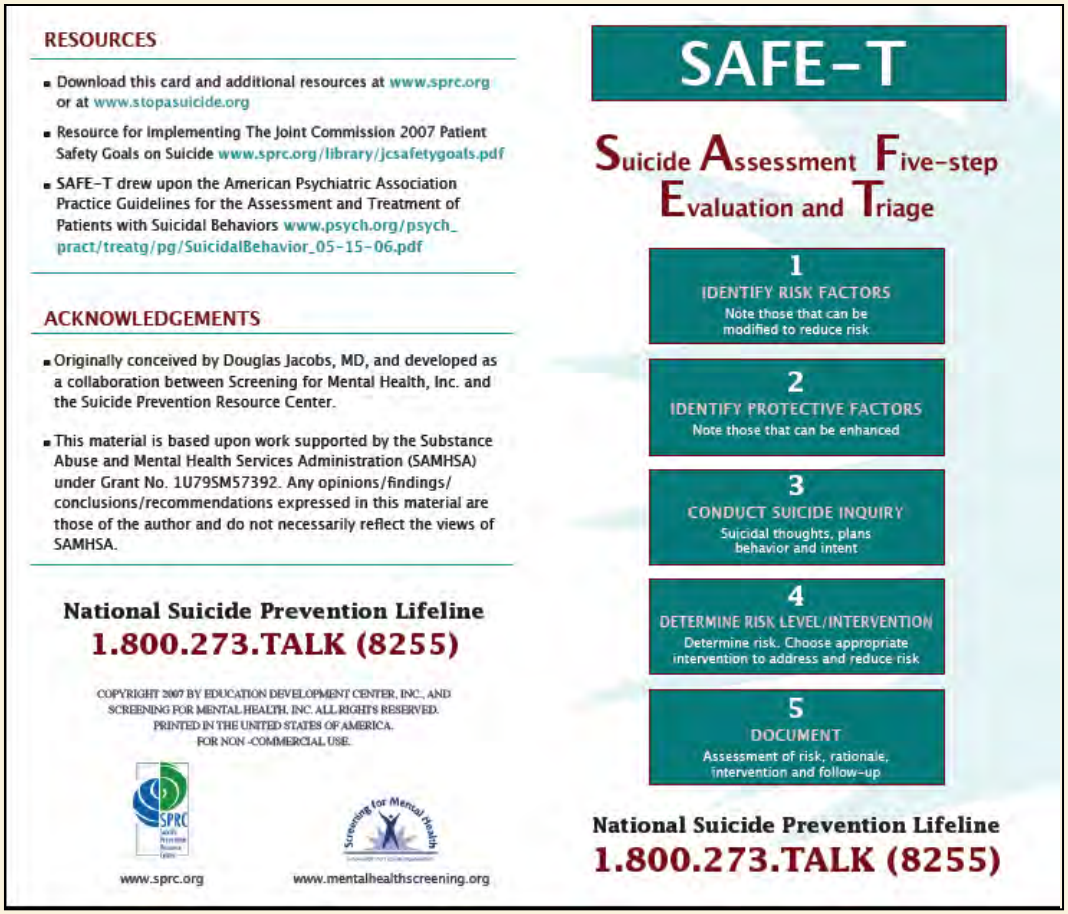
The nation's first and only federally funded suicide prevention resource center

- 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.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

- 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. 1U79SM57392. 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)

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)

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

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

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

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

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

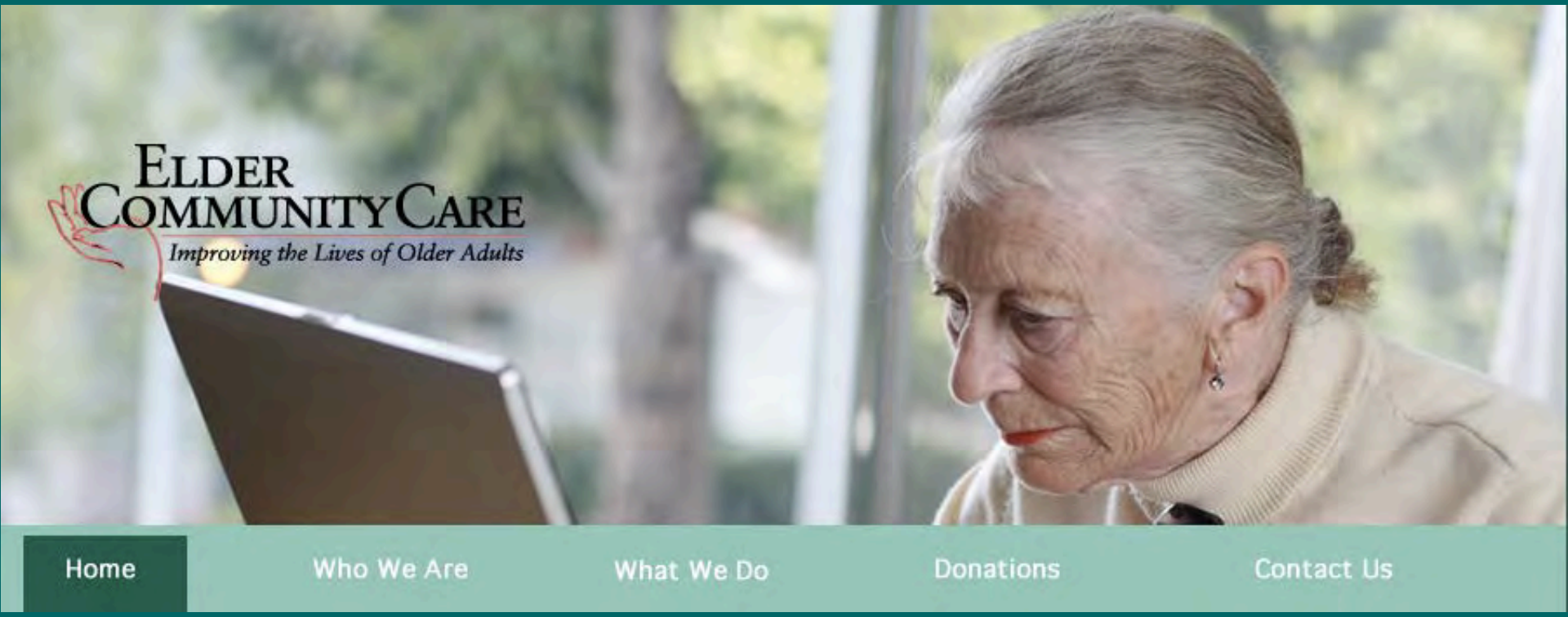
Richard McKeon, Ph.D., M.P.H.
Branch Chief, Suicide Prevention, SAMHSA
240-276-1873
Richard.mckeon@samhsa.hhs.gov

Suicide Prevention Resource Center

National Action Alliance for Suicide Prevention

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Elder Community Care (ECC)



Steve Corso - BayPath Elder Services
Lynn Kerner – Advocates, Inc.
Eileen Davis – The Samaritans

www.eldercommunitycare.org

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

Key Ingredients of the Model

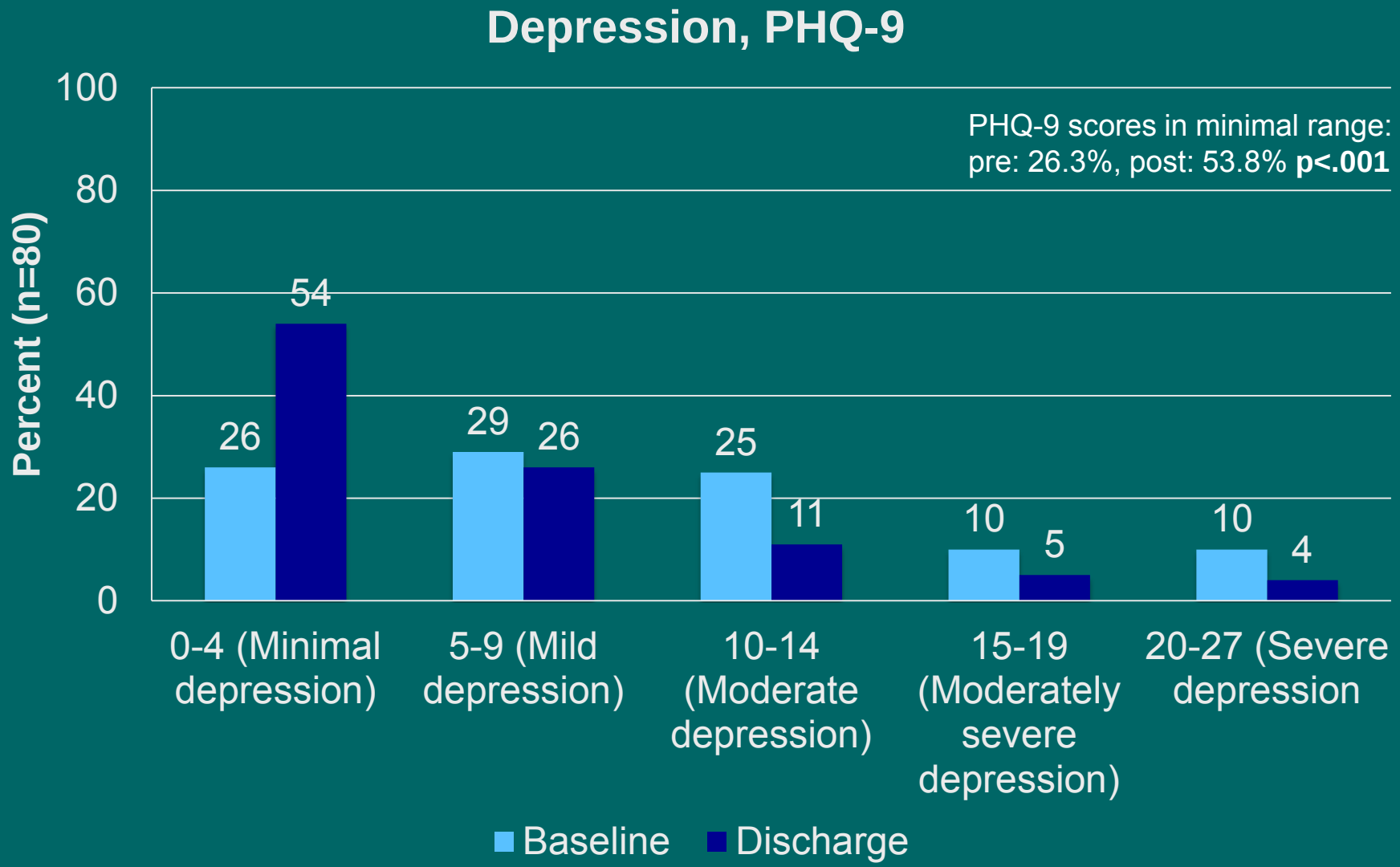
- Multi-agency
- Business Associate Agreements
- Outreach to home-bound older adults
- Aging services as entry point

- Aging services offers in-home depression screening
- Mobile assessment and counseling
- Telecheck
- 24-hour crisis team

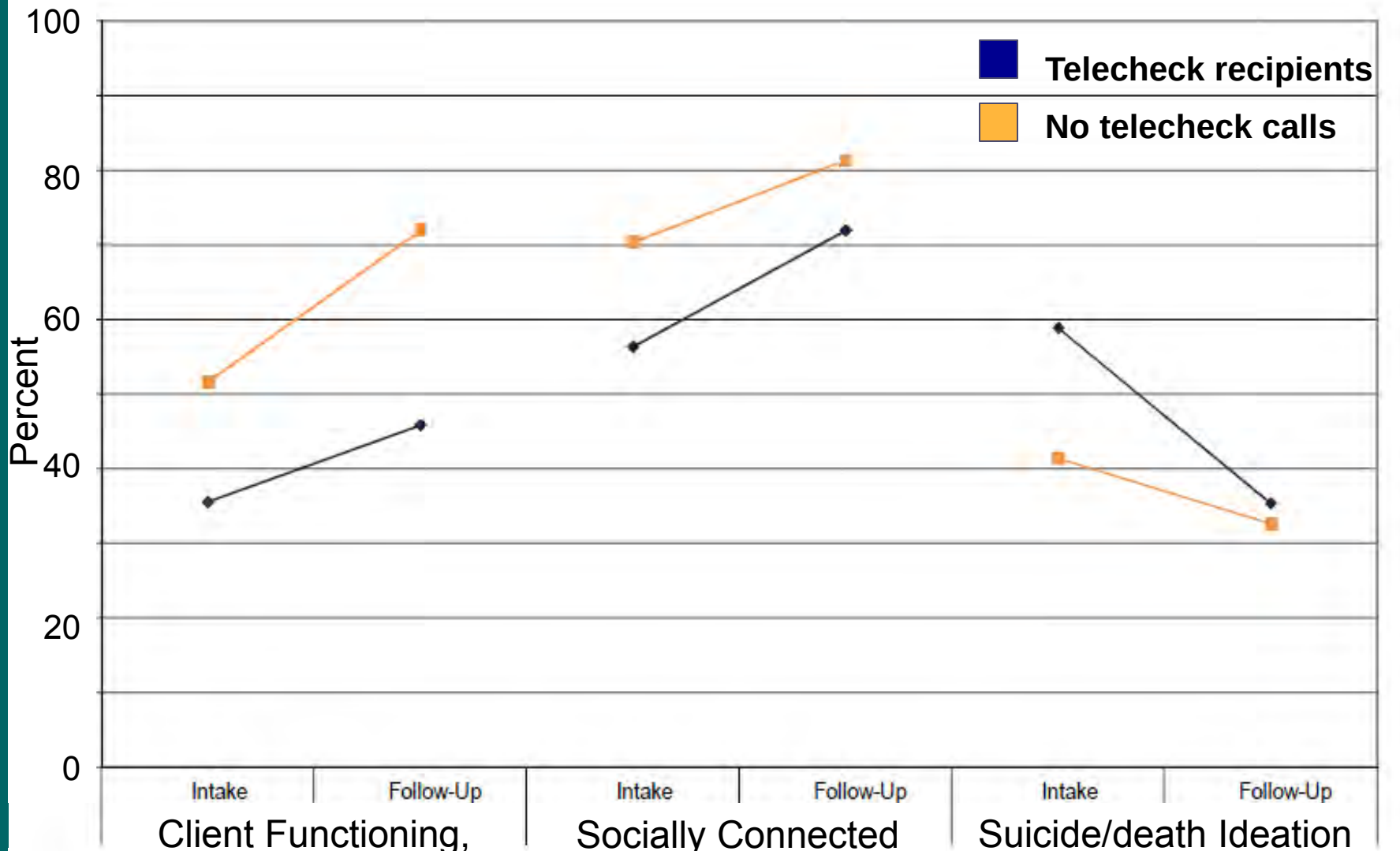
Process Outcomes SAMHSA Grant: 2008-2011

- 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



Selected Outcomes by Telecheck Participation

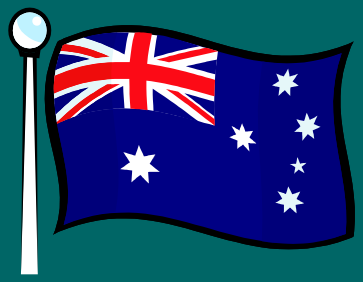


Samaritans

- Suicide prevention agency
- Use non-judgmental, active listening
- Provide emotional support and validation
- Telecheck volunteers receive additional training and are over age 60

Telecheck Referral & Log Forms

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

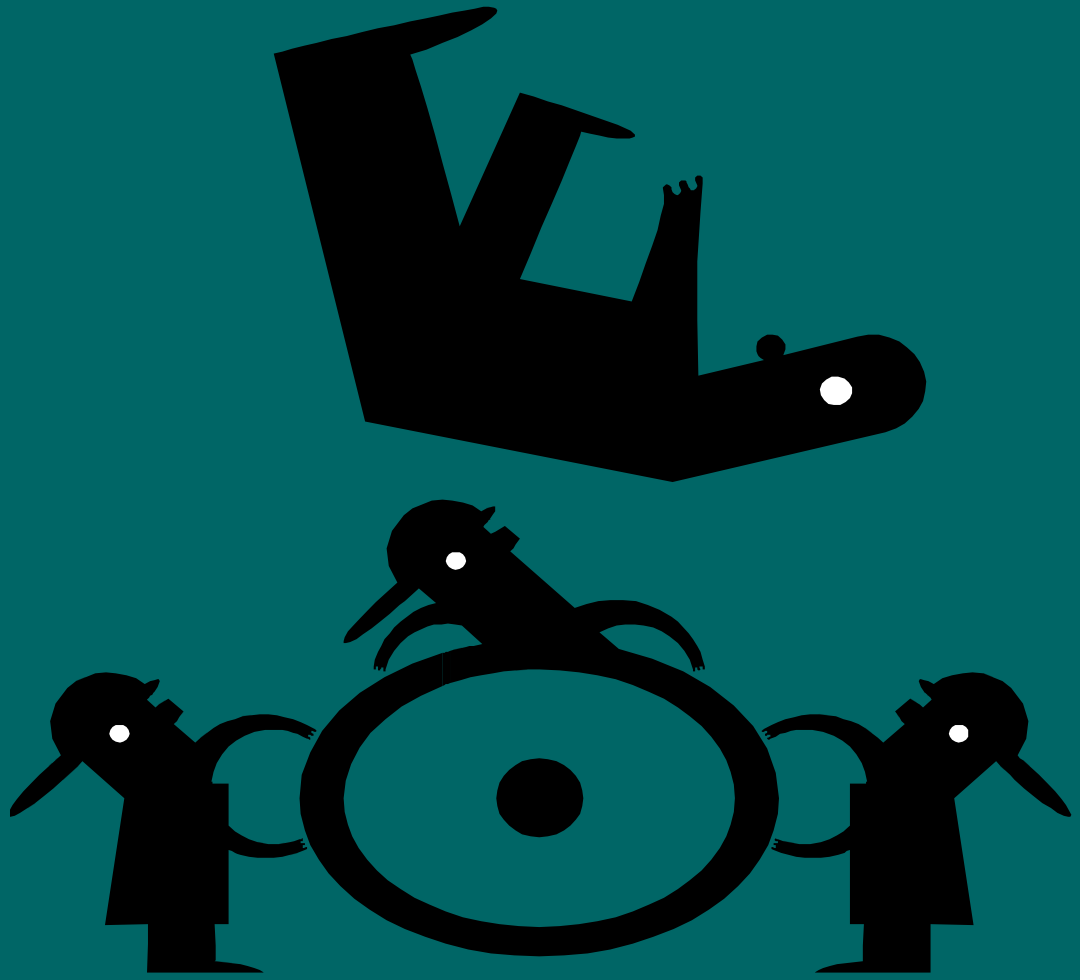
Emotional

- 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



Questions and Answers

Please send questions via WebEx Chat

Older Americans Behavioral Health Webinar and Issue Briefs Series

Older Americans Behavioral Health Webinar and Issue Briefs Series are available on AoA, NCOA, NASUAD and NASMHPD websites

Funded by SAMHSA in Collaboration with AoA