

# Community-Based Strategies for Suicide Prevention Among Older Adults

September 28, 2020



*Improving the lives of 40 million older adults by 2030*

# Welcome

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## INNOVATIONS IN NUTRITION SERVICES: SUICIDE PREVENTION/INTERVENTION WITH OLDER ADULTS

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# OVERVIEW

Disclaimer / Acknowledgement

Overview of Suicide in Later Life: Facts, Theory

Research Design

Treatment: Applied Suicide Intervention Skills Training (ASIST)

Findings from 6 studies from ACL funded grant

Resource to Enhance Social Support through Volunteers

Questions

# DISCLAIMER / ACKNOWLEDGEMENT

This Research was made possible by the US Department of Health and Human Services (HHS), through the Administration for Community Living (ACL)

Grant: 90INNU0010-01-00

# Overview of Older Adult Suicide

# OVERVIEW OF SUICIDE IN LATER LIFE

- Older adults make up 16% of the U.S. population, but account for 18.8% of all deaths by suicide (Drapeau & McIntosh, 2020).
- As of 2018, the suicide rate for individuals over 65 in the United States was 17.4 per 100,000, compared to the national rate of 14.8 per 100,000 (Drapeau & McIntosh, 2020).
- An older adult dies by suicide in the U.S. every 65 minutes (Drapeau & McIntosh, 2020).

# OVERVIEW OF SUICIDE IN LATER LIFE

- For those who have been reported to die by suicide, there are five to 25 times more who suicide, likely due to stigma and suicides that are mis-categorized as accidents (Lang et al., 2013).
- There are 40 – 100 times more suicide behaviors than the number of reported suicides (Lang et al., 2013).

**This means that while we know older adults have one of the highest rates of suicide in the U.S., there are likely even more deaths by suicide that go unreported and/or unnoticed.**

# OVERVIEW OF SUICIDE IN LATER LIFE

- Social isolation plays a key role in the lethality of suicide in later life (Conwell et al., 1998).
- Older adults completing suicide are more likely to be widow(er)s, live alone, perceive their health status as poor, experience poor sleep, experience loneliness, and experience a stressful life event such as financial discord (Blazer 2003).
- Research shows physicians are less willing to treat suicidal older persons compared to younger patients, **and believe suicidal ideation among older adults is normal** (Uncapher & Arian, 2000). Also, studies have shown that **20% of older adults who die by suicide saw their primary care physician within 24 hours of their death** (APA, 2003).

# Joiner's Interpersonal Theory of Suicide

## Interpersonal-Psychological Theory of Suicide

Thomas Joiner, PhD

## *Why People Die by Suicide*



Derived from Sketch of a Theory  
Power Point presentation, 2013  
Thomas Joiner, PhD

# TREATMENT: APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

- ASIST is a 2-day, 14 hour, standardized and manualized suicide *intervention* training (11th edition)
- Internationally recognized
- SAMHSA Evidence Based Registry
- National Registry of Evidence-Based Programs
- Adopted by branches of the U.S. Armed Forces
- Recognized by the Centers for Disease Control
- Used in crisis centers across the country



# Research Methods & Findings

# RESEARCH METHODS

- 6 Counties in Metro-Atlanta
  - Lab members: background checks, fingerprinting
- Piloted measure set
- 1-3 hr. interviews with older adults (in-home), average 1.5hr (measure set)
- Training of 160 HDM volunteers in ASIST intervention
- 1-3 hr. interviews with older adults (by phone), average 1.5 hr (revised measure set tailored to COVID-19)
- Series of studies examining (a) suicide predictors in homebound and congregate older adults, (b) pre/post effects of training, (c) intervention tracking, (d) impact of COVID-19

# BASELINE DATA (Time 1, pre-COVID)

- 493 older persons, Aged: 60-103, Mean = 77.03 ( $SD=8.99$ ), mostly Female (73.4%) and Minority (72.9%),
- **Anxiety** (1/2 met criteria on GAD-2); **Depression**: 1/4 met criteria on PHQ-2
- **Pain**: 1/2 had daily pain (1 in 5 were extremely isolated and depressed because of pain)
- **Suicidality precursor variables**
  - Perceived Burdensomeness & Thwarted Belongingness consistent with other samples
  - Fearlessness of Death considerably higher than younger samples
- **Risk for suicide (SBQ-R)**
  - 77 (15.62%) met clinical cut offs (when asked directly about suicide behavior)
  - 23.73% of homebound older adults reported a history of suicidal ideation and behavior
  - **Alarmingly, 65 (of 493)** indicated the possibility of ending their life in the future
- Wellness (Five Factor Wellness Inventory)
  - Sample is... **More well** on Essential Self (spirituality, culture),  
**Less well** on Social self (Friendship, love), and Physical Self
  - Gender gap on Social self... older men score low while older women do not
- **Key takeaways: These findings tell us that suicide is a problem in the Aging Services Network (ASN), that it is higher than typically reported, and this is before the COVID-19 pandemic.**

# HOMEBOUND VS. CONGREGATE

- Group differences in psychological distress, perceived burdensomeness, and thwarted belongingness (i.e., greater concern among homebound OA)
- Depression: 22% of homebound vs. 10.1% of congregate (*Homebound 2.61x more likely to have depression*)
- Anxiety: 29% of homebound vs. 14.1% of congregate (*Homebound 2.49x more likely to have anxiety*)
- ***Key takeaway: Attending congregate meal gathering strongly correlated with enhanced mental health; possible buffer due to social connectedness? What are implications for those who transition to home-delivered services?***

# PAIN & SUICIDE DESIRE

- Race moderated the relationship between pain and suicidal desire, indicating a stronger relationship between pain and suicidal desire among Black older adults compared with White peers.
- One form of chronic physical pain (i.e., emotional burden) interacted with race to predict perceived burdensomeness ( $p = .011$ ) and thwarted belongingness ( $p = .032$ ).
- Trends suggested racial differences moderated the relationship between pain interference and PB ( $p = .056$ ), and psychological distress and TB ( $p = .064$ ).
- ***Key takeaway: Greater attention to pain experiences among Black older adults is warranted, particularly in light of the impact of COVID-19 on racial and ethnic minorities' mental health.***

# HDM VOLUNTEER PERCEPTIONS OF ASIST

- Conducted 22 interviews with HDM volunteers who were ASIST-trained to explore their experiences with the training & application to their meal delivery routes
- Currently analyzing this data
- Preliminary findings:
  - Interviewees raved about the value of ASIST training; found it very meaningful and useful; perceived it as an investment in their role as volunteers
  - Use of ASIST skills emerging, although shifts due to COVID-19 impacted immediate usage; volunteers were eager to return to their routes
  - Potential barriers to using ASIST: 1) brief nature of encounters with meal recipients; 2) some volunteers have different clients each time out; 3) variance in which recipients want “more than a meal”; 4) certain volunteers more adept at knowing when to use skills
- ***Key takeaways:***
  - **How might skilled volunteers be matched to HDM recipients who are most at-risk?**
  - **Are there opportunities to change norms around HDM programs so that volunteers are encouraged to build supportive relationships?**

# INTERVENTION OUTCOMES (*preliminary*)

- Tracking tool developed based on PAL model
- Of 160 volunteers and ASN professionals trained in ASIST, **51** reported suicide interventions
  - We provided 14 trainings over the course of a year (pre-COVID)
  - These interventions were with HDM clients, county senior services clients, family, friends, neighbors, and peers
- At least **17 different** volunteers tracked at least one suicide intervention
- At least **5** volunteers tracked multiple interventions with multiple individuals
- Of the **51 interventions**, we matched 2 older adults (case study)

# NEXT STEPS (and preliminary pandemic trends)

## Administration of Community Living Grant (2020-2023)

- Tracking the **impact of COVID-19 with older adults** *over time* (4 time points)
  - COR Theory to ground hypotheses between COVID-related resource loss and mental health and social support
    - signif. main effects for resource loss and perceived social support
      - depression: resource loss [ $\beta = .27, p < .001$ ]; social support [ $\beta = -.29, p < .001$ ])
      - anxiety: resource loss [ $\beta = .28, p < .001$ ]; social support [ $\beta = -.32, p < .001$ ])
      - distress: resource loss [ $\beta = .27, p < .001$ ]; social support [ $\beta = -.36, p < .001$ ]).
        - » Higher levels of pandemic-related resource loss (and lower levels of social support) were positively related to depression, anxiety, and psychological distress.
  - **Key takeaway: By providing connections and resources, the ASN can improve mental health!!**

## NEXT STEPS

- **Development of BE WITH innovation** to address social isolation, loneliness, and elevated suicide risk
- **PN-RCT** (partially nested randomized control trial)
  - 60 volunteers
  - 3,840 calls with older adults
  - 2 conditions:
    - (1) “Be” (belonging and empathy)
    - (2) “With” (with intentional targeted helping)
  - Calls recorded, and double coded (coding protocol)
  - Goal: to establish higher tiers of evidence for NCOA evidence-based registry
- **Replication of ASIST & BE WITH innovation** in other parts of the country

# ENHANCING SOCIAL SUPPORT TIP SHEET



<https://tinyurl.com/ACLsocial>

1. When possible, **use the same volunteers each time** to increase familiarity and build rapport. It may take a few iterations of the check-in calls to develop sufficient trust between the volunteer and older adult. Be patient, and persistent.
2. **Use active listening.** Active listening is a full-body activity that requires your full attention and heart. The older adult (or anyone for that matter) needs your full attention when listening. Try to minimize distractions and noise as much as available.
3. **Be aware of euphemisms** that may indicate an older adult is sad, lonely, or anxious. They may not flat out say they are feeling "tired," "blue," or "not myself." Try to listen for these cues and respond with a clarifying question such as, "You said you were feeling a bit down or depressed?"
4. **Normalize experiences**, such as feeling lonely or isolated. You can say, "You know, many people in your situation are feeling lonely or isolated. Do you ever feel that way?"
5. **Provide empathic responses** when older adults share their feelings. You can say, "I miss having meals with your friends", "it's



### Talking Points Table

Day/Time of Call \_\_\_\_\_

Older Adult Name \_\_\_\_\_

<b>Names to keep track of....</b>	
Children	
Grandchildren	
Siblings	
Parents	
Friends	
<b>Favorite things...</b>	
Hobbies / activities	
Places	

# RESOURCES TO DATE

## Publications:

- Mental health distress in homebound older adults: Importance of the aging network  
<https://www.tandfonline.com/eprint/CIG4HCUYQBUM7SMUIAGQ/full?target=10.1080/13607863.2020.1758920>
- Addressing suicide risk for older adults: The importance of belonging  
<https://acl.gov/news-and-events/news/addressing-suicide-risk-older-adults-importance-belonging>
- COVID-19 and older adults: When social distancing meets social isolation  
<https://www.psychologytoday.com/us/blog/hope-resilience/202003/covid-19-and-older-adults>
- COVID-19 and older Adults: Time to connect  
[https://www.psychologytoday.com/us/blog/hope-resilience/202003/covid-19-and-older-adults-0?fbclid=IwAR0Ni3pvDMQ1ZJEmV3L5ZhsRneYqnG\\_0EIExzenrJOpzWC9Wppn4hnwURyk](https://www.psychologytoday.com/us/blog/hope-resilience/202003/covid-19-and-older-adults-0?fbclid=IwAR0Ni3pvDMQ1ZJEmV3L5ZhsRneYqnG_0EIExzenrJOpzWC9Wppn4hnwURyk)

## Tip Sheets:

- Caring for older adults during Covid-19  
<https://www.wheaton.edu/media/humanitarian-disaster-institute/Tip-Sheet-Caring-for-Wellbeing-of-Older-Adults-During-COVID-19.pdf>
- More than a meal: Facts, stress, & coping for home delivered meal volunteers during COVID-19  
[https://www.wheaton.edu/media/humanitarian-disaster-institute/tip-sheets/Final\\_HDM-volunteer.pdf](https://www.wheaton.edu/media/humanitarian-disaster-institute/tip-sheets/Final_HDM-volunteer.pdf)
- Caregiver tips during Covid-19  
<https://www.wheaton.edu/media/humanitarian-disaster-institute/tip-sheets/Caregiver-tips-during-COVID-19.pdf>
- Quick tips for social distancing (older adults) <https://www.wheaton.edu/media/humanitarian-disaster-institute/tip-sheets/Caregiver-tips-during-COVID-19.pdf>

## National Nutrition Resource Center Resource:

- Enhancing socialization through making meaningful volunteer connections during COVID-19  
<https://nutritionandaging.org/wp-content/uploads/2020/06/Enhancing-Socialization-Through-Making-Meaningful-Volunteer-Connections-During-COVID-19-6-3-2020.pdf>

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# Thank You!

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Program to **E**ncourage **A**ctive and  
**R**ewarding **L**ive**S**



**PEARLS**

# Reducing Depression in Older Adults

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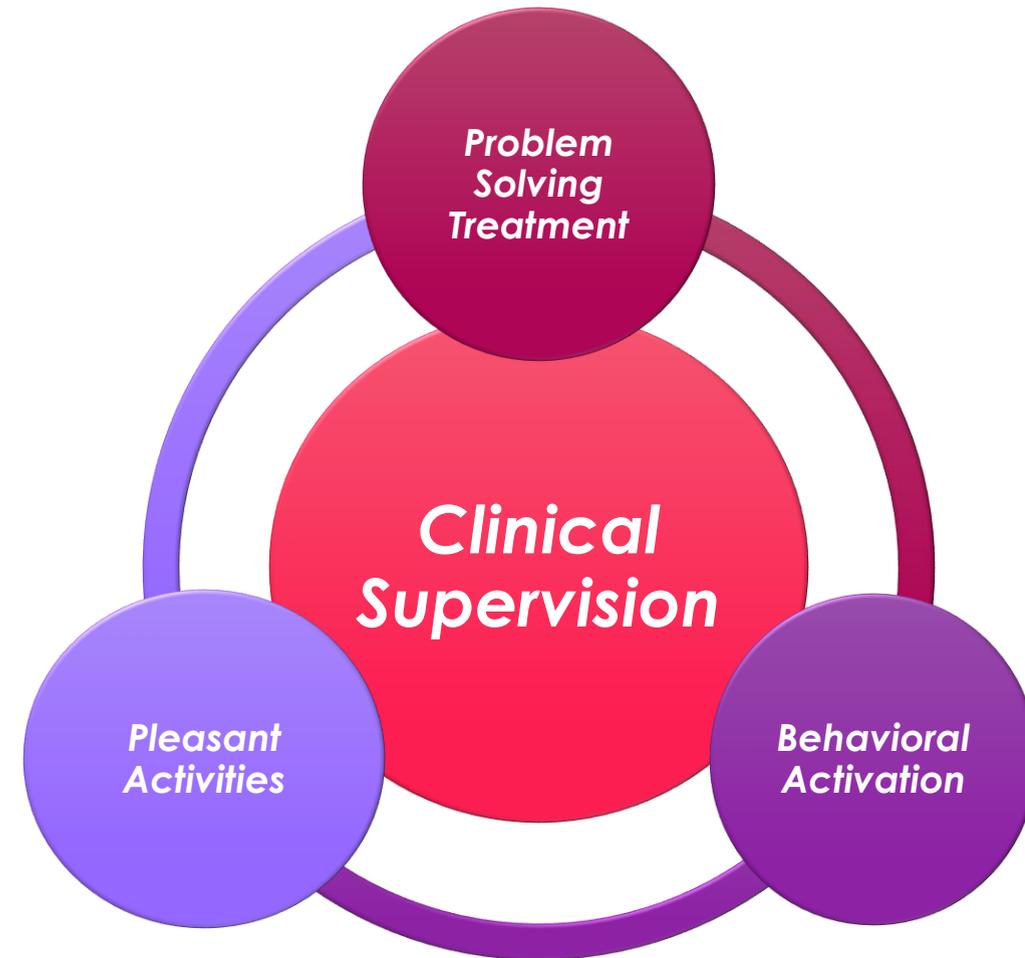
MARYLAND  
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# WHAT IS



# PEARLS?

- **Community-based program** designed to reduce depression and social isolation in older adults ages 50 and older.
- Concrete, **easy-to-learn** and empowering approach to solving problems and reducing depression.
- Delivered **One-on-one** via telephone or at a community location by a certified & trained **PEARLS** counselor.





**PEARLS**

**PRINCIPLES**

**PEARLS is based on three fundamental principles:**

- Utilizes the PHQ-9 to score depression risk at each session
- Participant's experiencing symptoms due to depression
- Link between unsolved problems and depression
- Participation in social, physical and other pleasant activities leads to a decrease in depressive symptoms

# COST AND IMPACT OF DEPRESSION

According to the Centers for Disease Control and Prevention (CDC), “Depression is a treatable medical condition, not a normal part of aging, however, older adults are at increased risk for experiencing depression.” Healthy Aging: Depression is not a normal part of growing older, Centers for Disease Control and Prevention, accessed 3-9-2018, <https://www.cdc.gov/aging/mentalhealth/depression.htm> .

- **Depressive Symptoms Are Associated With Higher Rates of Readmission or Mortality After Medical Hospitalization.** Jenelle L. Pederson, MSc<sup>1</sup>, Lindsey M. Warkentin, MSc<sup>2</sup>, Sumit R. Majumdar, MD, MPH<sup>1,3</sup>, Finlay A. McAlister, MD, MSc<sup>1,4</sup>, Journal of Hospital Medicine Vol 11 | No 5 | May 2016



# CLINICAL OUTCOMES

- Over 50% of clients had a **significant reduction in level of depression**, which was maintained for over 12 months
- 44% achieved **remission of depression symptoms**, maintained for at least 6 months
- Depression Screening and enrollment into PEARLS results in an **average \$1100 savings** in health care costs per patient

(Ciechanowski, JAMA, April 7, 2004—Vol 291, No. 13 1569)

(Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A. Am J Public Health 2011;101(8):1456–65.)



# THE LINK BETWEEN SOCIAL ISOLATION AND RISK FOR DEPRESSION

**The lack of social relationships are a major risk factor for health**—rivaling the effect of health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity <sup>[1]</sup>

- The health risks of **prolonged isolation** are equivalent to **smoking 15 cigarettes a day**

- A lack of social connections can **increase the risk of death** by at least 50%, and in some circumstances, by more than 90% <sup>[2]</sup>
- Lonely individuals are more **prone to depression** <sup>[3]</sup>
- Loneliness and low social interaction are **predictive of suicide in older age** <sup>[4]</sup>

1. House, Landis, and Umberson; *Science* 1988

2. Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015.

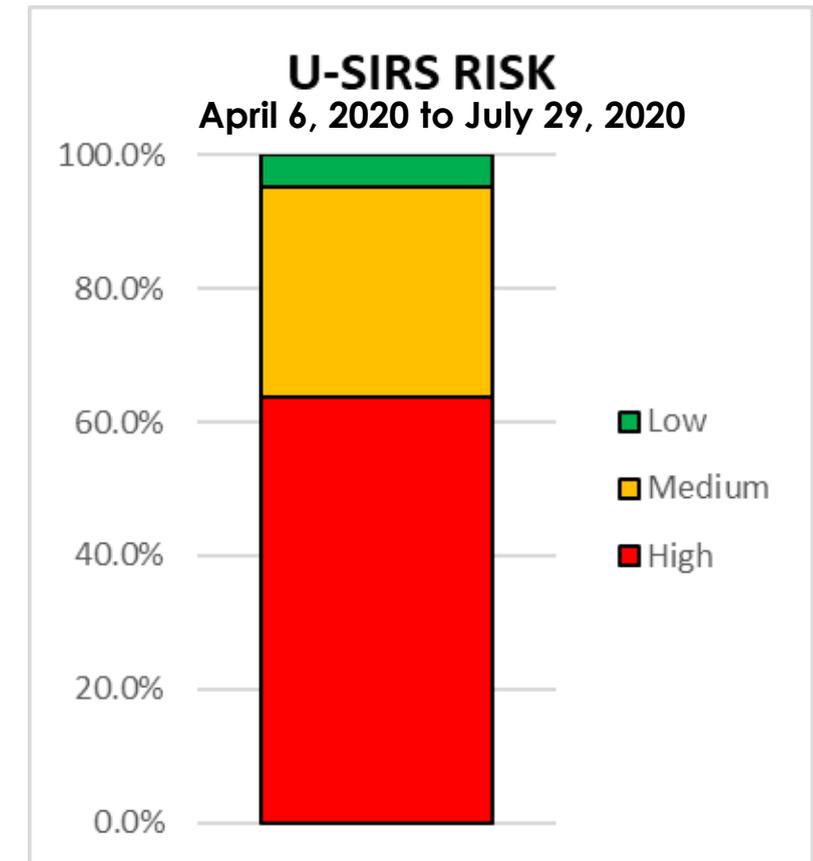
3. Cacioppo et al, 2006 and Green et al, 1992, <https://www.campaigntoendloneliness.org/about-loneliness/>

4. O'Connell et al, 2004, <https://www.campaigntoendloneliness.org/about-loneliness/>

5. Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med* 7(7): e1000316. <https://doi.org/10.1371/journal.pmed.1000316>.

# SOCIAL ISOLATION RISK IN MARYLAND DURING COVID-19

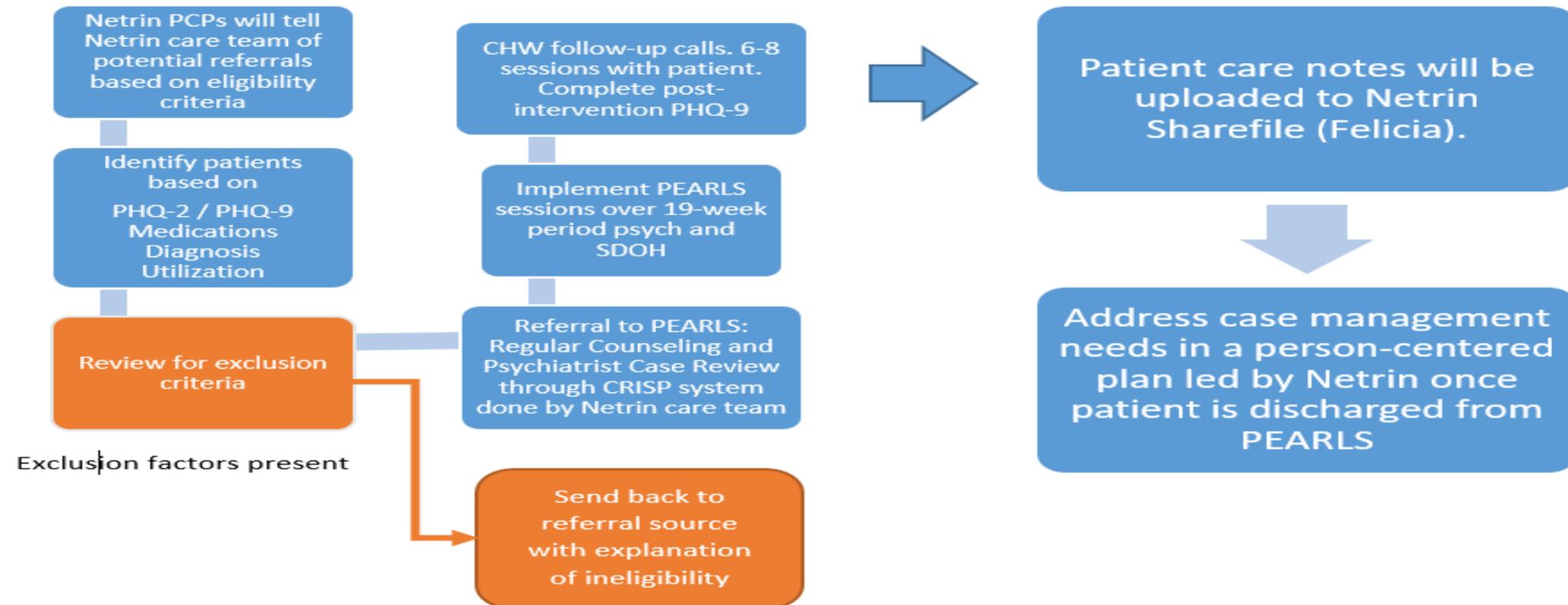
- Data collected from 124 older adults telephonically (from 19 ZIP Codes)
  - On average, age 72.8 ( $\pm 9.1$ ) years
  - 74% female
  - 89% non-Hispanic white; 8% African American
  - 37% not married/do not live with partner
  - 10% do not always have a ride or transportation
- About 63.7% at high risk on the U-SIRS
  - 31.5% a medium risk
- Additional risk and vulnerability observed
  - Virus risk for older adults and those with chronic conditions
  - Stay-at-home and shelter-in-place orders
  - Store and organization closures

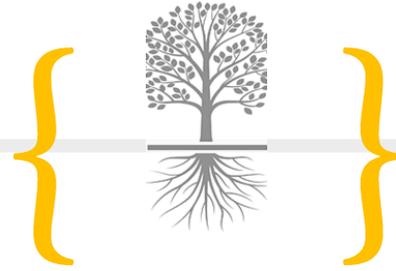


# MARYLAND PRIMARY CARE PROGRAM COLLABORATION

- Assist in facilitating increased PCP utilization of CRISP for referrals
- Ability to link providers to AAAs and/or CHWs to provide PEARLS (Program to Encourage Active and Rewarding LiveS Depression/social isolation program
- Scaling of PEARLS virtual trainings to meet statewide demands
- Linking PEARLS delivery to PCP referral and integrating into Medicare reimbursement

# PROCESS FLOW CHART FOR REFERRAL TO PEARLS, ELIGIBILITY DETERMINATION, PROGRAM IMPLEMENTATION AND BILLING





## *Questions & Answers*

- Enter questions into the “Q&A box”
- This webinar is being recorded. The slides and recording will be shared by email within a few days and archived on [www.ncoa.org/cha](http://www.ncoa.org/cha).