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Center of Excellence for Behavioral Health Disparities in Aging
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# *Late-Life Suicide Prevention:*
## *From Assessment to Intervention*

**April 3, 2025**
**noon—1 pm EDT**

Sponsored by the Medicare Mental Health Workforce Coalition and the E4 Center

# Meeting Details

1. **Closed Captioning** is enabled and attendees can turn CC on or off as they desire.
2. **Interpreter Phone Number: 305-224-1968 Webinar ID: 814 9419 4977 Passcode: 022220**
3. **Session Evaluation / Take our survey at the end of the webinar.** (CE credit for live attendance only)
4. Webinar will be posted on the NBCC website a few days following the webinar.
5. **Q&A:** Please add your questions in the Q&A box at any time during the meeting.

# Previous Webinars

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# Medicare Mental Health Workforce Coalition Members

- American Association for Marriage and Family Therapy
- American Counseling Association
- American Mental Health Counselors Association
- Association for Behavioral Health and Wellness
- California Association of Marriage and Family Therapists
- Centerstone
- Center for Medicare Advocacy
- Michael J. Fox Foundation for Parkinson's Research
- National Association for Rural Mental Health
- National Association of Community Health Centers
- National Association of County Behavioral Health and Developmental Disability Directors
- National Association of Social Workers
- National Board for Certified Counselors
- National Council for Mental Wellbeing
- National Council on Aging
- Network of Jewish Human Service Agencies
- The Jewish Federations of North America

# Learning Objectives

## After this webinar, attendees will be able to:

1. **describe** three key facts about the epidemiology of suicide in later life.
2. **identify two assessment tools** to assess suicide risk in later life and understand how to use them.
3. **identify two promising intervention approaches** and where to learn more about providing them.

***One hour of continuing education credit is available for attendance of the live event.***

# Kimberly A. Van Orden

**Kimberly A. Van Orden, PhD,** is an Associate Professor in the Department of Psychiatry at the University of Rochester Medical Center (URMC). At URMC, Dr. Van Orden is the Co-Director of the Center for the Study and Prevention of Suicide, which is one of only a few research centers around the world that focuses on suicide, and is the Director of the Postdoctoral Training in Suicide Prevention Research. Her work mainly focuses on suicide prevention, injury prevention, and suicidal ideation. She also directs the HOPE (Helping Older People Engage) Lab, which focuses on developing and testing interventions to increase connectedness.

# Jordan B. Westcott

**Jordan Westcott, PhD, NCC,** is a counselor educator and National Certified Counselor focused on how communities access mental health care and their unique mental health needs, with emphasis on older adulthood, LGBTQ+ identity, and intersections therein. Her research, teaching, and service focus on the needs of marginalized communities in the context of counseling, with an emphasis on how counselors can be change agents. Dr. Westcott is an Assistant Professor of Counselor Education in the Counseling, Human Development and Family Science department at The University of Tennessee, Knoxville. She is a leader in the counseling profession, with service experiences including Chair of the ACA Public Policy and Legislation Committee, Member of the SACES Legislative Advocacy Taskforce, and presently the SAIGE Research and Scholarship Trustee. Much of her advocacy, service, and scholarship is focused on counselors as Medicare providers and how that enables access to counseling for older people and people with qualifying disabilities.

# Katherine M. Hertlein

**Katherine M. Hertlein, PhD, LMFT,** is a Professor in the Department of Psychiatry and Associate Dean of Faculty Affairs and Professional Development in the Boonshoft School of Medicine at Wright State University in Dayton, Ohio. She was previously a Professor and Program Director of the Couple and Family Therapy Program at the University of Nevada, Las Vegas. She received her master's degree in marriage and family therapy from Purdue University Calumet and her doctorate in human development with a specialization in marriage and family therapy from Virginia Tech. Across her academic career, she has published over 100 articles, over 50 book chapters and 12 books in two areas: sexuality and technology and families. She developed the first multitheorectical model for describing the effect of technology on couple and family life. Dr. Hertlein has won numerous awards for research, teaching, mentorship, and supervision across her career, including the Nevada System of Higher Education’s Regent’s Rising Researcher Award, the Barrick Scholar Award, and the Barrick Distinguished Scholar Award from UNLV. Dr. Hertlein was also awarded a Fulbright Core Scholar Award (2018–2019) and, in this role, served as a Guest Lecturer and Guest Researcher at the University of Salzburg in Salzburg, Austria. She serves on the board of the Telebehavioral Health Certification Institute and on the Fulbright Austria Alumni Advisory Board. Dr. Hertlein is also the Editor-in-Chief of the *Journal of Couple & Relationship Therapy*.

# *Late-Life Suicide Prevention:*
## *From Assessment to Intervention*

**Kim Van Orden, PhD**
Co-Director, Center for the Study & Prevention of Suicide
Director, Postdoctoral Training in Suicide Prevention Research
Department of Psychiatry
University of Rochester Medical Center

Center for the Study & Prevention of Suicide
#researchtosavelives
CSPS
urmc.rochester.edu/psychiatry/suicide-prevention

MEDICINE *of* THE HIGHEST ORDER

UNIVERSITY *of* ROCHESTER MEDICAL CENTER

# Disclosures and Acknowledgments

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  - R01AG082882 (Van Orden, PI), Connection in Caregivers
  - 5R61MH129476 (Van Orden, PI), Social Connection Coaching
  - NIMH T32MH020061 (Conwell, PI), Postdoctoral Training in Suicide Prevention Research
  - 1K24AG084885-01A1 (Van Orden, PI)

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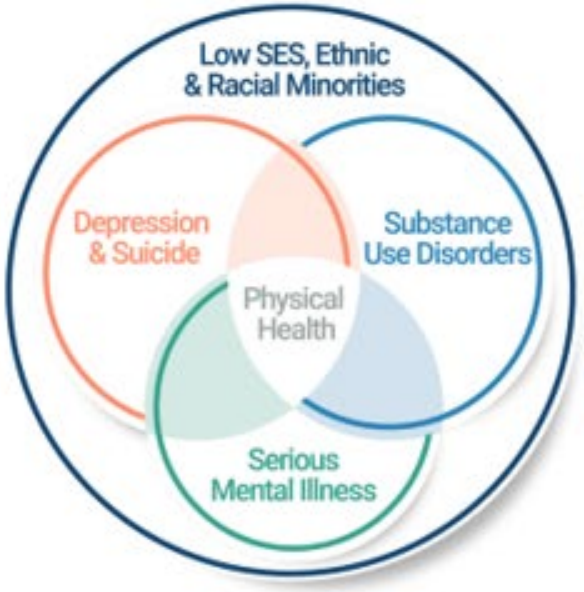
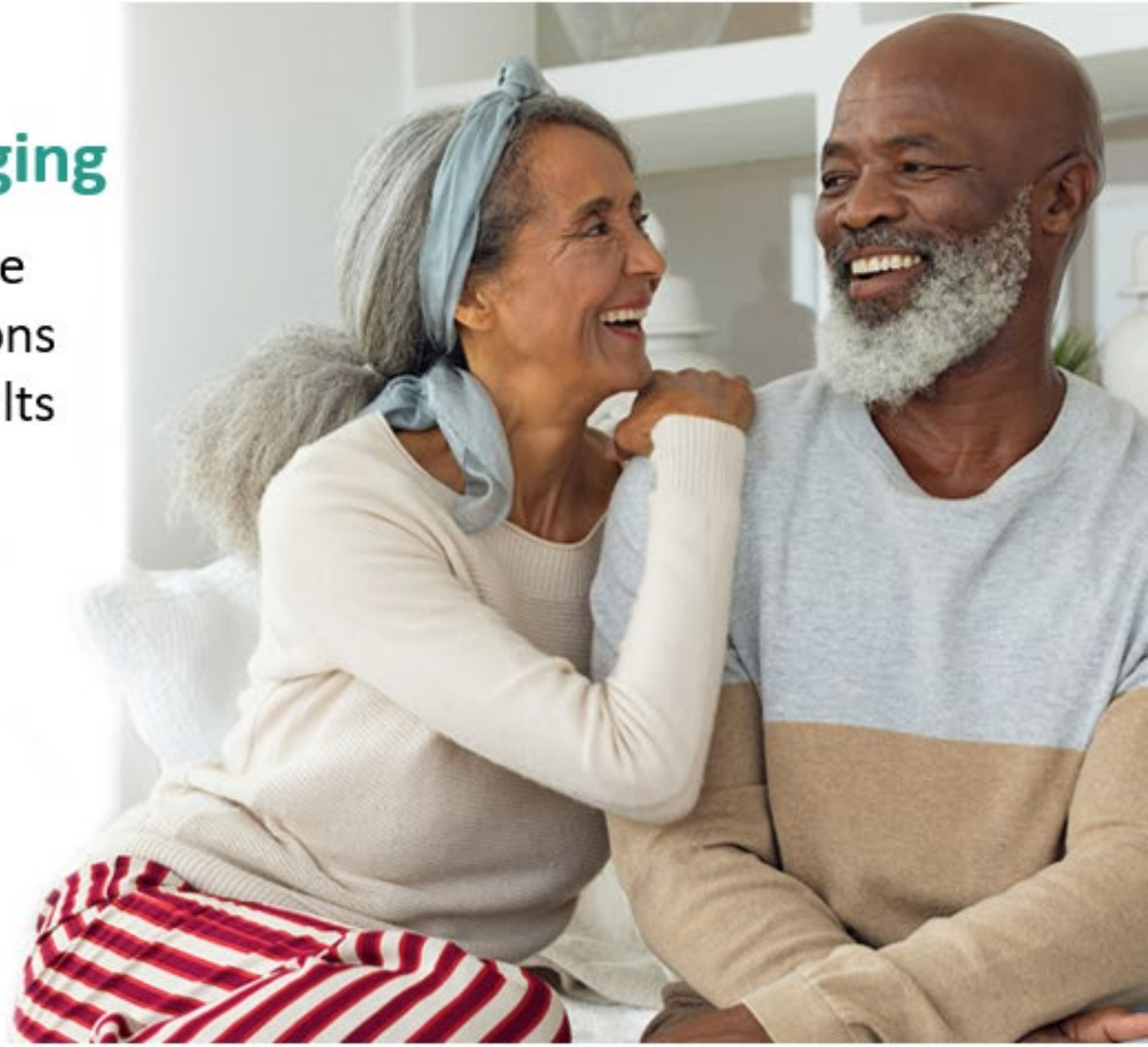
**Engage**, **Empower**, and **Educate** health care providers and community-based organizations for **Equity** in behavioral health for older adults and their families across the US.



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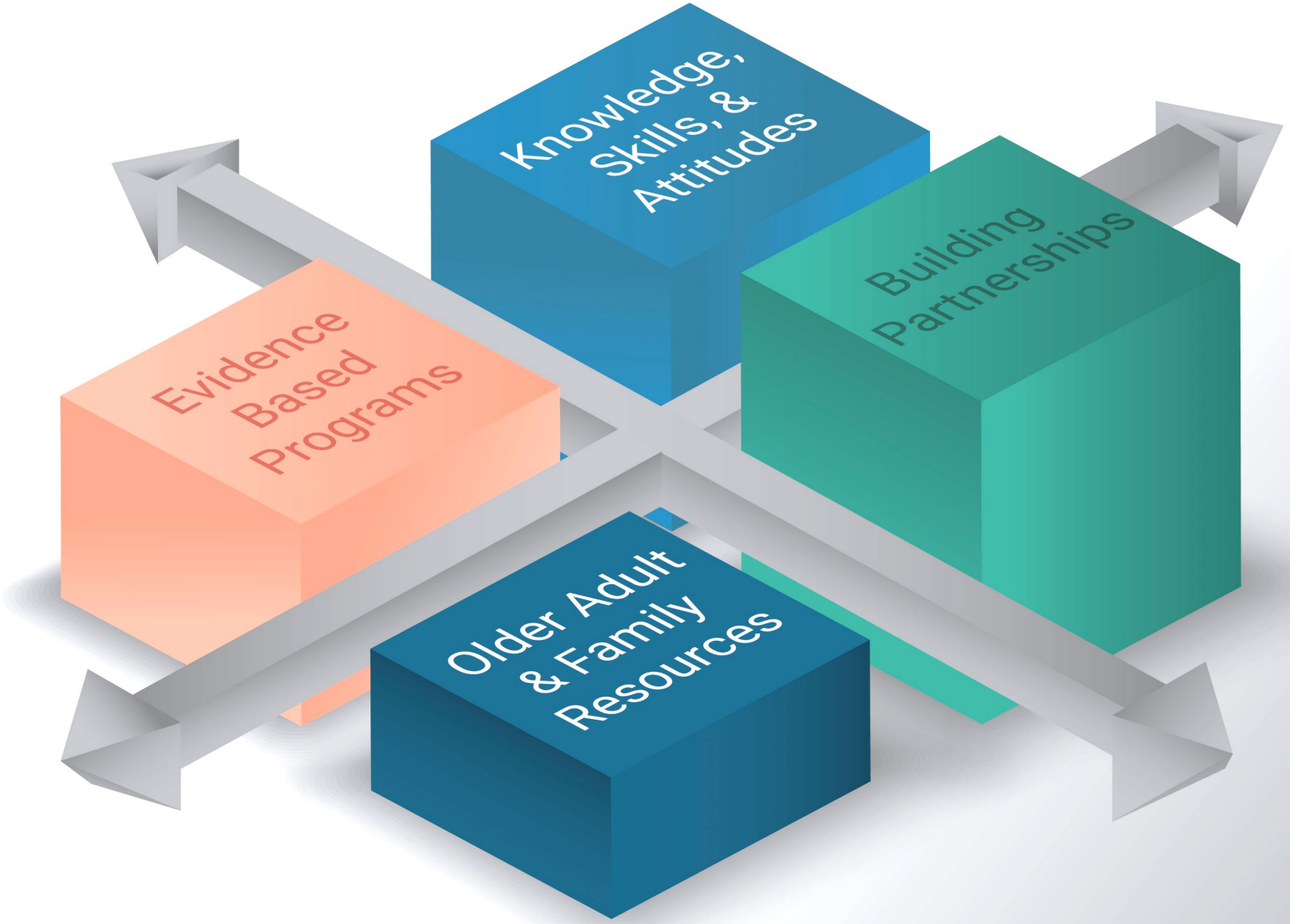


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# E4 Center: Evidence-Based Practice

**Schaalman Senior Voices Thought Leader Lecture: Ageism Unmasked**

**Tracey Gendron, MS, PhD**

Wednesday, May 7th, 2025

**10-11:30AM PT / 11AM-12:30PM MT / 12-1:30PM CT / 1-2:30PM ET**

**Evidence Based Practice Series: Prevention**

**Friday April 18: Jo Anne Sirey, PhD**

**Friday May 2: Ipsit Vihang Vahia,M.D.**

**Friday May 16: Patrick Raue, PhD**

**9-10:30AM PT / 10AM-11:30PM MT / 11-12:30PM CT / 12-1:30PM ET**

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# 4Ms Behavioral Health Series



## Implementing the 4Ms of Behavioral Health for CCBHCs:
## Applying the 4Ms of an Age-Friendly Health System in Mental Health and Substance Use Services

Erin Emery-Tiburcio, PhD, ABPP, Laura Porter, PhD, Caryn Blanton, LCSW

**Series will be held from June 27th —September 5th, 2025**

**Every Other Friday starting at 9:00am PT / 10:00 am MT/11:00am CT / 12:00pm ET**

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# Upcoming E4 Center Events


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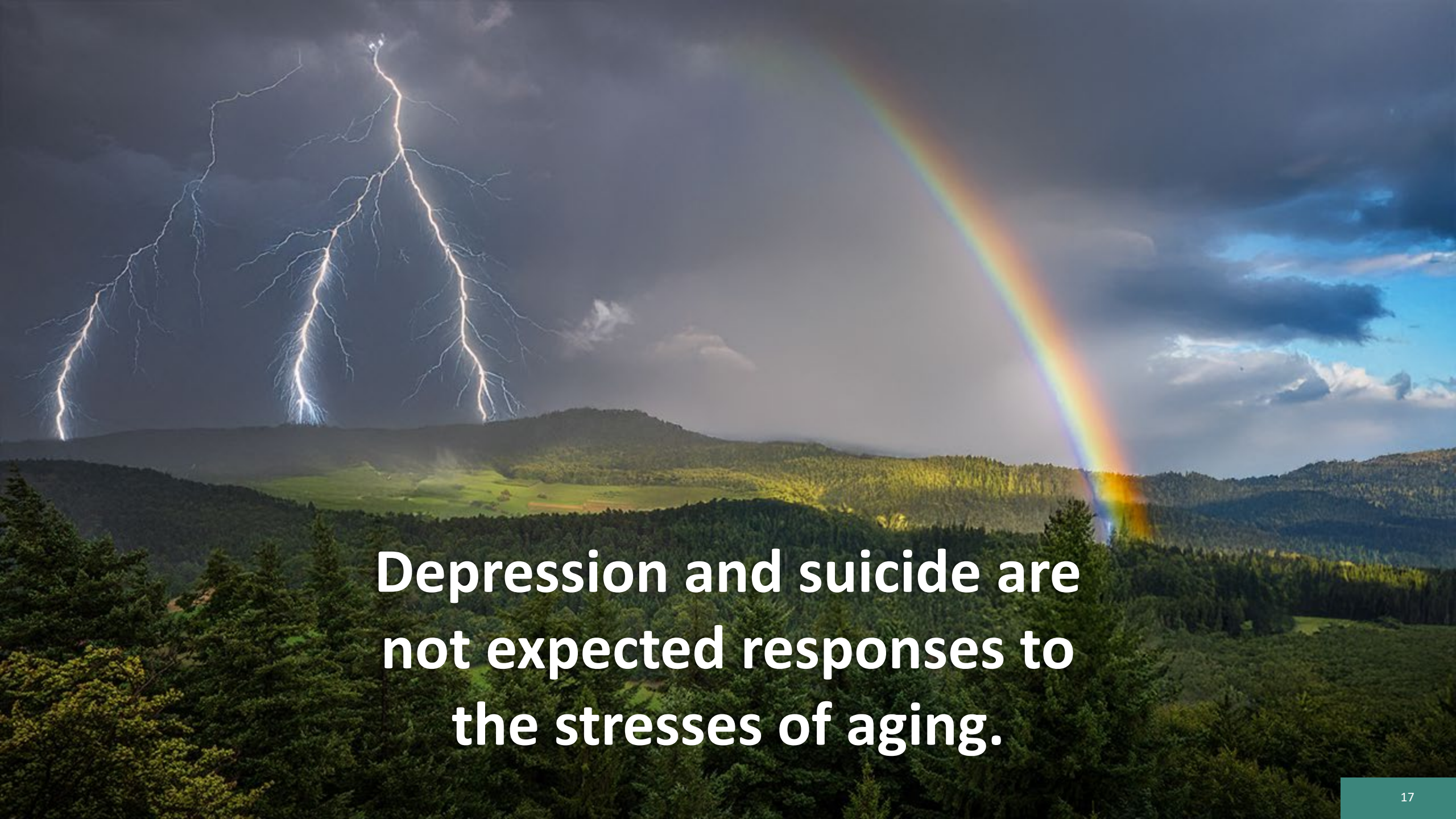

Depression and suicide are
not expected responses to
the stresses of aging.

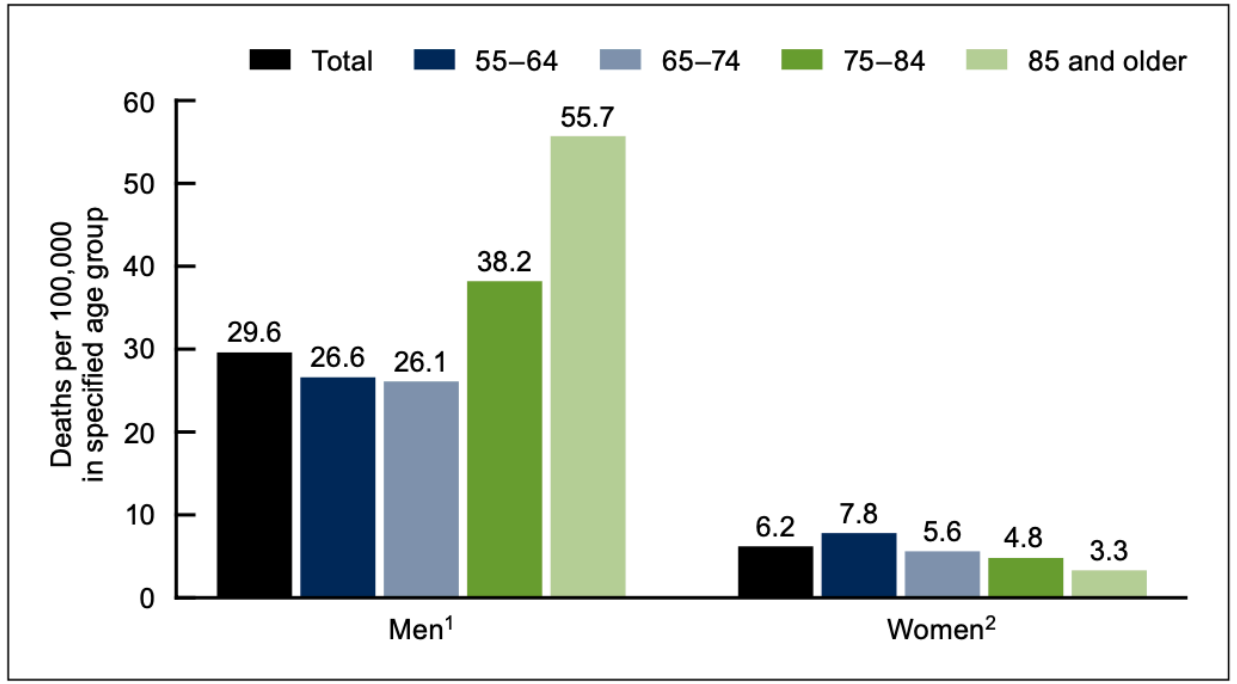
# PART 1

# Epidemiology of Late-Life Suicide

# Suicide in Later Life: *Epidemiology*

- **Older adults** are the most rapidly growing segment of the population.
- **Suicide rates** increase with age around the world.
- **Older men** in the U.S. have higher rates of suicide than other segments of the population.
- **In successive cohorts**, the problem may increase (Phillips, 2014).

Figure 1. Suicide rate among adults age 55 and older, by age group and sex: United States, 2021




[1]Rates for men were significantly higher than rates for women for all age groups, $p < 0.05$.
[2]Significant linear trend by age group, $p < 0.05$
NOTES: In 2021, the overall U.S. suicide rate was 14.5 per 100,000 population. Suicide deaths are identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db483-tables.pdf#1.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

# Suicide in Later Life: *Epidemiology*

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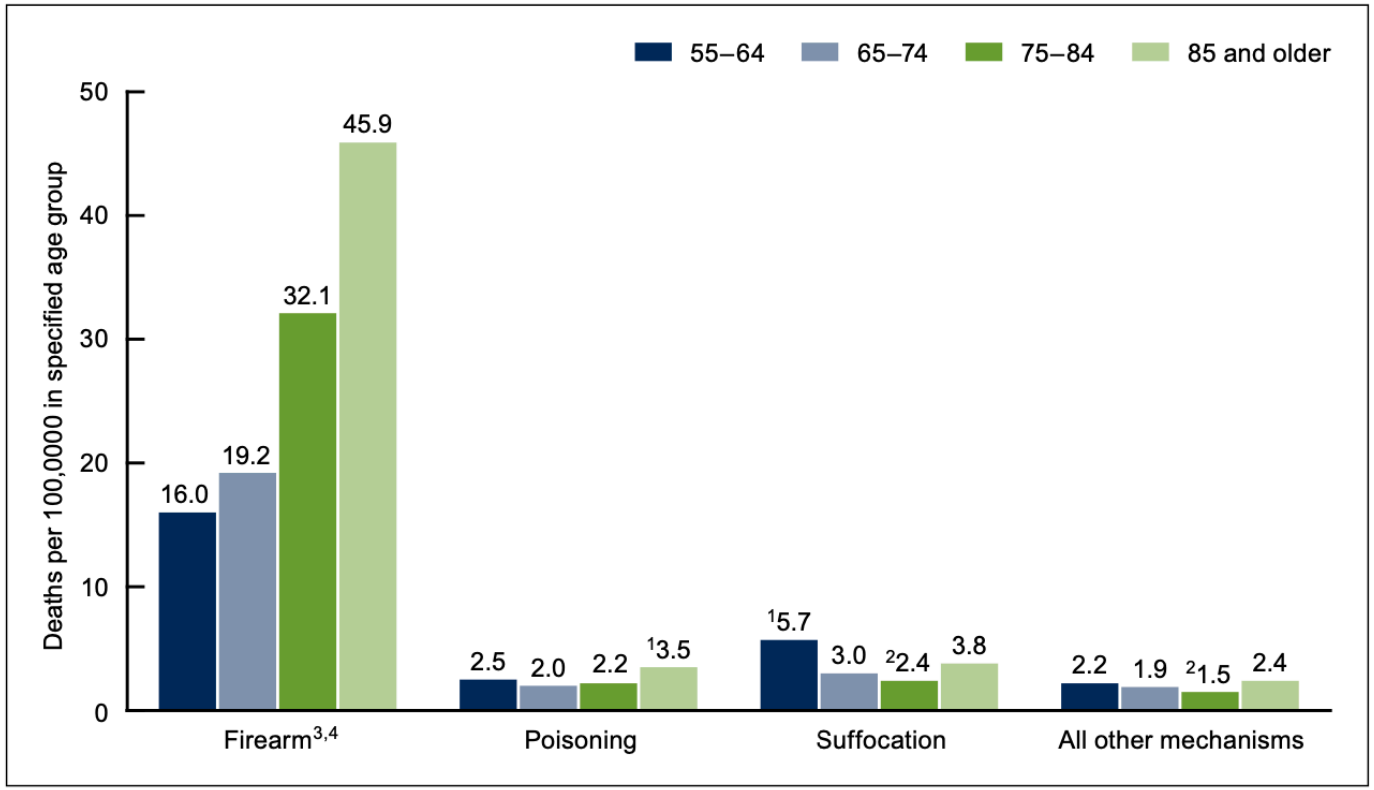
- **Suicide rates** increase with age around the world.
  - **Older men** in the U.S. have higher rates of suicide than other segments of the population.
    - **In successive cohorts**, the problem may increase (Phillips et al., 2014).
- **Suicidal behavior** is more lethal in later life.
  - more planful and determined (firearms →)
  - less likely to be rescued; more frail

Figure 3. Suicide rate among men age 55 and older, by age group and mechanism of death: United States, 2021




[1]Age group has the highest rate compared with all other age groups in specified mechanism of death, $p < 0.05$.
[2]Age group has the lowest rate compared with all other age groups in specified mechanism of death, $p < 0.05$.
[3]Suicide rates for men were significantly higher than poisoning, suffocation, and all other mechanisms of death for all age groups, $p < 0.05$.
[4]Significant linear trend by age group, $p < 0.05$.
NOTES: Suicide deaths are identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Mechanisms of suicide are identified using *International Classification of Diseases, 10th Revision* codes X72–X74 for firearm, X60–X69 for poisoning, and X70 for suffocation. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db483-tables.pdf#3.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

# Optimal Suicide Prevention for Older Adults

## Suicidal behavior is more lethal in later life.

- **Interventions must be aggressive** (indicated)
- **More distal prevention is key** (selective and universal)

**Indicated** – *detect and treat depression*

+

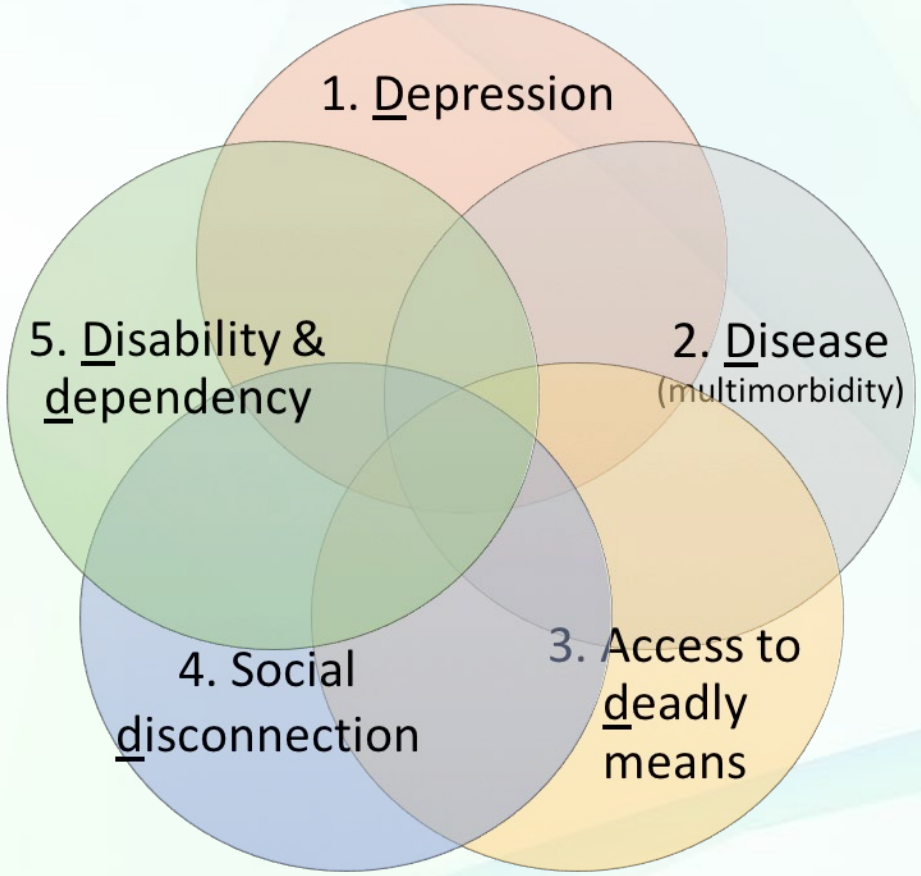
**Selective** – *optimize independent functioning, increase social connectedness*

+

**Universal** – *education to reduce ageism, promote gun safety*

# 5 Dimensions of Risk for Suicide in Late Life

1. Psychiatric illness (primarily **d**epression)
2. Physical illness (multiple comorbid **d**iseases)
3. Access to lethal (**d**eadly) means (e.g., firearms)
4. Social **d**isconnection (isolation, loneliness, family conflict)
5. **D**isability (functional impairment) and distress over **d**ependency (feeling like a burden)




Conwell (2022); Van Orden et al. (in press)

# Depression and Suicide: *What We Know*

- **Mood disorders** (esp. Major Depression) are common among older adults who die by suicide; present in 54% to 87%.
- **Few will have received** formal psychiatric diagnoses or treatment.
- **The combination of** depressive disorders and medical illness is particularly common in later life.
- **Depression in older adults:**
  - less likely to report sad/depressed mood
  - more likely to report anhedonia, apathy, problems with memory, concentration, processing speed, and executive functioning; describe somatic symptoms as primary concern, including sleep, fatigue, psychomotor slowing

# Physical Illness: *What We Know*

**Older adults who died by suicide are characterized by:**

| | |
|---|---|
|  | Decline in physical health (year before death) |
|  | Multimorbidity |
|  | Poor sleep quality |
|  | Commonly seen in primary care |
|  | Depressive disorders + physical illness |

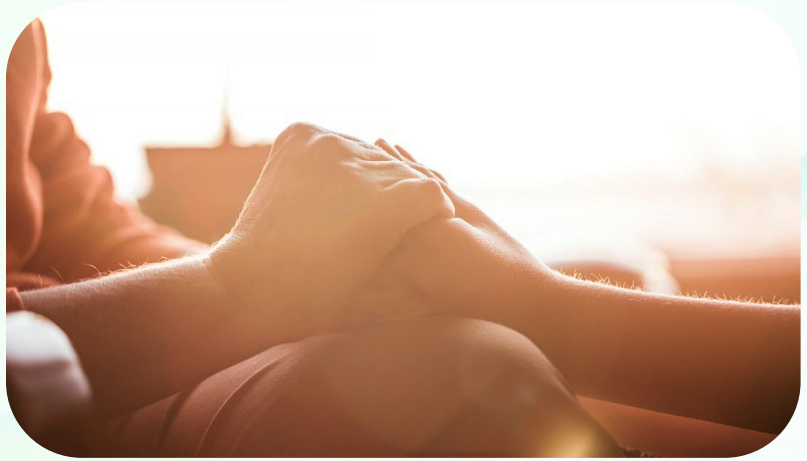
# Physical Illness

## What we do not know yet:

- **Inconsistency** as to which specific diseases (or organ systems) are most strongly associated with suicide.
- **Some illnesses** may be associated with ideation but not attempts or deaths.

## Potential mechanisms include:

- neurobiology of stress
- neurobiology of illness
- functional impairment



# Disability: *What We Know*

- **Physical disability** (also called functional impairment) is linked to suicide ideation, attempts, and deaths
  - Instrumental Activities of Daily Living (IADLs)
  - Activities of Daily Living (ADLs) are associated with suicide
- **Sensory impairment**, including vision loss

# Disability: *What We Know*

## Most with disability do not die by suicide; risk increases when:

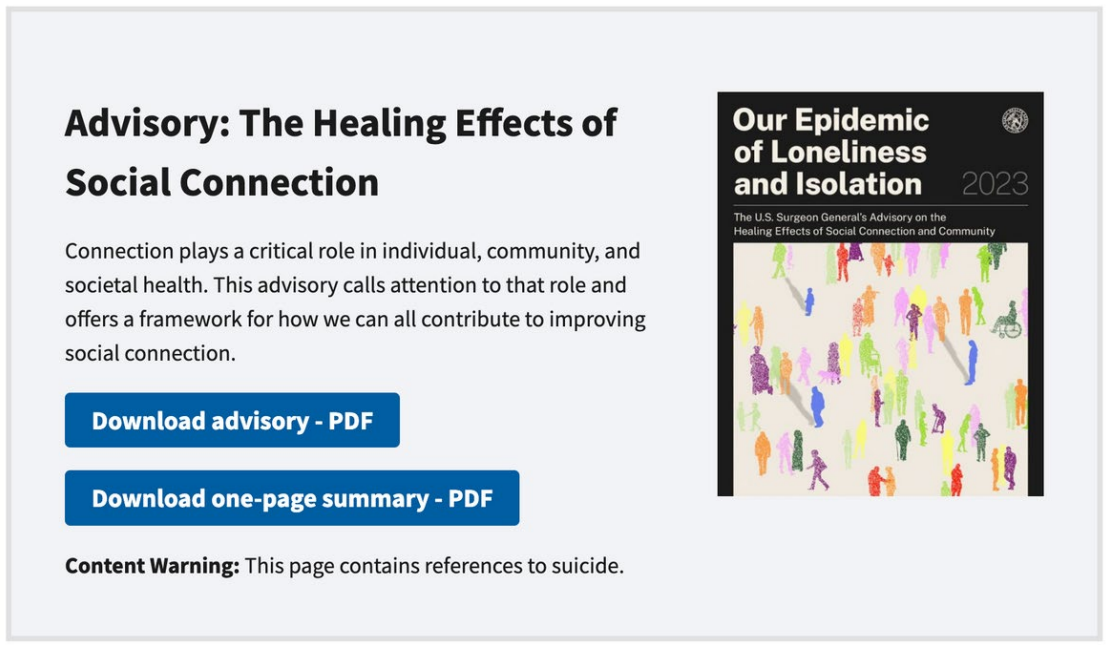
| | |
|---|---|
|  | **Assistance with ADLs:** visiting nurse, home health aides |
|  | **Personality:** high need for control and autonomy |
|  | **Lack of diverse coping strategies**, flexibility |
|  | **Internalized ageism** linked to decreased will to live |

# Disability: *What We Know*

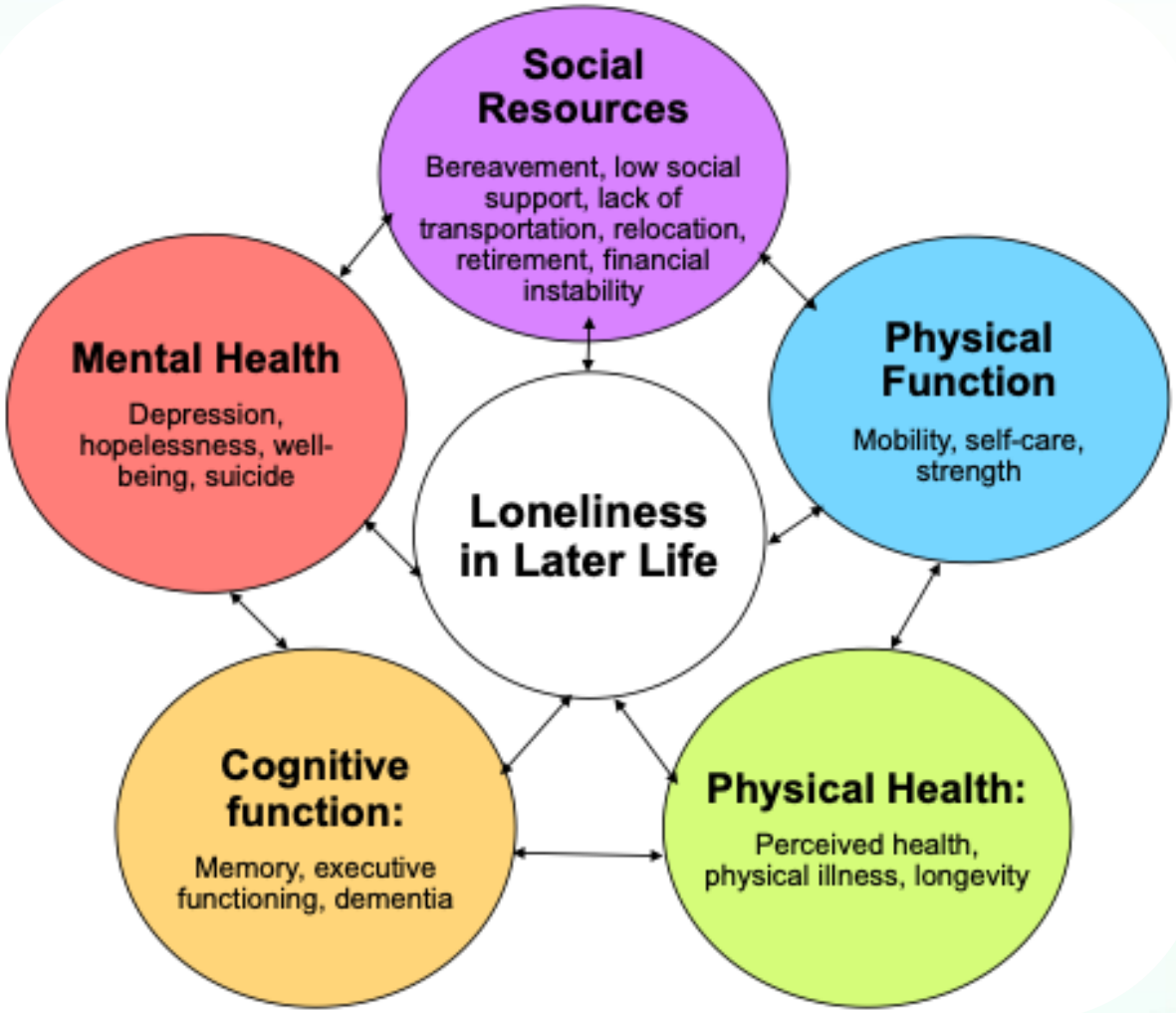
- **Complex association between suicide and cognitive functioning:**
  - **dementia and suicide:** typically, soon after the diagnosis and early in the illness
  - **cognitive control deficits** increase risk for suicide attempts in later life

# Social Disconnection: *What We Know*

- **Social connections** that create a sense of caring, contributing, and community have a range of benefits for health and well-being.
- **Indices of low social connection** are linked to suicide risk factors in later life as well as suicide ideation, attempt, and death.
  - living alone
  - small social networks
  - absence of a confidant
  - loss of a spouse
  - social (dis)engagement
  - family discord
  - loneliness
  - low social integration



# Social Disconnection: *What We Know*



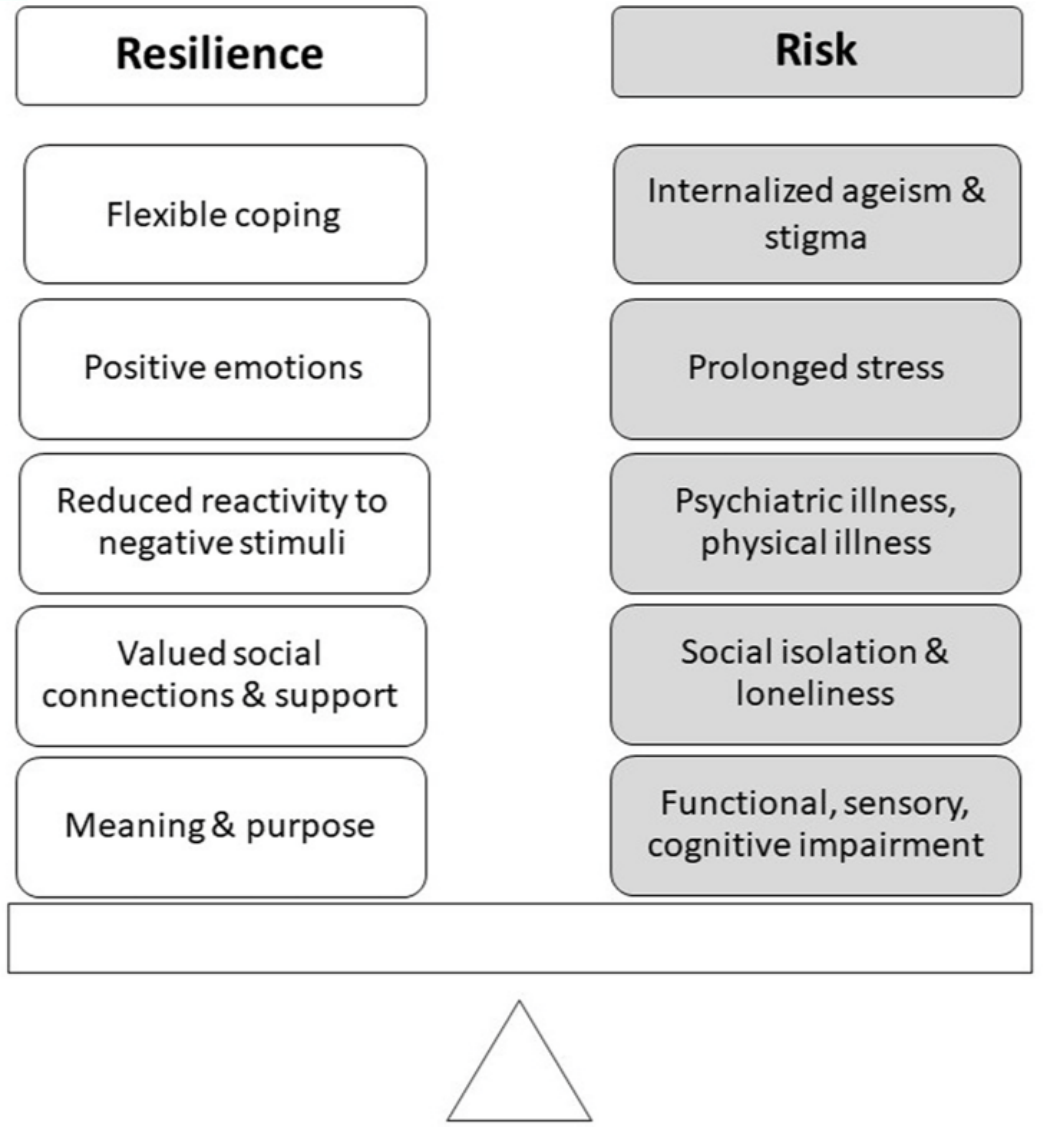

- **Three intervention studies** have shown effects on suicide deaths in older adults.
- **All involved promoting social connection**—but the studies were not designed to test this mechanism.

(Chan et al., 2011; De Leo et al., 2002; Oyama et al., 2008)

# Firearms: *What We Know*

- **Suicide attempts** are more often fatal among older adults, in part because older adults tend to use more lethal means (e.g., firearms in the United States), are more planful and determined, are frailer, and often are more isolated and thus less likely to be discovered.
- **Older adults** in the United States who use firearms as the suicide method are more likely to live in rural areas and to have served in the military.
- **Cognitive control deficits** combined with access to lethal means may be a pernicious combination in later life.

# Risk and Resilience




Lutz & Van Orden, 2020

PART 2

# Suicide Risk Assessment

# Why do we use screening tools?

- **The goal** of suicide risk assessment is **NOT** a prediction about whether a patient will die by suicide.
- **The goal IS** to determine the most appropriate actions to take to keep a patient safe.
- We need to **take action** for all endorsements of suicide ideation, but not the same action for every type of endorsement.

# Key Components

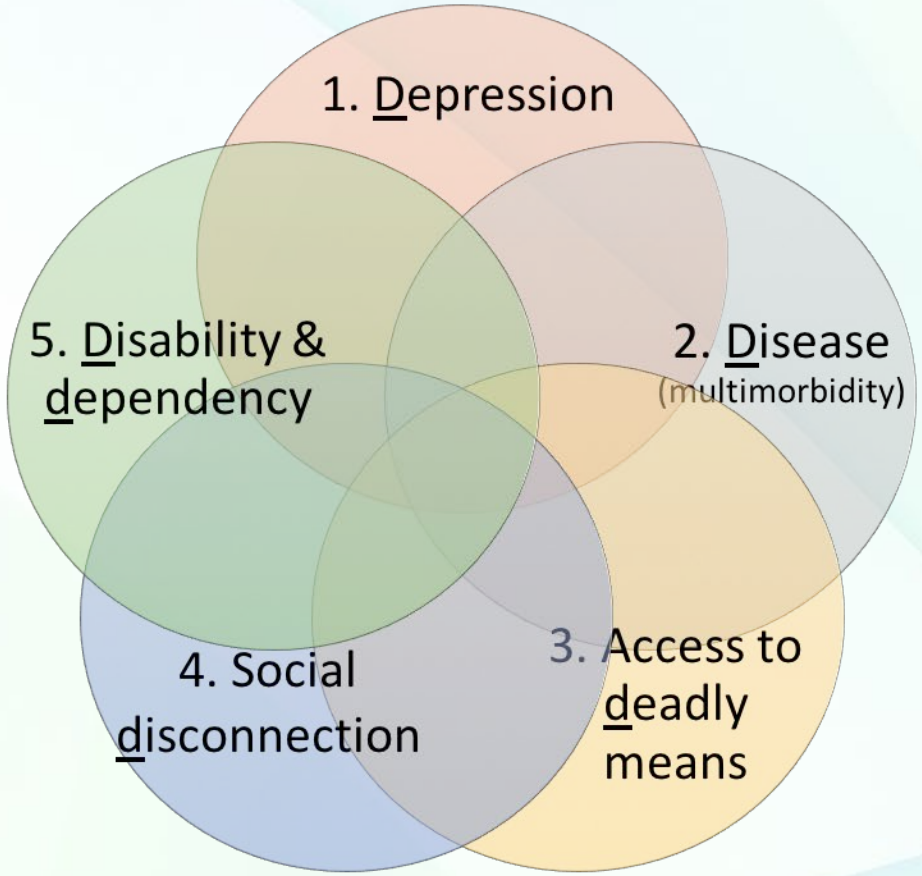
1. **Your attitude:** collaboration, connection, [your] comfort
2. **Gathering information** (asking questions)
3. **Making sense of the information and organizing it** (assessment)
4. **Taking actions while meeting with patient** (responding/planning)
5. **Taking actions after meeting with patient** (extending)

# Clinical Data: *5 D's*

## The goals of suicide risk assessment:

- **Take appropriate actions** to manage safety right now.

- **Guide treatment planning** to reduce risk over the course of treatment (select treatment targets that will reduce suicide risk, in addition to psychiatric diagnoses).



# Columbia Suicide Severity Rating Scale

## Semi-structured interview:

- **Flexible:** suggested prompts; goal is to get the info you need; don't need to ask questions you don't need
- Also a self-report version

## Benefits:

- **Comprehensive:** includes worst point and many types of behavior
- Standard definitions
- Useful suggested prompts

# Definitions

## Spectrum of specificity

Least → Greater

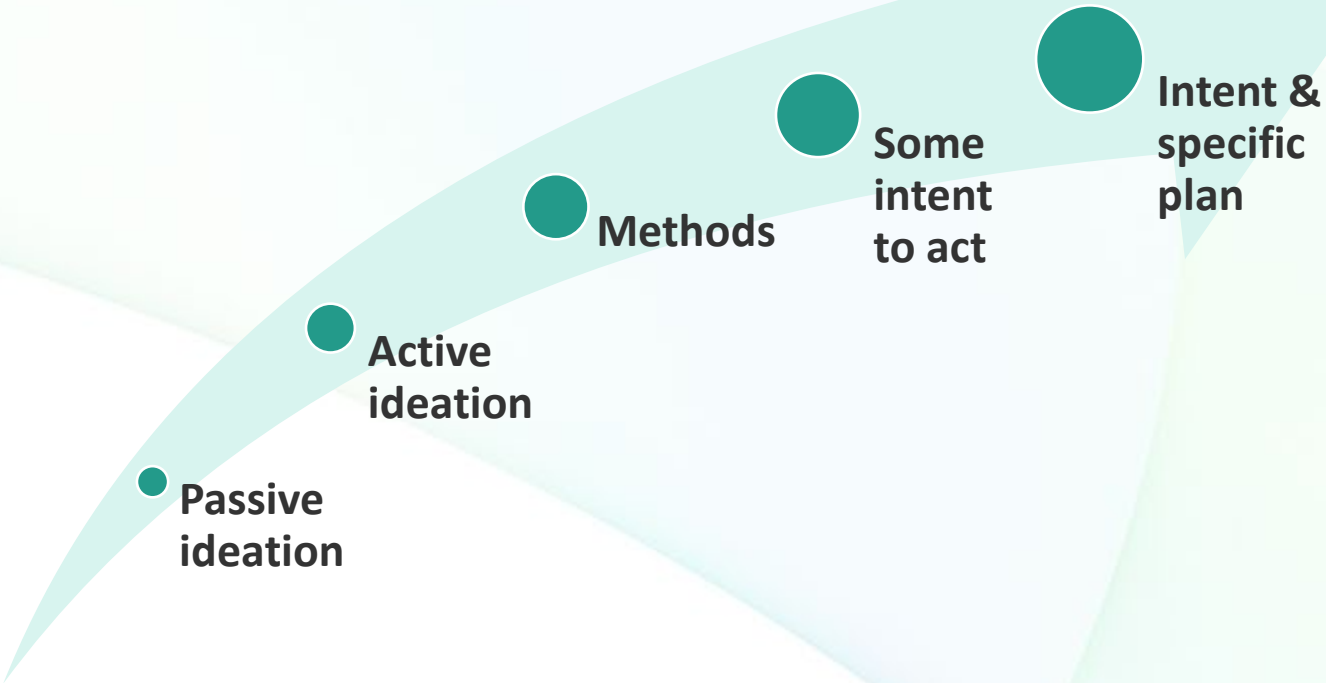



Image adapted from McDowell, Lineberry, & Bostwick (2011). Practical suicide-risk management for the busy primary care physician. *Mayo Clinic Proceedings*, *86*(8).

Definitions from the Columbia Suicide Severity Rating Scale.

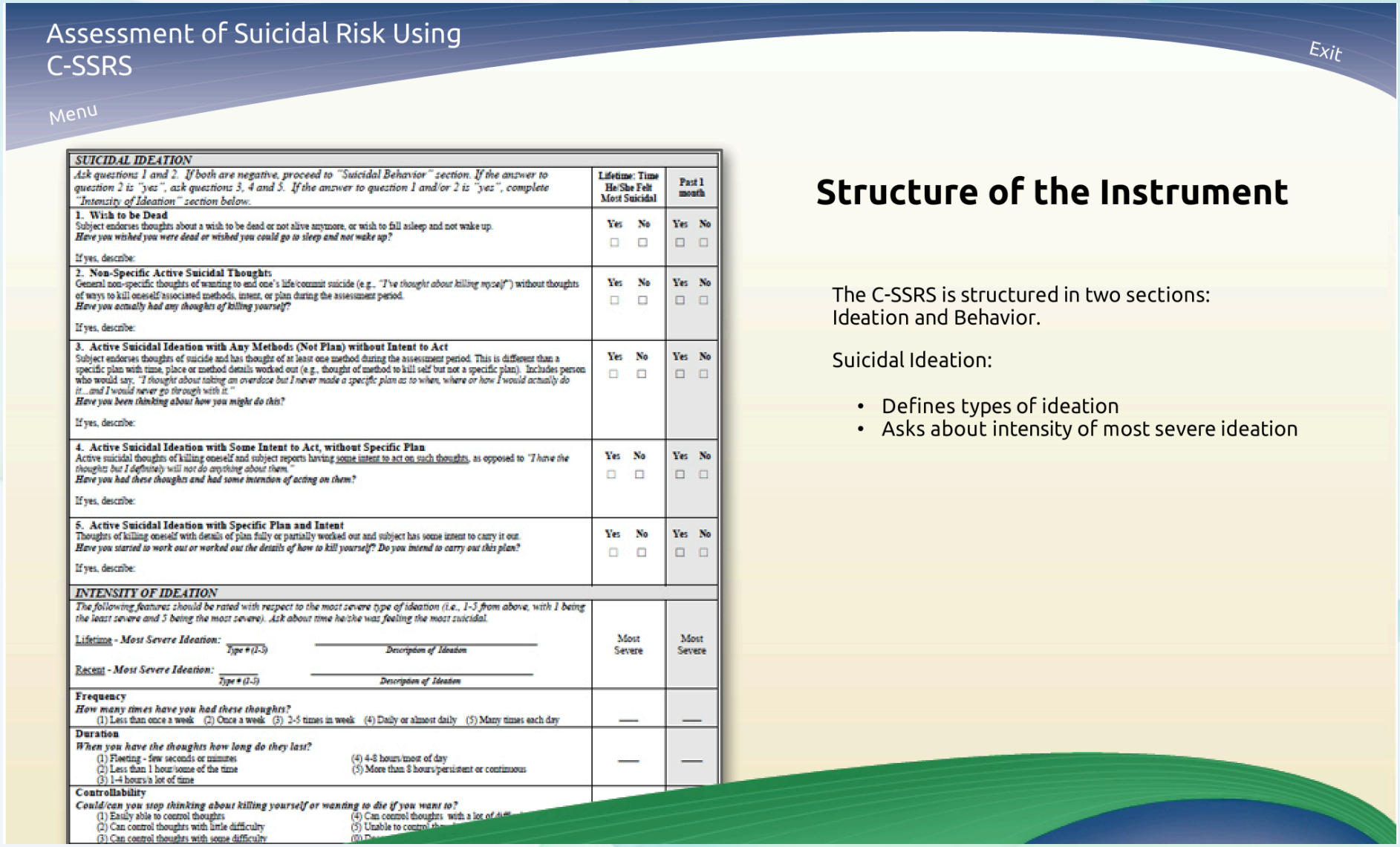
## Types of suicide ideation:

- Passive: wish to be dead
- Active thoughts of killing yourself
- Consideration of methods
- Some intent to act
- Intent and specific plan (imminent risk)

## Types of suicidal behavior:

- Suicide attempt (multiple attempts)
- Interrupted attempt
- Aborted attempt
- Preparatory behavior
- (NSSI)

# Columbia Suicide Severity Rating Scale: *Suicide Ideation*




| SUICIDAL IDEATION | Lifetime: Time He/She Felt Most Suicidal | Past 1 month |
|---|---|---|
| Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below. | | |
| **1. Wish to be Dead**<br>Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.<br>*Have you wished you were dead or wished you could go to sleep and not wake up?*<br>If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **2. Non-Specific Active Suicidal Thoughts**<br>General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.<br>*Have you actually had any thoughts of killing yourself?*<br>If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act**<br>Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."*<br>*Have you been thinking about how you might do this?*<br>If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan**<br>Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*<br>*Have you had these thoughts and had some intention of acting on them?*<br>If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **5. Active Suicidal Ideation with Specific Plan and Intent**<br>Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.<br>*Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*<br>If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **INTENSITY OF IDEATION** | | |
| *The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.*<br>Lifetime - *Most Severe Ideation:* Type # (1-5) ____ Description of Ideation ____<br>Recent - *Most Severe Ideation:* Type # (1-5) ____ Description of Ideation ____ | Most Severe | Most Severe |
| **Frequency**<br>*How many times have you had these thoughts?*<br>(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day | ____ | ____ |
| **Duration**<br>*When you have the thoughts how long do they last?*<br>(1) Fleeting - few seconds or minutes<br>(2) Less than 1 hour/some of the time<br>(3) 1-4 hours/a lot of time<br>(4) 4-8 hours/most of day<br>(5) More than 8 hours/persistent or continuous | ____ | ____ |
| **Controllability**<br>*Could/can you stop thinking about killing yourself or wanting to die if you want to?*<br>(1) Easily able to control thoughts<br>(2) Can control thoughts with little difficulty<br>(3) Can control thoughts with some difficulty<br>(4) Can control thoughts with a lot of difficulty<br>(5) Unable to control thoughts<br>(0) Does not attempt to control thoughts | | |

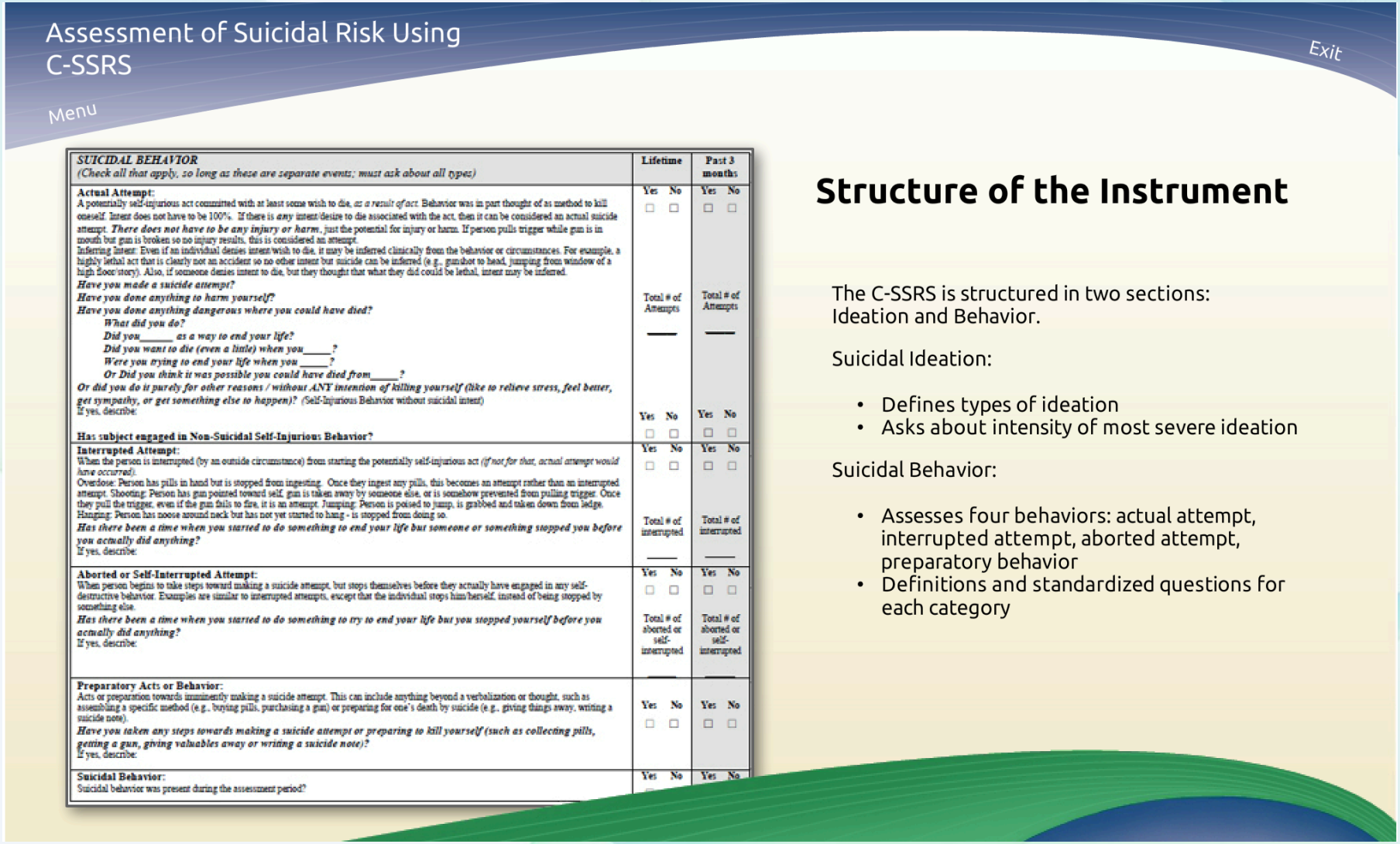
## Structure of the Instrument

The C-SSRS is structured in two sections:
Ideation and Behavior.

Suicidal Ideation:

- Defines types of ideation
- Asks about intensity of most severe ideation

# Columbia Suicide Severity Rating Scale: *Suicidal Behavior*




| *SUICIDAL BEHAVIOR* *(Check all that apply, so long as these are separate events; must ask about all types)* | Lifetime | Past 3 months |
|---|---|---|
| **Actual Attempt:** A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is *any* intent/desire to die associated with the act, then it can be considered an actual suicide attempt. *There does not have to be any injury or harm*, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. | Yes ☐ No ☐ | Yes ☐ No ☐ |
| ***Have you made a suicide attempt?*** | Total # of Attempts ____ | Total # of Attempts ____ |
| ***Have you done anything to harm yourself?*** | | |
| ***Have you done anything dangerous where you could have died?*** | | |
| ***What did you do?*** | | |
| ***Did you_____ as a way to end your life?*** | | |
| ***Did you want to die (even a little) when you_____?*** | | |
| ***Were you trying to end your life when you _____?*** | | |
| ***Or Did you think it was possible you could have died from_____?*** | | |
| ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **Has subject engaged in Non-Suicidal Self-Injurious Behavior?** | | |
| **Interrupted Attempt:** When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. | Yes ☐ No ☐ | Yes ☐ No ☐ |
| ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe: | Total # of interrupted ____ | Total # of interrupted ____ |
| **Aborted or Self-Interrupted Attempt:** When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. | Yes ☐ No ☐ | Yes ☐ No ☐ |
| ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe: | Total # of aborted or self-interrupted ____ | Total # of aborted or self-interrupted ____ |
| **Preparatory Acts or Behavior:** Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). | Yes ☐ No ☐ | Yes ☐ No ☐ |
| ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe: | | |
| **Suicidal Behavior:** Suicidal behavior was present during the assessment period? | Yes No | Yes No |

## Structure of the Instrument

The C-SSRS is structured in two sections: Ideation and Behavior.

Suicidal Ideation:

- Defines types of ideation
- Asks about intensity of most severe ideation

Suicidal Behavior:

- Assesses four behaviors: actual attempt, interrupted attempt, aborted attempt, preparatory behavior
- Definitions and standardized questions for each category

# Two-Step Screening

**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. 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 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

Have you had thoughts of actually hurting yourself?

NO YES

4 Screening Questions

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.

- **PHQ-9, item 9**
  - Thoughts that you would be better off dead or of hurting yourself in some way?
  - If positive (any >0)→
- **P4 Screener**
  - Dube et al. (2010)

# The Evidence Base for These Actions

- There are no evidence-based assessment methods for suicide risk (i.e., data showing that certain assessments *prevent* suicidal behavior), but there are clear best practices.
  - We know that responses on these measures are associated with future suicide ideation and behavior, but:
    - only three randomized trials of interventions shown to prevent suicide deaths in the world, ever.
    - psychotherapies and collaborative care models for depression have been shown to reduce the severity (or frequency) of suicidal thoughts and prevent non-lethal suicide attempts.

# Tips for Asking About Suicide

## Gentle persistence:

- "No, not really" usually means some form of suicidal thinking is present.
  - Some individuals think that we are not interested in hearing about their suicide ideation unless they are seriously thinking about taking action.
- "What kind of thoughts have you had, even if they were just fleeting or you wouldn't act on them?"

## **Normalizing** helps people feel comfortable:

"When people are feeling upset or stressed, they sometimes have thoughts that they wish they were dead. Have you ever had thoughts like this?"

## **Gentle assumptions** help individuals feel comfortable telling you about suicidal thoughts:

"What other ways have you thought about killing yourself?"

Adapted from Shea, S. C. (1999). *The practical art of suicide risk assessment: A guide for mental health professionals and substance abuse counselors.* Mental Health Presses.

# Risk Management:
## *Adaptations for Older Adults in Crisis*

- **Remember:** Suicide ideation is not normative in later life, even if the older person conveys it as such.
  - Internalized ageism is linked to reduced will to live and premature mortality.
- **Consider 'capability' for suicide:** ***Most die on their first attempt.***
  - alcohol (less common but potent)
  - firearms in the home
  - executive dysfunction
  - over control (versus under control) of emotions
- **Older adults are less likely to spontaneously report suicide ideation or reach out for help in a crisis.**

# PART 2

# Management and Treatment

# Intervention Studies: *Suicide Deaths in Later Life*

**All three studies** involved promoting social connection, but none were designed to test mechanisms.

- Chan et al., 2011
- De Leo et al., 2002
- Oyama et al., 2008

# INDICATED PREVENTION: *Best Practices*

**Routine screening for depression and suicide risk**

- Validated screener (e.g., PHQ-9, GDS, CES-D, PROMIS)
- Screening for suicidal ideation and intent for those with depressive symptoms (e.g., C-SSRS & Geriatric Suicide Ideation Scale)

**Diagnose and treat depression *to remission***

- Depression treatment is effective, including at reducing suicidal ideation and *maybe* suicidal behavior
- Antidepressants, lithium, ketamine/esketamine
- Psychotherapy—including Problem Solving Therapy (PST), Interpersonal Psychotherapy (IPT)
- Collaborative care
  - Meta-analysis indicating a reliable effect of collaborative care for reducing suicide ideation, especially when embedded psychotherapy is part of the CCM (Grigoroglou et al., 2021)

# INDICATED PREVENTION: *Best Practices*

## Suicide-Specific Behavioral Interventions:

- **Safety Planning (and Connection Planning):** include the family, address lethal means, include 9-8-8
- **Caring Contacts:** don't wait for older people to call us (proactive)
- **Address social determinants of health**—collaborate with PCPs and Area Agencies on Aging
- **Evidence-based psychotherapy** for suicide ideation and behavior:
  - Problem-Solving Therapy (PST) and Engage Psychotherapy
  - Interpersonal Therapy (IPT)
  - Behavioral Activation (BA)
  - Dialectical Behavior Therapy (DBT)
  - Cognitive Behavioral Therapy (CBT) for Late-Life Depression and CBT for Suicidal Behavior

# Safety Planning

Brief clinical intervention that results in a prioritized written list of warning signs, coping strategies, and resources to use during a suicidal crisis.

## Safety Planning plus caring contacts (Stanley et al., 2018):

- 45% fewer suicidal behaviors, approximately halving the odds of suicidal behavior over 6 months (odds ratio, 0.56; 95% CI, 0.33-0.95, P = .03)
- More than double the odds of attending at least 1 outpatient mental health visit (odds ratio, 2.06; 95% CI, 1.57-2.71; P < .001).

**SAFETY PLANNING**

**COPING:**
Focus on breathing, play with dog, pray

**PEOPLE/PLACES:**
Go to coffee shop, call friend (Bill 777-7777)
Text daughter Melissa

**SAFETY:**
Bill will keep my rifles until I feel better

**FOR EMERGENCIES:**
Call wife Linda (888-8888)
Call Dr. Price (999-999-9999)

**FRIENDSHIP LINE:** 800.971.0016

**SUICIDE PREVENTION HOTLINE:**
800.272.TALK (8255) Press "1" for Veterans

**YOUR VA HOSPITAL EMERGENCY DEPARTMENT:**
MEDVAMC - 2002 Holcombe
911

# Safety Plans Can Address Risk Factors

(Conti et al., 2020)

**Table 1.** Coping skills to target risk factors for late-life suicide during a crisis.

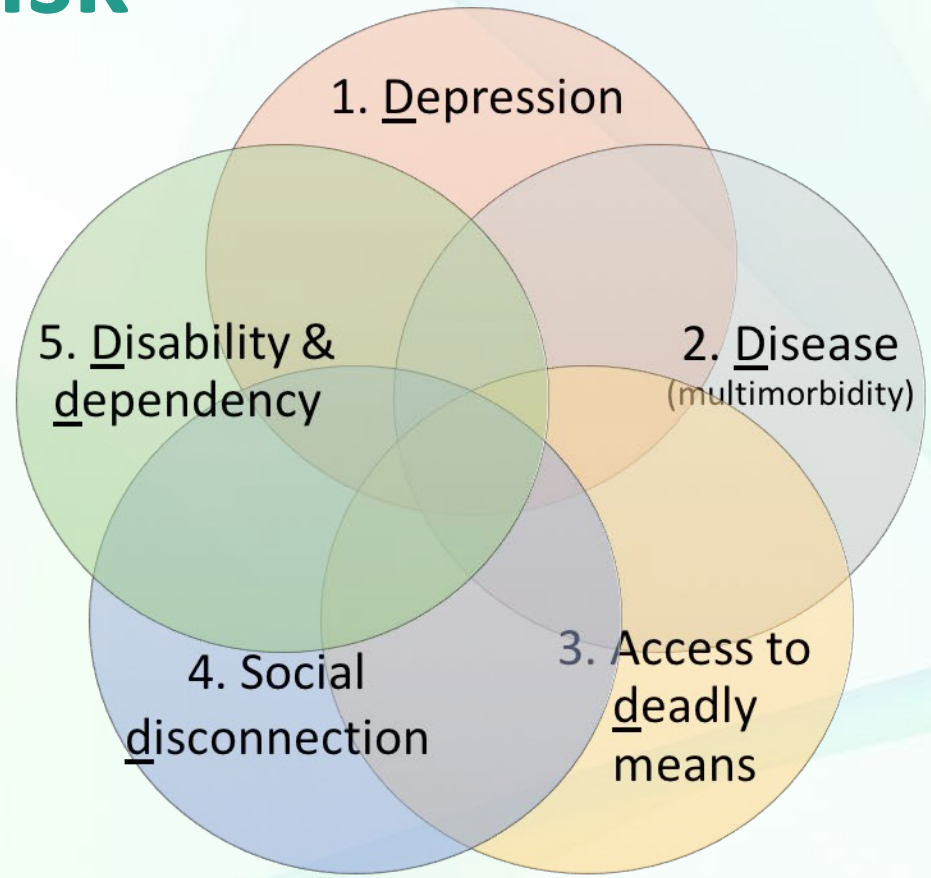
| Depression symptoms | Disability & Dependence | Disease | Disconnectedness | Deadly Means |
|---|---|---|---|---|
| Anhedonia more common than sadness: pleasant activities, exercise, helping others, prayer/religious readings | Talk back to thoughts about being a burden (these thoughts are associated with suicidal behavior) | Take medications as prescribed; attend to physical illness to increase mastery; list primary care doctor's number | Loneliness: reach out to friends/ family, call support hotline, attend social groups, online support groups, plan for future social activities, write letters, help others, volunteer | Firearm safety: store unloaded firearms in a locked cabinet, separately from ammunition; use a gun lock |
| Irritability: exercise, soothe with 5 senses (music, tea, pets), relaxation exercises | Help/support others (in a way that is safe) to counter burden thoughts | Refocus attention on reasons for living and meaning. | Grief: journaling, looking at photographs, writing a letter to loved one; containment exercises if grief is too intense | Enlist family in helping with safe storage of medications |
| Apathy: enlist family to schedule & start pleasant events | Practice meditation & acceptance exercises to tolerate distress | Coping skills for stressors involving lack of control: Relaxation & other pain management strategies | List resources for transportation assistance on plan | Planned check-ins with family, neighbors, providers |
| Insomnia: Sleep hygiene | Activities that promote feelings of dignity | List helpful thoughts to cope with hopelessness about illness (especially new diagnoses) | Go to common areas (if in senior housing), listen to the radio or music, distract with mentally engaging activities (e.g., puzzles) | Remove alcohol from home during crises |

# Tailoring Evidence-Based Psychotherapies for Suicide Risk

**Evidence-based psychotherapies for mental health in later life:**

**Can be used to target an older person's personal drivers for suicide risk (think 5D's)**

- **Example:** Problem-solving therapy (PST) for coping with increased **disability**
- **Example:** IPT to navigate **disconnection** and grief after spousal loss
- **Example:** Behavioral activation to cope with **depression** after a new **disease** diagnosis
- **Example:** Engage coaching to get 'unstuck' from the loneliness cycle—**disconnection**



# Tailoring Evidence-Based Psychotherapies for Suicide Risk

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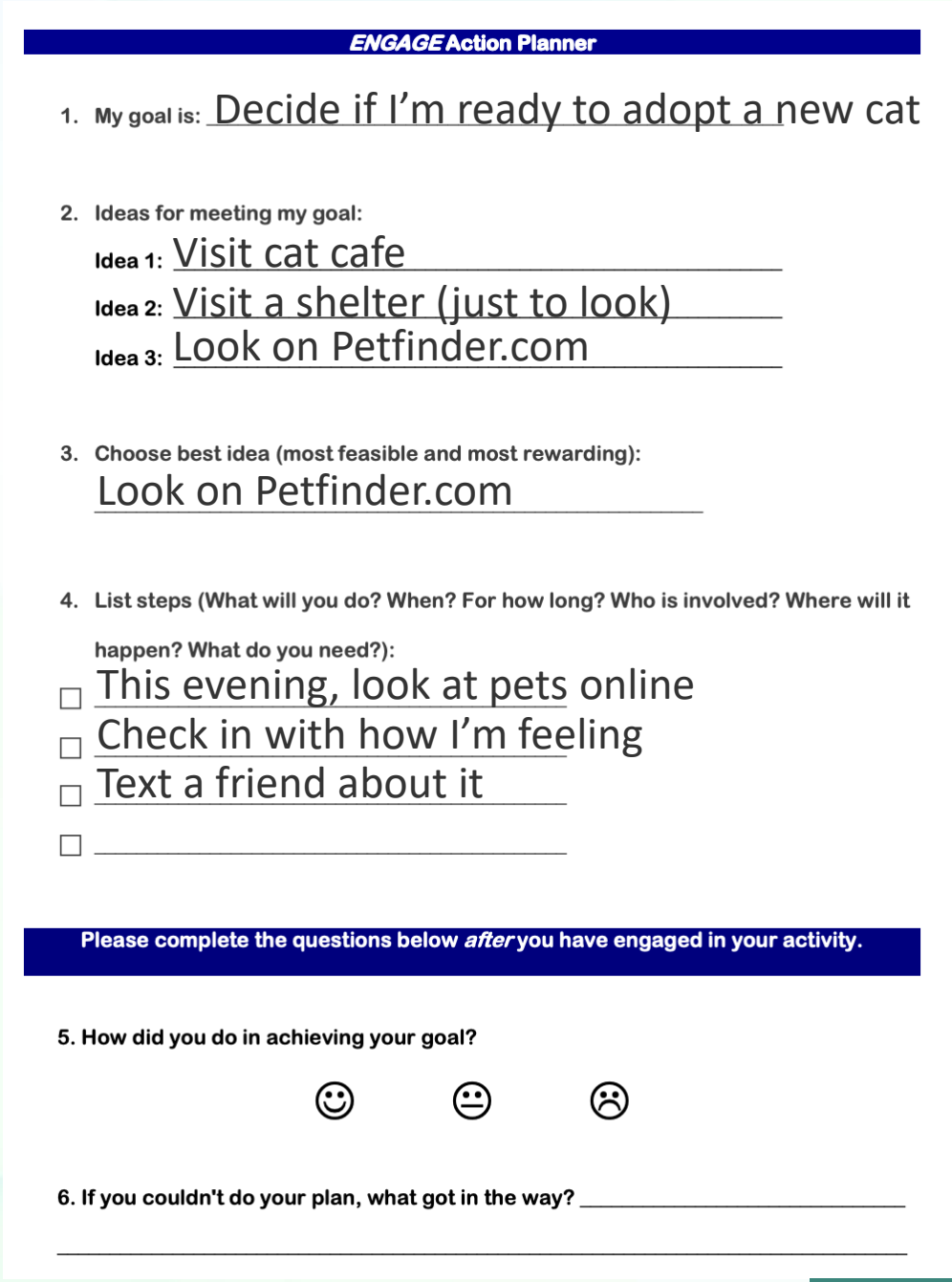


***ENGAGE* Action Planner**

1. My goal is: Decide if I'm ready to adopt a new cat

2. Ideas for meeting my goal:
   - Idea 1: Visit cat cafe
   - Idea 2: Visit a shelter (just to look)
   - Idea 3: Look on Petfinder.com

3. Choose best idea (most feasible and most rewarding):
   Look on Petfinder.com

4. List steps (What will you do? When? For how long? Who is involved? Where will it happen? What do you need?):
   - ☐ This evening, look at pets online
   - ☐ Check in with how I'm feeling
   - ☐ Text a friend about it
   - ☐ _____

**Please complete the questions below *after* you have engaged in your activity.**

5. How did you do in achieving your goal?

☺ 😐 ☹

6. If you couldn't do your plan, what got in the way? _____

# How did I do in achieving my goal????

## COACHING MANUALS:

I realized that when I was connected to others, there was hope.

**HOPE Lab PARTICIPANT**

# PART 3

# Resources

# Resources

- **Resources for suicide prevention for older adults (grounded in 5D's):**

  https://e4center.org/wp-content/uploads/2024/07/E4-Center-Equity-Focused-Suicide-Prevention-Resources-for-Older-Adults-1.pdf

- **Safety Planning for Older Adults (free manual, handout, video):**

  https://www.mirecc.va.gov/visn16/collaborative-safety-planning-manual.asp

- **Free article in *Clinical Gerontologist* on using the 5D's in safety planning:**

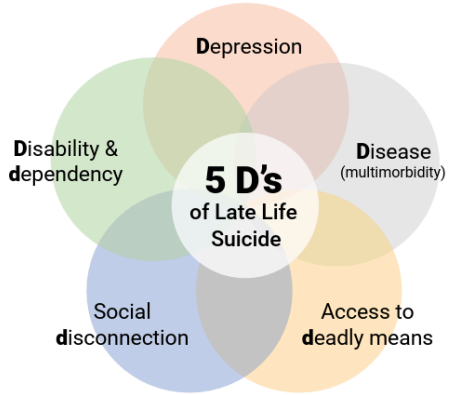
  https://pmc.ncbi.nlm.nih.gov/articles/PMC6858938

- **Training in Problem-Solving Therapy and Behavioral Activation:**

  AIMS Center: https://aims.uw.edu/interventions

## Equity Focused Suicide Prevention Resources for Older Adults

This resource guide addresses suicide prevention in older adults (defined as age 60 or older). The model guiding the selection of resources for this guide is the '5 D's of Late Life Suicide.'[1,2] This model (see Figure) describes the most common characteristics of older people who die by suicide (with the accumulation of factors suggesting greater risk)—**depression** (and other mental disorders), **disability** (functional and sensory impairment), **disease** (physical illness, including multimorbidity) and **access to deadly means** (in the U.S. firearms are most common).




Key facts about the epidemiology late-life suicide were also used to guide the development of this resource, including that:

1) most older people die on their first attempt (necessitating the use of universal and selective programs);
2) the most common method of suicide in later life is firearms;
3) older people are unlikely to present to care in specialty mental health clinics but do present for care in primary care clinics in the months and weeks before their deaths.

Users of this guide should keep several limitations in mind. First, programs that have shown some effectiveness for late-life suicide prevention often (if not always) contain multiple components and layers (i.e., universal, selective, and indicated prevention strategies). There are no such models readily available in the U.S. for older adults, so users should understand the limitations of selecting a single program from this list.

As well, this guide focuses on resources tailored for older adults. Given that there are relatively few of these resources, considering programs not specifically designed for older adults may be useful to address current gaps. A particularly notable gap is the lack of suicide-specific gatekeeper programs for older adults given the differing presentation of older people at risk for suicide (from younger people) and the fact that older people do not commonly seek out specialty mental health care; the exception is for senior living communities and senior centers, as there are suicide prevention toolkits for these settings (that may be useful for other settings where older adults frequent). Gaps are also especially apparent regarding intersecting identities (e.g., older adults who identify as LGBTQ, Native American, Black, Hispanic, Asian among others), as suicide-specific resources are not available that address the specific needs of older people in those groups; to address this gap, programs and resources are included in this guide for selective prevention programs that address the 5D's for these older adults.

1. Van Orden, Silva, & Conwell (2019). Suicide in Later Life. *Oxford Research Encyclopedia of Psychology*, Oxford University Press.
2. Conwell (2022). "My Work is Done. Why Wait?" Lessons Learned from Older Adults who Died by Suicide. *Am J Geriatr Psychiatry*, 12, 1339-1341. doi: 10.1016/j.jagp.2022.09.015.

# Connection Planning Resources

- **Free handouts:**

https://www.eenet.ca/resource/social-connection-isolated-older-adults

- **Article in *The American Journal of Geriatric Psychiatry* (free download):**

https://www.ajgponline.org/article/S1064-7481(20)30333-X/fulltext

- **VA VISN 5 MIRECC Connection Plans manual:**

https://www.mirecc.va.gov/visn5/training/connection_plans.asp

- **FREE Training online (Finger Lakes Geriatric Resource Center):**

https://www.urmc.rochester.edu/medicine/geriatrics/flgec/online-training.aspx



# Stay Connected!

**Kim Van Orden:**
kimberly_vanorden@urmc.rochester.edu

**The HOPE Lab**

- https://www.urmc.rochester.edu/labs/van-orden/projects.aspx
- **Email:** HOPE@urmc.Rochester.edu

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Jordan B. Westcott

Katherine M. Hertlein

# Questions and Answers

# Resources

# Critical Resources on Medicare Part B Coverage of Counselors and MFTs

### Legislation Mandating Medicare Part B Coverage of Counselors and Marriage and Family Therapists

https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

## How to Enroll in the Medicare Program

- **Medicare Enrollment for Providers and Suppliers**
  https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos
- **New Provider Type: Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) FAQs (36 questions answered) Published Sept 2023**
  https://www.cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf
- **The Medicare Learning Network:**
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlngeninfo
- **Web-Based Training:**
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining
- **Becoming a Medicare Provider (World of Medicare):**
  https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN9329634-WOM/WOM/index.html
- **Weekly Email Newsletter for Medicare Providers:**
  https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive

# Critical Resources on Medicare Part B Coverage of Counselors and MFTs cont.

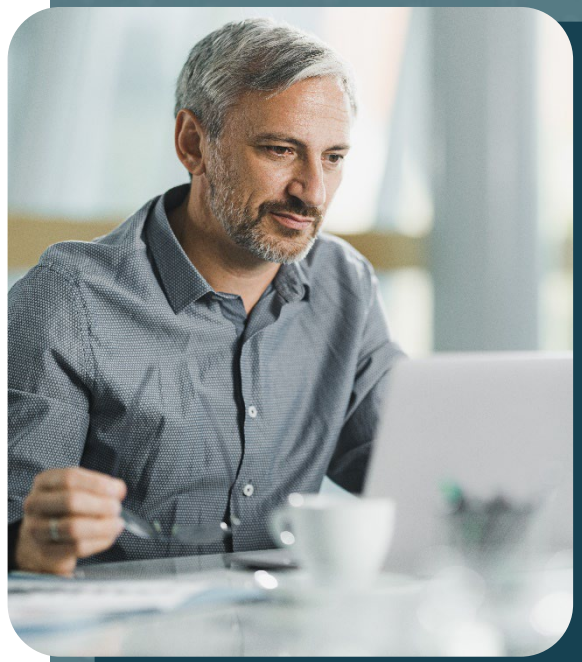
## Role of the Centers for Medicare and Medicaid Services (CMS)

- https://www.investopedia.com/terms/u/us-centers-medicare-and-medicaid-services-cms.asp
- https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive

## Medicare Mental Health Benefits for Beneficiaries

**Medicare Mental Health:**
https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf

**Medicare Beneficiary Handbook:**
https://www.medicare.gov/medicare-and-you



# Critical Resources on Medicare Part B Coverage of Counselors and MFTs cont.

## Medicare Administrative Contractors (MACs)

https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/what-is-a-mac

## Medicare Physician Fee Schedule

https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

## Key Steps to Becoming a Medicare Provider

1. Register in the I&A System
2. Get an NPI
3. Enter information into PECOS
4. Decide if you want to be a participating provider

**Form CMS-855I: Physicians and non-physician practitioners (PDF link)**


Thank you
for attending!
Medicare Mental Health
Workforce Coalition