National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314

Assessment #10

Weaving a Community Safety Net to Prevent Older Adult Suicide

August 2018

Alexandria, Virginia

Tenth in a Series of Ten Briefs Addressing: Bold Approaches for Better Mental Health Outcomes across the Continuum of Care

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Weaving a Community Safety Net to Prevent Older Adult Suicide

Technical Writer:

Vanessa Hastings

National Association of State Mental Health Program Directors

66 Canal Center Plaza, Suite 302, Alexandria, VA 22314
703-739-9333 FAX: 703-548-9517

www.nasmhpd.org

August 2018

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

The National Association of State Mental Health Program Directors (NASMHPD) wishes to thank the following individuals for providing guidance during the preparation of this paper.

Daniel Silbert, Policy Specialist, Illinois Department of Human Services/Division of Mental Health; NASMHPD Older Person Division Representative

Debbie Webster, Mental Health Program Manager, North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services; Chair, NASMHPD Older Persons Division

Ellyson Stout, Director, Suicide Prevention Resource Center (SPRC), Education Development Center

Judith Fox, Senior Health Promotion Specialist, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; NASMHPD Older Person Division Representative

Laurie Rosenblum, Research Associate/Writer, SPRC, Education Development Center

Table of Contents

Executive Summary

The 21st Century Cures Act of 2016[i] authorized the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) to enhance coordination across federal departments through the common goals of improving early identification of people with serious mental illness and serious emotional disturbances and better facilitating their access to services. In December 2017, the ISMICC released to Congress a report outlining several key recommendations, including advancing the national adoption of effective suicide prevention strategies (ISMICC, 2017). In line with those recommendations, the National Association of State Mental Health Program Directors (NASMHPD) has released a series of papers entitled *Breaking Through: Seven Bold Goals for Better Mental Illness Outcomes*. These goals include the prevention of all suicides.

Although most older adults live productively and do not take their own lives, late-life suicide remains a pressing public health concern, and NASMHPD wishes to draw attention to the issue and present strategic solutions. This *Breaking Through* paper details the often-entwined risk factors for suicide among older adults—disease, disability, disconnectedness, depression, and deadly means—and provides numerous tools that NASMHPD members, their providers, and other key stakeholders can use together to weave a safety net for the population.

Research for this paper included interviews with the following experts:[ii]

Ana Sullivan, MS, Senior Talk Line Coordinator at the Crisis Center in Birmingham, Alabama

Jill Harkavy-Friedman, PhD, Clinical Psychologist and Vice President of Research for the American Foundation for Suicide Prevention

Jo Anne Sirey, PhD, Clinical Psychologist, researcher, and Professor of Psychology, Department of Psychiatry, Weill Cornell Medical College

John Draper, PhD, Executive Director of the National Suicide Prevention Lifeline

Kimberly Van Orden, PhD, researcher and Associate Professor, Department of Psychiatry, University of Rochester Medical Center (URMC)

Noah Whitaker, Community Outreach Manager, Tulare County (California) Health & Human Services

Patrick Arbore, EdD, Founder and Director of the Center for Elderly Suicide Prevention & Grief Related Services at the Institute on Aging

Sandra Black, MSW, suicide prevention consultant

Yeates Conwell, PhD, Professor of Psychiatry at URMC, Director of the URMC Office for Aging Research and Health Services, and Co-Director of URMC Center for the Study and Prevention of Suicide

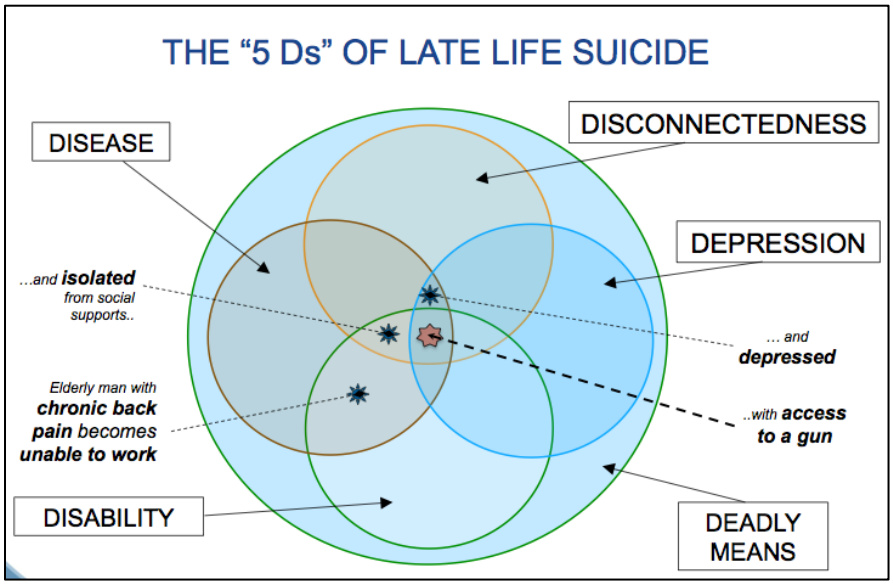
A Pressing Public Health Problem

Given the large and rapidly growing older adult population, late-life suicide remains a pressing public health problem. The suicide rate among older adults (people aged 65 years and older) in 2016 was 16.70, compared with the national rate of 13.9 (Drapeau & McIntosh, 2017), and the rate among men in that population for the years 1999 through 2016 was particularly high at 30.99 (Centers for Disease Control and Prevention, 2018).

Perhaps the most insidious and pervasive component of older adult suicide is society's marginalization of the population. Although numerous cultures around the world and some cultural groups within the United States revere older adults for their experience and wisdom, many Americans—even older Americans—tend to regard the aging process with disdain and older adults as lacking value, as evidenced by the media and entertainment industry's focus on youth.

This leads to dangerous, population-wide misconceptions, perhaps most critically the idea that aging and depression go hand in hand. "Almost no one I talk to is aware of the gerontological literature showing that in a lot of ways, well-being improves with age. There is really compelling research showing that our satisfaction with our relationships increases and the frequency of our positive emotions increases with age up until very, very old and near the end of life," says Kimberly Van Orden. Jill Harkavy-Friedman, among others, emphasizes that depression is not a natural part of aging but rather a health condition that's treatable. "Depression can be a sign that something else is going on," she says. "We should be paying attention to that and not just saying, 'Well, they're old; of course, they're depressed.'"

Yeates Conwell says that older adult depression interplays complexly with a constellation of risk factors, the "5 Ds" of late-life suicide, which also include disease, disability, disconnectedness, and deadly means.



Source: Adapted from Conwell, Y. (2013). Suicide and Suicide Prevention in Later Life. *Focus* 11(1), 39–47. Reprinted with permission from FOCUS, (Copyright ©2013). American Psychiatric Association. All Rights Reserved.

"The depressive symptoms of older people so often get confused with the symptoms of their medical comorbidities or, even in a more ageist kind of way, with normal aging ... On top of that, the older person doesn't reveal suicidal ideation or depressive symptoms at the prevalence that is the case for younger and middle-aged people—not because they don't have the symptoms, but because they don't talk about it in the same way or they're not heard in the same way," Dr. Conwell says, referring to generational stigma against help-seeking. Jo Anne Sirey explains that older adults tend to hesitate to reach out for various reasons. "They remember hospitalizations, they remember straightjackets, they remember when psychiatry was a blunt instrument, they know the movie *One Flew Over the Cuckoo's Nest*."

The 5 Ds can come together in a deadly combination that thwarts "belongingness" and fosters "perceived burdensomeness," two key components of the Interpersonal-Psychological Theory of Suicidal Behavior (Joiner, 2009), which Dr. Van Orden and Dr. Conwell have further developed in regard to older adults. "Just like we have a need for food and water and air, we need to be connected to other human beings, so when that need is unmet, a lot of negative health outcomes happen, including suicide," Dr. Van Orden says. "That's one of the key parts of the theory, and the other is feeling like a burden on others, so much so that you start to believe that others would be better off if you were gone."

Ana Sullivan notes that our primal need for connection has not diminished with modern advancements. "When we were more tribal, connectedness was a key aspect of survival," she says. "If you were not connected to the group, your likelihood of survival was drastically decreased. Today researchers are finding that the brain processes and responds to the pain of disconnection in the same way that it processes and responds to physical pain. So, when people feel that sense of loneliness, they experience that like they would a physical threat. And even with technology and so many options for connection, more and more people feel lonely and disconnected. It has become a serious problem, because unlike a physical threat, which can be very time limited, this threat that people are experiencing around loneliness is pervasive. It goes on continually. It connects to those feelings of anxiety, that fight-or-flight response, and it causes a downward spiral as it continues. And with seniors, they have more challenges as they age," including loss of connection through the passing of friends, retirement, and decreased mobility.

"Further compounding the problem is that older people—both men and women—use more immediately lethal means, that is, firearms, at higher rates than other age groups," Conwell says, noting that approximately 75 percent of suicides among men over 65 involve firearms. The lethality of all means of suicide increases among older adults because they are more physically vulnerable than people in other age groups.

However, with the right support, including interventions that take place upstream before conditions converge to create suicidal crisis, older adults can overcome their challenges and thrive. Members of the National Association of State Mental Health Program Directors (NASMHPD) can play a leading role in providing this support within their respective states.

Recommendations for Creating a Community Safety Net

Shifting cultural norms around aging to help get at the root of older adult isolation and feelings of burdensomeness requires a strategic, multi-pronged undertaking on the part of a variety of federal, state, and local partners. Dr. Conwell considers changing attitudes toward aging only one approach to a problem that requires several universal, selective, and indicated preventive interventions (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). "Indicated preventive interventions, like detection of suicidal ideation—indeed, even depression screening, diagnosis, and aggressive treatment—are necessary. We would argue that they're not sufficient by a long shot and that we need to be putting a lot more focus on selective and universal preventive intervention."

In addition, older adult suicide prevention experts generally agree that various service providers must unite to weave a community safety net for this population. Collaboration between mental health and medical care providers is not a new concept, and since research shows that an average of 58 percent of people aged 55 and older who died by suicide had contact with primary care in the month preceding their death (Luoma et al., 2002), primary care providers make obvious candidates for a team approach.

"Then we're looking at, to some extent, specialty care and home-based delivery of medical services, such as visiting nursing services, and an unaddressed perspective is the incorporation of non-medical, community-based aging social services into that equation," Conwell says. "The community aging services agency we work with here is called Lifespan, which has money from the New York State Department of Health to do a demonstration project in which they link aging services social workers with primary care practices to show an ability to reduce healthcare utilization costs, rehospitalization, and emergency room visits. It's an upstream suicide prevention intervention." Dr. Van Orden adds that "it can be really powerful to link primary care and these social agencies together to address holistically a person's health and promote quality of life, as opposed to just keeping someone from wanting to die."

Others envision subtly addressing mental health in aging social services settings such as senior centers. "You are able to access a population that needs something other than a medical or other traditional service," Dr. Sirey says. "They're coming for nutritional support or to spend time with their friends at a senior center, or they need home-delivered meals because they've just had hip replacement surgery, or they can't live independently any longer and they're reliant on some case-management services. Sometimes you can catch older adults you don't see in primary care but who are at a transition in their own lives and are needing more support to maintain their independence. And that's really the goal of aging services: to help older adults be as successful as they can possibly be. I think the premise is that mental health is a part of that necessary support." The publications *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers* (SAMHSA, 2015) and *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities* (SAMHSA, 2011) offer staff and volunteers a variety of helpful resources.

The National Council on Aging promotes several behavioral health resources for community organizations that serve older adults, one of which is *Healthy IDEAS*

(Identifying Depression, Empowering Activities for Seniors), an evidence-based tool "that integrates depression awareness and management into existing case management services provided to older adults," according to the program's website (Healthy IDEAS Programs, 2017). Sandra Black, who oversaw SAMHSA's Older Adults Targeted Capacity Expansion Grant Program for approximately one year, has observed that older adults are more receptive to discussing mental health and offers of support when the topics come up as part of broader conversations and events in aging social services settings. "If a senior center offered a series of lectures, and one of those lectures involved a physician talking about mental health issues in a matter-of fact-way, that worked well because older adults respect physicians and none of the audience members felt singled out."

But not every community is positioned to implement integrated care, and various challenges to drawing in community-based aging social services exist, not the least of which is financial. Dr. Conwell believes the most promising avenue for overcoming this barrier is through broader healthcare delivery and payment remodeling. "There may be a way forward in doing more creative value-based reimbursement that focuses on risk factors for older people, such as functional impairment, independent living, and depression," Dr. Conwell says. "These are the kinds of things that could be managed much better by teams in people's homes but are not currently reimbursable in a fee-for-service environment. But they could be reimbursable, for instance, within a prepaid Medicare Advantage Plan or where reimbursement is keyed to the quality of care delivered. The downstream payoff would be, first and foremost, reduced healthcare utilization and costs and greater patient satisfaction. That's good from a suicide prevention perspective."

Dr. Conwell encourages NASMHPD members and others to strive to understand integrated care models, learn how to advocate for the incorporation of community-based aging social services into those models, and learn how to help lobby for associated value-based reimbursement, noting that the website of the Administration for Community Living offers numerous resources. And Dr. Sirey welcomes inquiries from parties who want help with the easier-said-than-done task of operationalizing mental health services in aging social services settings, which is one of her specialties. "It's like putting a business plan together: What are our objectives? What are our barriers? What is a reasonable time frame for implementation? What are our resources?"

At the same time, say older adult suicide prevention experts, NASMHPD members should encourage their providers to build relationships with the providers of other services in their communities. "We as mental healthcare providers haven't been traditionally as good as we could be about getting out into the community. I think for older adults we need to get our services and information about the importance of mental health out where older adults are," Dr. Sirey says. NASMHPD members can contact their respective Area Agencies on Aging to learn about and connect with local older adult social services providers. "In my book, it's not that challenging to invite a group of folks to lunch and start the conversation," Noah Whitaker says. "Right off the bat, I think, most people will discover a plethora of supports for older adults or identify gaps and ways in which they might be able to bridge those gaps."

In some cases, community partners may find they have the capacity to develop and administer a multifaceted older adult suicide prevention strategy. Others may find they can implement only one intervention at a time initially. Either way, we feature several options here.

Suicide Prevention Training

"At minimum, staff and volunteers working in existing older adult services, such as Area Agencies on Aging, adult protective services, and adult systems of care, should receive suicide prevention training, including risk assessment, and those services should have a suicide prevention plan," Ms. Black says, noting that any given plan should include a protocol for responding to at-risk individuals and linking them with support appropriate to their level of risk. Many state and federally funded prevention programs, sometimes in partnership with local prevention coalitions and chapters of the nonprofit American Foundation for Suicide Prevention (AFSP), offer trainings such as Question, Persuade, Refer (QPR) and Applied Suicide Intervention Training Skills (ASIST) to the general public, organizations, and businesses, as well as Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (AMSR).

Recommended Standard Care

The National Action Alliance for Suicide Prevention (Action Alliance) recently released the publication *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe*. The guide offers recommendations for providers of care to people with suicide risk in outpatient mental health and substance abuse settings, inpatient mental health and substance abuse settings, emergency department settings, and primary care settings; information on the Zero Suicide model, which hundreds of healthcare organizations are implementing; and considerations for counseling on access to lethal means (Action Alliance, 2018). Appendix A of the document offers screening and assessment tools, and Appendix B provides resources for safety and stabilization planning (Action Alliance, 2018). NASMHPD members and their providers should become familiar with the guide, work to encourage their peers and community emergency departments and primary care providers to do the same, and support communication about the recommendations among all of these key stakeholders to ensure collaboration. Since most older adults with mental illness who receive treatment get that treatment from primary care physicians (Friedman, n.d.), we spotlight here the Action Alliance's recommendations for the primary care sector of the healthcare community.

Recommendations for Primary Care Settings

In *Recommended Standard Care for People with Suicide Risk,* the Action Alliance notes that the U.S. Preventive Services Task Force (USPSTF) has not yet recommended universal screening for suicide in primary care settings (Action Alliance, 2018). However, the USPSTF does urge primary care providers to be aware of mental health conditions and concerns in patients and to ask patients with those conditions about suicidal ideation and refer them for appropriate treatment or case management, if

necessary (USPSTF, 2016). Further, the task force recommends that "primary care clinicians screen adolescents and adults for depression when appropriate systems are in place to ensure adequate diagnosis, treatment, and follow-up" (USPSTF, 2016). The fact that depression screening recently became a reimbursable service may bolster primary care providers' use of that tool.

Ultimately, the Action Alliance concluded in *Recommended Standard Care for People with Suicide Risk* (Action Alliance, 2018) that it is essential for primary care providers "to explicitly consider suicide risk among all patients who present key risk factors for suicide–including having a diagnosed mental illness or substance abuse disorder–or who are being treated with a psychiatric medication." The guide (Action Alliance, 2018) specifically recommends the following standard care elements:

- *Identify and assess suicide risk in all patients who have a mental illness, misuse substances, have a substance use disorder or who have been prescribed a psychiatric medication. Assess degree of suicide risk for patients with any risk by using a standardized instrument or scale. Stratify patients by risk.*
- *For those with elevated suicide risk:*
    - *Complete a collaborative safety plan during the same visit:*
        - *As part of the safety plan, provide information on telephone crisis lines, including the National Suicide Prevention Lifeline. Carry out steps to reduce access to lethal means, including asking assistance from family members and significant others.*
    - *Engage the patient in treatment with a behavioral health professional, if possible with one who has training in suicide.*
    - *Complete a follow-up caring contact with the patient (by phone, text, e-mail or face-to-face), preferably in the manner preferred by the patient, within 24 hours of discharge or on the next business day.*

Screening Specific to Older Adults

After a spike in older adult suicides in Tulare County, California, approximately 10 years ago, Tulare County Health & Human Services Agency (HHSA) set out to better support the population. As a new employee of the agency, Mr. Whitaker conducted a literature review on existing approaches and honed in on screening tools that open the door to intervention. From that research came *Check-in With You: The Older Adult Hopelessness Screening Program* (OAHS), which Mr. Whitaker conceptualized and a handful of local mental health professionals have fleshed out and refined over the past decade. Beyond screening, this promising program provides a vital community safety net for older adults. According to the National Network to Eliminate Disparities in Behavioral Health (2015), OAHS "assesses levels of hopelessness in older adults and provides early intervention services to reduce suicide risk, improve quality of care, and prevent the onset of serious mental illness. All adults age 55 and older receiving primary health care services are screened for hopelessness and suicidal intent. The Beck Hopelessness Scale® is administered before patients' health appointments. Those who screen as moderate to severe are offered early intervention services. Patients who choose to participate receive

ongoing support, mental health case management, short-term intervention, and warm linkages to local services that can help improve social, physical, environmental, emotional, and financial wellness."

Today, the program is a fixture of the HHSA's Visalia Health Care Clinic and Tulare County's home-delivered meals program and senior centers. "Some of the best outcomes that we've seen are better engagement with primary care services, which are essential in helping to offset feelings of hopelessness and depression, as well as linkage to very simple sorts of services the seniors weren't aware of that helped them overcome really significant barriers in their lives. So, we've seen some amazing gains from case management services," says Mr. Whitaker, who invites communities interested in implementing the program to contact him directly. He notes that such communities may need to consider using screening instruments other than the Beck Hopelessness Scale® to comply with the requirements of their respective electronic medical records systems. Appendix A of *Recommended Standard Care for People with Suicide Risk* offers several alternatives (Action Alliance, 2018).

Ensuring Connectedness

Perhaps one of the most important components of the community safety net for all people, and especially older adults, is simultaneously addressing perceived burdensomeness and disconnectedness. The following programs and phone lines can help achieve this.

Senior Corps

Dr. Van Orden uses the Interpersonal-Psychological Theory of Suicidal Behavior to inform the development and testing of interventions for older adults. "Most of my work centers around interventions that can help people feel more connected and as if they are not a burden, as if they contribute." She, Dr. Conwell, and others, with funding from the Centers for Disease Control and Prevention (CDC), conducted a randomized trial called The Senior Connection to evaluate the effectiveness of peer companionship in reducing late-life suicide risk (Van Orden et al., 2013).

The researchers have begun writing up the results of the study. "Half of the people were matched with a peer companion for a year, and the other half received care as usual, or no peer companion," Dr. Van Orden says. "We found that the people who were matched with the peer companion had significant reductions in depression and anxiety symptoms and in the degree to which they felt like a burden on others." After the peer companions reported they believed they were getting as much out of the program as the people they were helping, the researchers sought and received support from the National Institute on Aging (NIA) for another randomized trial with a focus on volunteerism as an intervention. That trial is under way.

NASMHPD members need not wait for the final outcomes of these studies to help older adults maintain or re-establish connection. The three main programs of the Senior Corps—Foster Grandparents, Retired Senior Volunteers Program, and Senior Companions—are available nationwide. Ms. Black appreciates such initiatives for

bolstering cultural competence in engaging and assisting older adults. “How do you relate to seniors if you’re not a senior yourself? How do you talk to them about these issues without reinforcing the stigma that they experience?” Care teams that lack older staff who might better relate to older clients should consider these questions and supporting, linking with, and/or developing peer companion programs in their own communities. “The Senior Corps is run by the Corporation for National & Community Service, which has grants to develop these programs.” Dr. Van Orden says. “They have manuals for how to run them, how to develop them—all of it is on their website.”

Peer Support Programs

NASMHPD’s 2017 *Beyond Beds* series of papers includes Older Adults Peer Support: Finding a Funding Source, which summarizes the principles of peer support and its benefits to older adults with behavioral health challenges (Gordon and Zubritsky, 2017). In recent years, Pennsylvania’s Certified Older Adult Peer Specialists (COAPS) initiative has proven particularly effective, and other states have begun to adopt the program. COAPS initiative goals for older adults with or in recovery from mental and substance use disorders consist of promoting health and recovery-oriented service systems, ensuring the availability of permanent housing and supportive services, increasing gainful employment and educational opportunities, and promoting peer support and social inclusion (Zubritsky et al., 2016).

Helplines

Helplines provide another means for supporting connectedness and reducing perceived burdensomeness. The following include some community-based examples of helplines. At the very least, providers within the NASMHPD network should be prepared to distribute helpline information to older adults, as needed.

National Suicide Prevention Lifeline (800-273-8255)

The National Suicide Prevention Lifeline network consists of 160 crisis centers nationwide and strives to provide support and connection for people in crisis around the clock. Many of the Lifeline’s callers are younger than 65; John Draper believes that’s because much of the network’s outreach takes place online, which appeals less to older adults. “In some ways reaching older populations will be easier as the years advance, because people in their 50s and 60s who are going online and reaching us will become older later. In terms of reaching older people now, print media and broadcast media is certainly one way to do it. I also think it would be important for us to expand our partnerships among older adult–serving organizations like AARP, etc. It is an area of needed and greater focus, and for our organization something we look forward to doing more of.” He says crisis center staff receive training on cultural sensitivity, including age and all demographics, but “it’s really about listening to what the caller needs and wants, how they like to relate; that’s ultimately what we’re all about.”

The Lifeline must grow to meet increasing demand. Providers within the NASMHPD network who believe they might have the capacity to operate a crisis center can apply through the Lifeline's website.

Friendship Line (800-971-0016)

"Friendship Line's core belief, as far back as 1973, has been that that if we reduce loneliness in older adults, we will reduce their risk of suicide," says Patrick Arbore, who founded the program that year in San Francisco. Today, as a part of the Institute on Aging, Friendship Line serves older adults as a crisis intervention hotline and a warmline for non-urgent calls. As the only accredited crisis line in the country for older adults, the helpline has expanded its reach over the years. "Of the approximately 150,000 contacts we manage yearly, 70 percent of these calls are generated in California, and 30 percent are generated outside of California," Dr. Arbore says.

Dr. Arbore and a small staff of full-time administrators, several full- and part-time telephone counselors, and numerous volunteers answer calls from not only older adults but also caregivers and younger disabled adults. The team also makes regular outreach calls to lonely older people and those striving to maintain their independence. Sustaining such an operation in an ageist environment has proven difficult but is clearly not outside the realm of possibility, Dr. Arbore says. "Meeting our budget each year is always a challenge. Even though the Institute on Aging is very supportive of my program, finding enough dollars to ensure proper staffing for Friendship Line is an ongoing battle. I am hopeful, however, that more and more counties in various parts of the country will see that partnering with Friendship Line would be an advantageous way for them to provide telephone services to their elderly populations."

Senior Talk Line (205-328-8255)

The Senior Talk Line of the Crisis Center of Birmingham, Alabama, is funded by United Way and relies on Ms. Sullivan as a part-time employee and volunteers to serve older adults in five counties. According to the center's website, "The Senior Talk Line service is a free telephone reassurance service for senior citizens, their caregivers, retirees and widowed persons, grandparents and others who might find comfort in having a trained volunteer call them on a regular basis to talk." Older adults use the service to deal with loneliness and isolation. In some cases, people link to the service through the center's crisis line. "Crisis line staff will work to stabilize seniors who call in as at risk for suicide and make sure they're safe and receive treatment," Ms. Sullivan says. "Later, as appropriate, we'll transition them to the Senior Talk Line, if that's something they would like. That support can really help in long-term stabilization, as far as building that connection so they don't feel so alone." Regardless of how clients come to the Senior Talk Line, volunteers call them at least three times a week and encourage them to share interests or concerns.

Ms. Sullivan would be happy to discuss the Senior Talk Line with representatives of other communities interested in setting up a similar service. She says partnering with a crisis line is ideal but not necessary, emphasizing the importance of building community

connections and the value of Area Agencies on Aging as a starting point for such an effort. “It’s critical for my program, even with the setup we have, because a lot of times one of the biggest challenges is connecting with seniors who are very isolated. I work with a lot of different agencies to get the word out about the program.”

New Frontiers in Research

Some treatment practitioners might wish to explore older adult suicide prevention research, which can lead to the development of effective interventions. As previously mentioned, the CDC funded the Senior Connection (Van Orden et al., 2013), which illustrates the effectiveness of peer companionship in reducing late-life suicide risk, and a related study is under way with backing from the NIA. The National Institute of Mental Health and nonprofit organizations, such as the American Association of Suicidology and AFSP, also support research. In any case, interested investigators will benefit from reading *A Prioritized Research Agenda for Suicide Prevention* (Action Alliance: Research Prioritization Task Force, 2014).

Conclusion

The prevention of late-life suicide requires teams of NASMHPD members and other key stakeholders to develop strategies specific to their respective communities’ challenges and resources. At the very least, these teams should strive to disseminate suicide prevention training broadly among aging services providers, follow the Action Alliance’s *Recommended Standard Care for People with Suicide Risk*, consider screening specific to older adults, and ensure connectedness within the population. In addition, supporting or participating in research into late-life suicide can lead to new interventions that tighten the community safety net for older adults.

References

Centers for Disease Control and Prevention. (2018). Web-based Injury Statistics Query and Reporting System (WISQARS). Fatal Injury Reports, National, Regional and State, 1981–2016. 1999 to 2016 (ICD-10), National and Regional. Retrieved from https://webappa.cdc.gov/sasweb/ncipc/mortrate.html

Drapeau, C. W., & McIntosh, J. L. (2017). U.S.A. Suicide: 2016 Official Final Data. Retrieved from http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2016/2016datapgsv1b.pdf?ver=2018-01-15-211057-387

Friedman, M. B. (n.d.). Meeting the Mental Health Challenges of the Elder Boom. New York, New York: The Geriatric Mental Health Alliance of New York. Retrieved from http://www.networkofcare.org/library/Issues%20brief.pdf

Gordon, S. Y., & Zubritsky, C. D. (2017). Older Adults Peer Support: Finding a Funding Source. National Association of State Mental Health Program Directors. Assessment #8. Alexandria, Virginia: National Association of State Mental Health Program Directors. Retrieved from https://www.nasmhpd.org/sites/default/files/TAC.Paper_.8.Older_Adults_Peer_Support-Finding_a_Funding_Source.pdf

Healthy IDEAS Programs. (2017). Identifying Depression & Empowering Activities for Seniors. Retrieved from http://healthyideasprograms.org/

Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). (2017). The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers. Retrieved from https://store.samhsa.gov/shin/content//PEP17-ISMICC-RTC/PEP17-ISMICC-RTC.pdf

Joiner, T. (2009, June). The Interpersonal-Psychological Theory of Suicidal Behavior: Current Empirical Status. *Psychological Science Agenda*, *23*(6). Retrieved from http://www.apa.org/science/about/psa/2009/06/sci-brief.aspx

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence. *American Journal of Psychiatry*, 159(6), 909–916. doi:10.1176/appi.ajp.159.6.909

National Action Alliance for Suicide Prevention (Action Alliance). (2018). *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe*. Washington, DC: National Action Alliance for Suicide Prevention. Retrieved from http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Action%20Alliance%20Recommended%20Standard%20Care%20FINAL.pdf

National Action Alliance for Suicide Prevention (Action Alliance): Research Prioritization Task Force. (2014). *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives*. Rockville, MD: National Institute of Mental Health and the Research Prioritization Task Force.

National Network to Eliminate Disparities in Behavioral Health. (2015). Check-in With You: The Older Adult Hopelessness Screening Program (OAHS). Retrieved from https://www.sprc.org/resources-programs/check-you-older-adult-hopelessness-screening-program-oahs

Substance Abuse and Mental Health Services Administration (SAMHSA). (2011). *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities*. HHS Publication No. SMA 4515, CMHS-NSPL-0197). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/SMA10-4515.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers* (HHS Publication No. SMA-15-4416). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA15-4416

Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). Mapping Interventions to Different Levels of Risk. Retrieved from https://www.samhsa.gov/capt/tools-learning-resources/mapping-interventions-levels-risk

U.S. Preventive Services Task Force (USPSTF). (2016). *Final Recommendation Statement. Suicide risk in Adolescents, Adults, and Older Adults: Screening*. AHRQ Publication No. 12-05188-EF-2. Retrieved from https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/suicide-risk-in-adolescents-adults-and-older-adults-screening#consider

Van Orden, K. A., Stone, D. M., Rowe, J., McIntosh, W. L., Podgorski, C., & Conwell, Y. (2013). The Senior Connection: Design and rationale of a randomized trial of peer companionship to reduce suicide risk in later life, *Contemp Clin Trials* 35(1), 117–126. doi:10.1016/j.cct.2013.03.003

Zubritsky, C., Keogh, B., & Cantiello, H. (2016). Certified Older Adult Peer Specialist (COAPS) Initiative.

[i] Pub. Law No. 114-255 (2016).

[ii] Interview with Ana Sullivan on May 17, 2018; interview with Jill Harkavy-Friedman on May 3, 2018; interview with Jo Anne Sirey on May 15, 2018; interview with John Draper on April 11, 2018; interview with Kimberly Van Orden on May 11, 2018; interview with Noah Whitaker on May 14, 2018; interview with Patrick Arbore via email on May 21, 2018; interview with Sandra Black on April 6, 2018; and interview with Yeates Conwell on April 18, 2018.