MEALS ON WHEELS ANNUAL CONFERENCE AND EXPO

AUGUST 27-29, 2019

DALLAS, TX

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INNOVATIONS IN NUTRITION: SUICIDE PREVENTION/INTERVENTION WITH OLDER ADULTS

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OVERVIEW

- Disclaimer / Acknowledgement
- Problem: Suicide in Later Life, Facts, Figures, Theory
- Project: Theory, RQs/Objectives, Research Design
    - Treatment: Applied Suicide Intervention Skills Training (ASIST)
- Preliminary Outcomes (time point 1)
- Lessons Learned & Recommendations

DISCLAIMER / ACKNOWLEDGEMENT

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SUICIDE IN LATER LIFE

- In the United States, suicide rates among older adults living in communities are comparable to or higher than any other age group and account for approximately 15% of all deaths by suicide (Barry & Byers, 2016).
  - As of 2014, older adults accounted for approximately 14.5% of the entire population (U.S. Census Bureau, 2014)
- As of 2014, the suicide rate for individuals over 70 in the United States was 17.4 per 100,000, compared to the global rate of 13.4 per 100,000 (CDC, 2014).

SUICIDE IN LATER LIFE

- There are 5-25 times more who suicide than are reported, due to stigma and suicides that are miscategorized 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.

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 that suicidal ideation among older adults is normal** (Uncapher & Arean, 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).

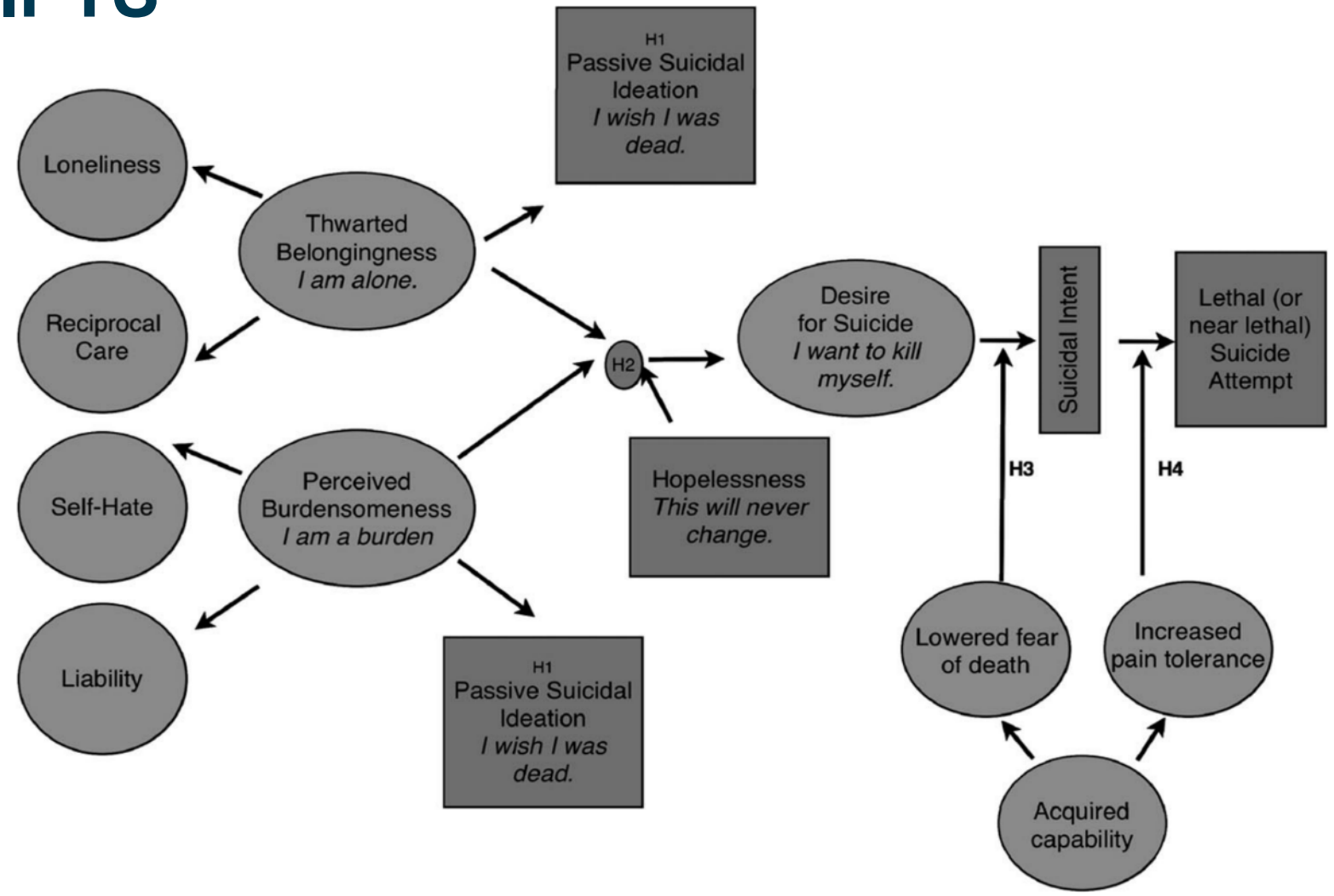
Interpersonal-Psychological Theory of Suicide

Thomas Joiner, PhD

Why People Die by Suicide

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

IPTS


H1
Passive Suicidal Ideation
I wish I was dead.
Loneliness
Thwarted Belongingness
I am alone.
Reciprocal Care
H2
Desire for Suicide
I want to kill myself.
Suicidal Intent
Lethal (or near lethal) Suicide Attempt
Hopelessness
This will never change.
H3
H4
Self-Hate
Perceived Burdensomeness
I am a burden
Liability
H1
Passive Suicidal Ideation
I wish I was dead.
Lowered fear of death
Increased pain tolerance
Acquired capability

NOW WHAT?

How do we address this problem?

How do we intervene with older adults at risk of suicide?

COMMUNITY APPROACH

How to get the entire community on the same page regarding suicide prevention and intervention with older adults?

Community Partnerships:

- Administration for Community Living (ACL)
- Area Agency on Aging (Atlanta Regional Commission)
- 3 Research Intensive Universities (Georgia State, Virginia Tech, UT Knoxville)
- Six Counties (i.e. Central Fulton, Dekalb, Henry, Clayton, North Fulton, Cobb)
- Community-Based Volunteers (i.e. HDM, Meals on Wheels, Open Hand)
- Graduate Students (HOPE Lab @ GSU; AgeWel @ Virginia Tech)

https://education.gsu.edu/cps/researchoutreach/hope-lab/
https://www.agewellcounseling.org/

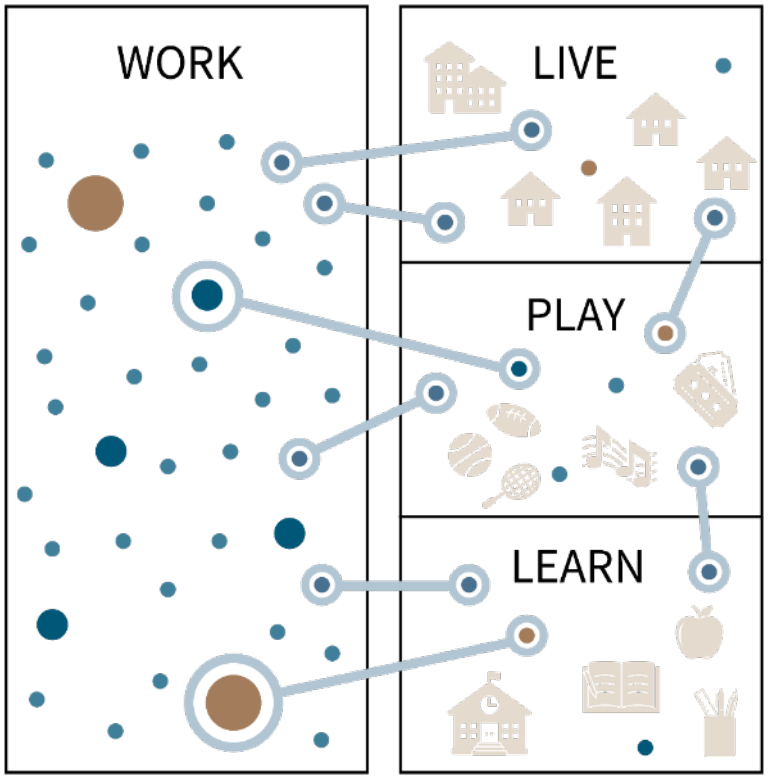
COLLECTIVE IMPACT

1	2	3	4	5
Common agenda	Shared measurement systems	Training and Mutually reinforcing activities	Continuous communication	Presence of a backbone organization

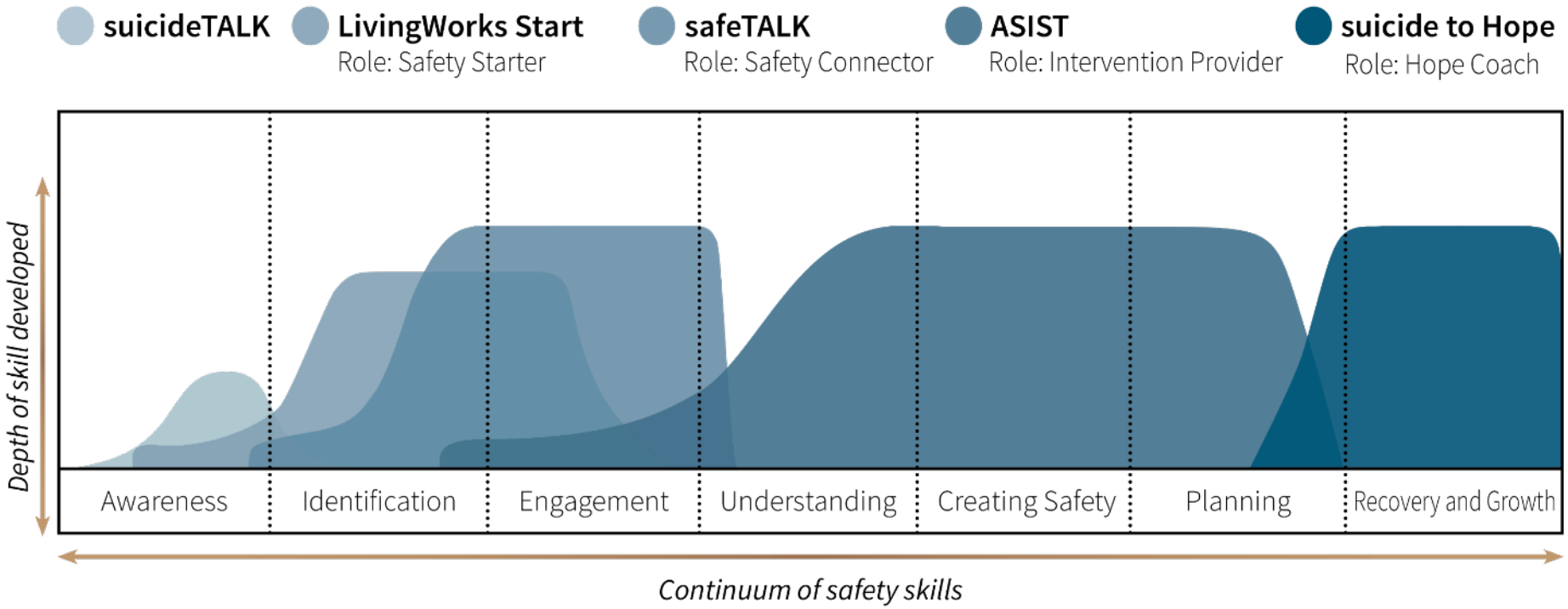
NETWORK OF SAFETY

safeTALK

ASIST



CONTINUUM OF SAFETY



STANDARDIZED AND MANUALIZED TREATMENTS: 3 CONDITIONS

Applied Suicide *Intervention* Skills Training (*intervention*)

- 2-day, 14 hour, standardized and manualized suicide intervention training
- Equips participants with "suicide first aid" skills
  - i.e. six step intervention model, *Pathway for Assisting Life Model*
- 11th edition; Internationally recognized
- Prior 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

ASIST

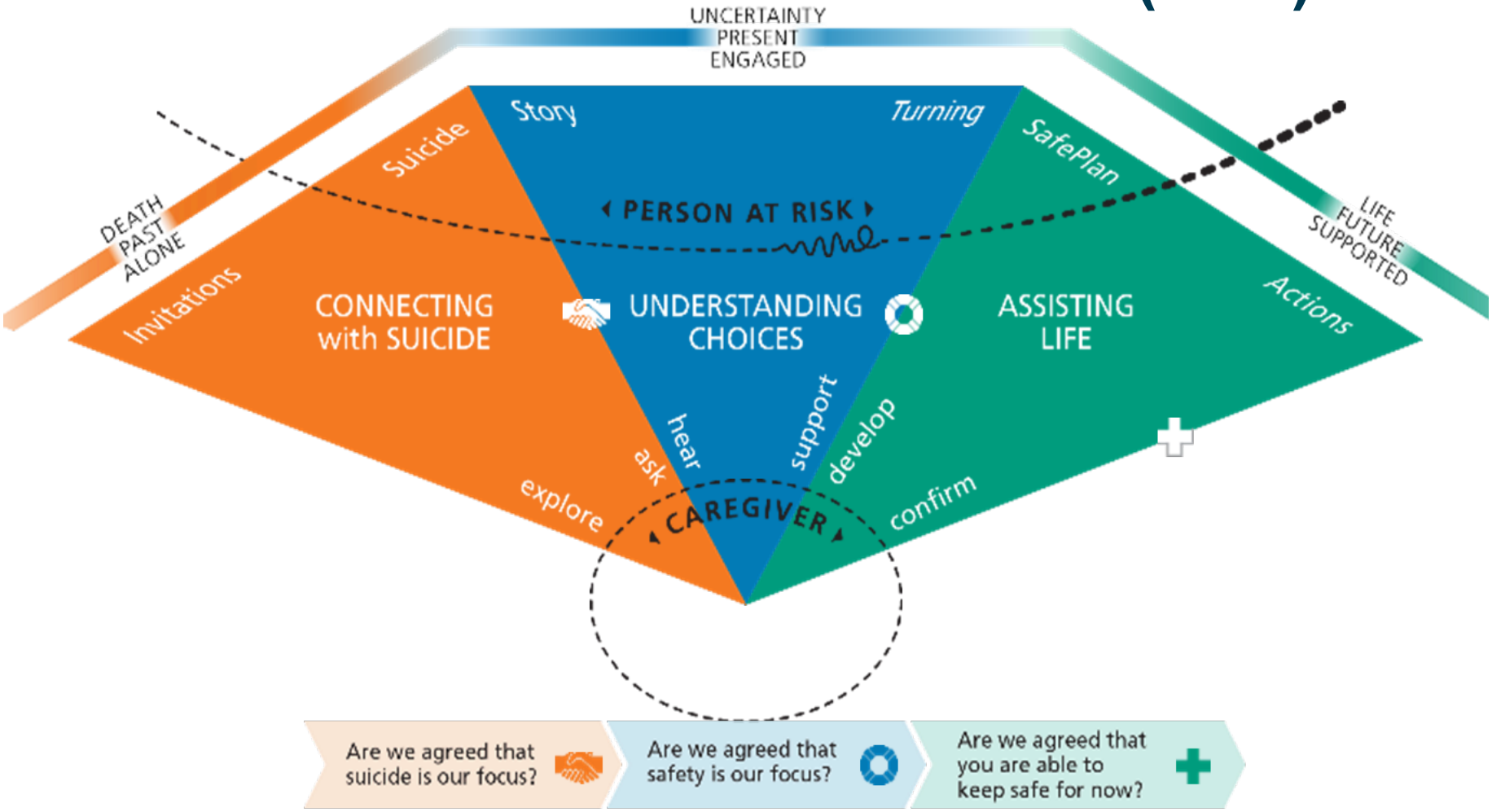
SafeTALK (*prevention*)

- Half day training in "suicide alertness"
- Participants learn to recognize and engage persons with thoughts of suicide
- Goals: Tell, Ask, Listen, and Keep Safe (connect to someone who knows "suicide first aid")

safeTALK

Delayed-Waitlist Control

PATHWAY FOR ASSISTING LIFE (PAL)



Taken with permission from LivingWorks, Inc. ASIST Training Materials

3 RESEARCH QUESTIONS

(1) Do NS get the skills?

(2) Do NS use the skills?

(3) What is the impact of the skills?

Major project **objectives**:

- 1) enhance the suicide *intervention* and mental health *awareness* skills of NS volunteers
- 2) increase the identification rate of older adults with elevated suicide risk (ESR) or in mental health distress (MHD) by NS volunteers;
- 3) improve mental health outcomes for older adults receiving NS that are identified as having ESR/MHD.

METHODOLOGY

Double Blind RCT

- Graduate Student Interns
  - Background checks, finger printing, *became* county interns
  - Individualized MOUs, each vetted through county boards of commissioners
- Piloted measure RQ3 measure set: PHQ9, GAD-7; 5F-Wel, Pain, SBQ, INQ
- Revised protocol
- Began collecting time point 1 data
  - 2 hr in home visits with older adults (n = 490; 11% veterans)
- Random assignment of HDM drivers/volunteers to one of 3 conditions
  - ASIST, SafeTALK, Delayed waitlist control
- Train
- Intervention tracking & Collection of time point 2, etc.
- Growth mixture modeling

EVALUATING TRAINING AND INTERVENTION OUTCOMES

1. Enhance skills of NS volunteers	Suicide Intervention Response Inventory (SIRI-2R), Attitudes to Suicide	Electronic surveys from volunteers	Baseline, post training	***Obj. 1b*** -ANCOVA
2. Increase identification of at-risk older adults	Number of referrals Identification behaviors Suicide risk, mental health distress	providers and sites coordinator volunteers surveys in-person data from older adults	Ongoing Ongoing Baseline, 6 & 12 mo follow-up	***Obj. 2c*** -ANCOVA ***Obj. 2d*** – frequency counts, qualitative methods
3. Improve mental health outcomes for older adults	Suicide risk, mental health distress	In-person data from older adults Interviews with	Baseline, 6 & 12 month follow-up	***Obj. 3b*** -Repeated measures ANOVA, ***Obj. 3c*** – Regression.

EVALUATING SKILL ACQUISITION AND IDENTIFICATION OUTCOMES

volunteer attitudes and skills	*Attitudes to Suicide Prevention Scale*, ASP, Herron et al., 2001[70]	Self-report measure of volunteer's perspectives towards intervention developed specifically for health care workers.
	Suicide Intervention Response Inventory 2nd edition, SIRI-2, Neimeyer & Bonnelle, 1997[71]	Assesses volunteer skills in providing facilitative responses to a person-at-risk of suicide. The alternate scoring suggested in Shannonhouse et al. (2017)[50] will also be computed
	Suicide Identification Reporting Tool, SIRT, Authors.	Survey with quantitative and free responses to assess the manner particular skills were employed in an at-risk identification.
at-risk identification	number of identified 'at risk' or 'in distress', older persons	Frequency counts collected by provider and site coordinators.

EVALUATING INTERVENTION OUTCOMES (ELEVATED SUICIDE RISK)

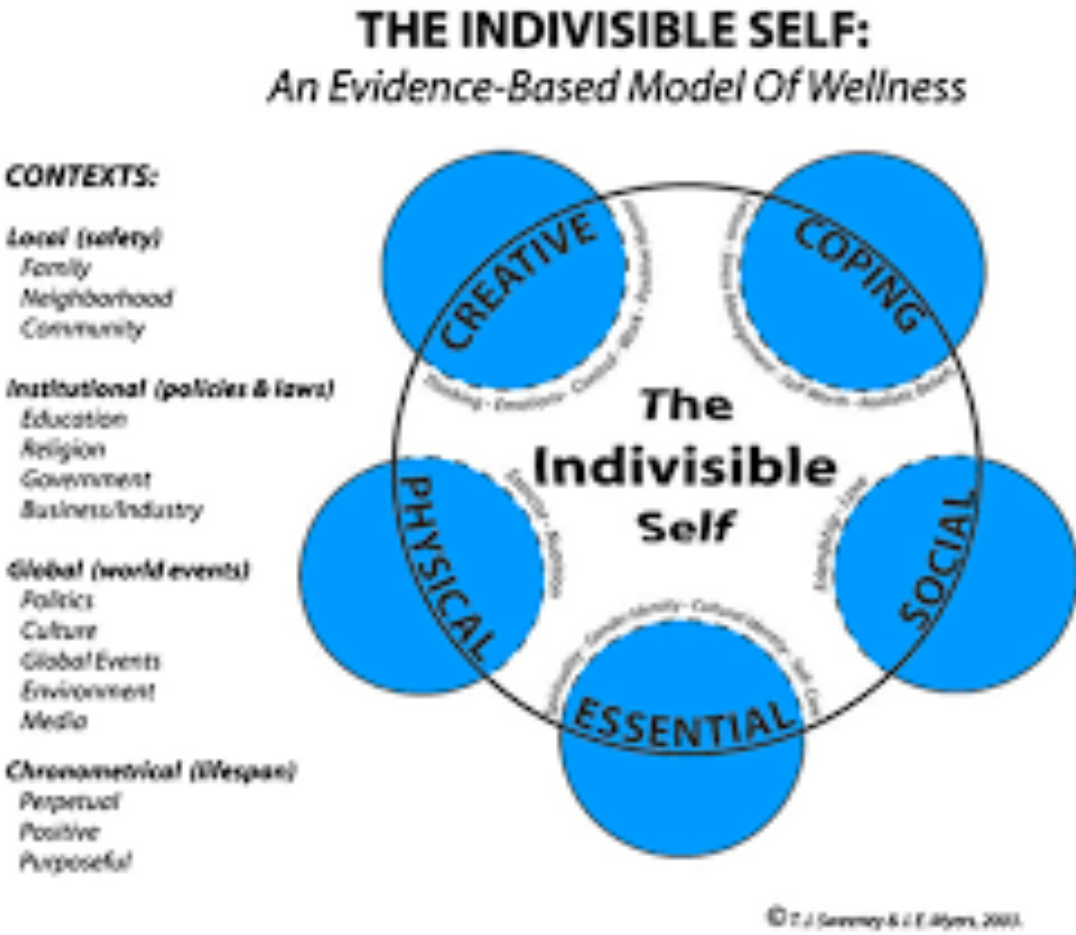
suicide risk	*Suicide Behavior Questionnaire*, SBQ-R, Osman et al., 2001[72]	Clinical assessment used to determine level of risk for suicidal behavior.
	Interpersonal Needs Questionnaire, INQ, Van Orden et al., 2012[73]	Developed specifically for use with Joiner's Interpersonal theory of suicide, the INQ assesses perceived burdensomeness and thwarted belongingness, which in combination lead to active suicidal desire.
	Acquired Capability for Suicide Scale – Fearlessness About Death, ACSS-FAD, Ribeiro et al., 2014[74]	Captures one's psychological defense against ending one's life, and in conjunction with the INQ, can be used as a predictor of suicidal intent or behavior.

EVALUATING INTERVENTION OUTCOMES (MENTAL HEALTH DISTRESS)

mental health distress	*Personal Health Questionnaire*, PHQ-9/PHQ-2, Kroenke et al., 2001; 2003[75]	This will be use a sequence for older adults as noted in (Richardson et al., 2011), with the PHQ-9 only administered to those that score above 3 on the PHQ-2.
	Generalized Anxiety Disorder Scale, GAD-7/GAD-2, Spitzer et al., 2006[76]; Kroenke et al., 2007[77]	This will also be administered as a sequence, using cut offs from Wild et al., (2013),[78] where the GAD-7 is only given to those older persons that score 2 or higher on the GAD-2.
	Kessler Psychological Distress Scale, K6, Kessler et al., 2002[79]	Self-report of how depressive and anxiety symptoms have changed. Can be used to distinguish dysthymia from emergent distress.
	Profile of Chronic Pain: Screen, PCP:S, Ruehlman et al., 2005	Self-report of older person's pain and emotional state. Includes demographic items. Questions on pain tolerance (suicide correlate) will also be included.

EVALUATING INTERVENTION OUTCOMES (WELLNESS)

wellness	*Five Factor Wellness Inventory*, 5F-Wel, Myers & Sweeney, 2005[81]
Measures general wellness, five second-order factors (Creative, Coping, Social, Essential, and Physical), and 17 discrete wellness scales.	



FINDINGS TO DATE

- 434 older persons, Aged: 60-103, Mean = 76.9, SD = 9.23
- Mostly Female (73.3%) and Minority (68.7% black), some veterans (11.4%)
- Anxiety: 1/3 (32.6%) met criteria (≥3) on GAD-2
- Depression: 1/4 (27.6%) met criteria (≥3) on PHQ-2
- Pain: 1/2 had daily pain
  - 1 in 5 were extremely isolated and depressed because of pain
- **Suicidality precursor variables**
  - 10.7% had Fearlessness About Death >= 25 (published mean for clinical sample)
  - 8.9% had Perceived Burdensomeness >=19 (suggested clinical cutoff)
  - 14.1% had Thwarted Belongingness >= 35 (suggested clinical cutoff)
  - Veterans: 2x as likely to be Fearless about death
    50% more likely to have both PB & TB (combination leads to desire for suicide)
- **Risk for suicide**
  - SBQ-R: clinical tool used when you can't directly ask about current suicidal thoughts
  - 16.0% meet threshold score for risk (>=7)
  - Veterans: 33% more likely to meet this threshhold

STORIES & NEXT STEPS

2 Stories

- County Director
- HDM volunteer

Next Steps

- Treatment implementation
- Time point 2 and 3; if possible up to 5
- Congregate meal sites
- Research with Student data collectors

LESSONS LEARNED & RECOMMENDATIONS

Help **ALL** partners understand the research design

- Trust they can understand, and take the time to explain it multiple times, in multiple ways, and then explain it again… all in lay terms, no research jargon.

Train regional ***and*** county leadership (i.e. collective impact theory)

- They are the decision makers, and have wisdom about how the innovation will operate in their system. They know what they need to make it successful and sustainable. Be flexible and adjust when appropriate.
- Provide a quality training that ***you believe in***. A 14 hour suicide *intervention* training is a major investment for them (an entire graduate course in 2 days)! They know the quality, and feel good/ excited about the investment in their volunteers.
- Get permission from them to tell their ***success stories*** (i.e. Clayton director)

Invest in counties and build sincere relationships

- After leadership is trained, enlist their wisdom to identify potential trainers
- We trained 10 as SafeTALK trainers, 2 as ASIST trainers (one ASIST is from ARC)
- Counties have initiatives that are important. Learn about them and care about them. Make connections for counties where you can (i.e. caregiver support in Dekalb, MREs with Open Hand).
- We **made 23 site visits in the first couple months** of the project, and would do it again in a heartbeat!

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Thank you for your sincere care and concern for the mental health and welfare of older adults!

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