Tennessee's Older Adult Suicide Prevention Plan

A publication of the Tennessee Suicide Prevention Network

Tennessee Suicide Prevention Network

September 29, 2015

Tennessee Suicide Prevention Network

Street and mailing address:
446 Metroplex Drive, Suite A-224
Nashville, TN 37211

Office phone: (615) 297-1077
Office fax: (615) 269-5413
www.tspn.org

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

Each year suicide claims more lives of Tennesseans homicide, drunk driving, or HIV infection. Yet most suicides are preventable. With public discourse, education, and awareness, each of us can help reduce the frequency of suicide in our communities.

The most important step in prevention is the recognition of the many signs of suicide. With compassion and courage, we can give a loved one hope in time of despair.

The Tennessee Suicide Prevention Network (TSPN) is the statewide organization responsible for implementing the Tennessee Strategy for Suicide Prevention as defined by the National Strategy for Suicide Prevention.

TSPN is a grass-roots association which includes counselors, mental health professionals, physicians, clergy, journalists, social workers, and law enforcement personnel, as well as survivors of suicide and suicide attempts. TSPN works across the state to eliminate the stigma of suicide and educate communities about the warning signs of suicide, with the ultimate intention of reducing suicide rates in the state of Tennessee.

We seek to achieve these objectives through organizing and promoting regular regional activities, providing suicide prevention and crisis intervention training to community organizations, and conducting postvention sessions for schools and organizations after suicides occur.

Suicide affects people of all ages, races, and socioeconomic groups. Hence we encourage and celebrate the engagement of people from all walks of life in our suicide prevention campaign, sharing their stories, making a difference in their communities, and helping to save lives.

Tennessee's Older Adult Suicide Prevention Plan

A publication of the Tennessee Suicide Prevention Network

Developed by the TSPN Older Adult Suicide Prevention Plan Committee

Table of Contents

Tennessee's Older Adult Suicide Prevention Plan

Executive Summary

Suicide among older adults is a serious but rarely addressed public health problem. In any given year, over 7,000 adults over the age of 65 die by suicide. Prevention of suicide among older adults was specifically mentioned as a priority in the *National Call to Action to Prevent Suicide* issued by the Office of the U.S. Surgeon General in 1999.

169 adults over the age of 65 died by suicide in 2014 in Tennessee, according to the Centers for Disease Control and Prevention (CDC)—at a rate of 17.1 per 100,000 population. For comparative purposes, the national rate in 2013 for this age group as published by the CDC was 16.1 per 100,000.

Older males have especially high rates of suicide: in 2014 the rate among Tennessee males (33.9 per 100,000) was more than nine times higher than that among women in Tennessee the same age (4.0 per 100,000). Over the most recent five-year period (2010-14), the suicide rate among adults aged 65 and older in Tennessee was more than two times higher than rates for those aged 10-24 (average rate of 17.9 vs. 8.1).

In the next three decades the aging of the "baby boomers" will cause the number of older adults in Tennessee to double. As Tennessee's population ages, the problem of suicide among this age cohort is likely to rise accordingly unless something is done to prevent these deaths.

Suicide can be understood as the result of the interplay of various risk factors in individuals, relationships, communities, institutions, and society. Although a wide range of factors contribute to the problem of older adult suicide, they fall into two main groups.

The first group of factors is related to the provision of medical and behavioral health care to older adults, and includes such factors as:

- the prevalence of mood disorders in the older adult population
- financial and logistical barriers to medical and behavioral care
- lack of linkage between medical care and behavioral care services, and
- failure by clinicians to identify and treat mood disorders among older adults.

The second group of factors is related to community attitudes and practices that affect suicidal behavior and engagement with clinical care, and includes such factors as:

- social isolation
- lack of awareness about the problem of suicide
- social stigma and misconceptions about suicide and behavioral health care
- low rates of care-seeking by older males
- the ageist assumption that depression is an inevitable consequence of aging, and
- lack of community-based suicide prevention programs for older adults.

Alleviation of these factors and research on new community-based medical and behavioral health techniques would enhance improvements in public health surveillance of older adult suicides and suicidal behavior.

Although many suicides are preventable, suicide prevention requires the implementation of a multifaceted approach. Just as there is no single cause of suicide, there is no single prevention activity that alone will reduce suicide. To be successful, prevention efforts must address factors at the individual, relationship, institutional, community and societal levels.

In 2009, the Tennessee Suicide Prevention Network assembled the Older Adult Suicide Prevention Plan Committee, a multidisciplinary workgroup charged with developing a plan for a coordinated and focused suicide prevention effort targeting Tennessee's older adults. The Committee used the Tennessee Strategy for Suicide Prevention (based on the National Strategy for Suicide Prevention) as its framework and consulted other plans developed in Oregon and Pennsylvania.

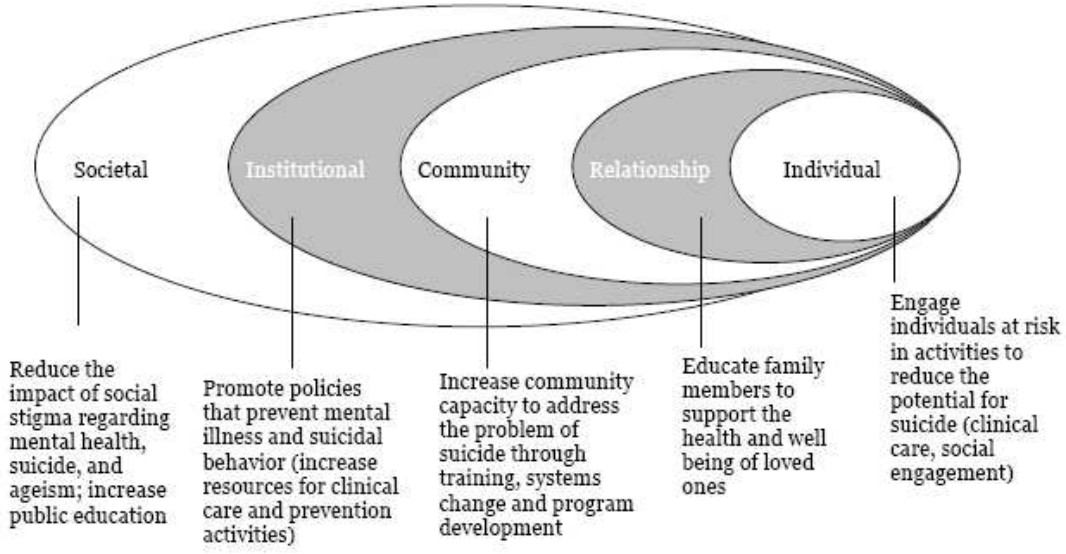
The Division of Health Statistics within the Tennessee Department of Health's Office of Planning, Policy, and Assessment provided data on suicidal behavior among older adults. The Committee reviewed data available from deaths, hospitalization, adult risk surveys and research literature. The group also fielded suggestions from national and local experts, older adults, and medical and social service professionals during the development of the plan. A draft of the plan for public comment was presented at "Older Lives Count: Depression and Suicide in Mature Adults" held on May 28, 2009, in Nashville.

A list of objectives and a set of action items are included for each of these strategies. They are updated periodically to reflect current focuses in strategy related to older adults. While these lists of strategies are not exhaustive, they are included in order to make the objectives more concrete for readers.

While this plan represents the hard work of many contributors, a plan itself will not save lives. The challenge for the future is to take this plan and use it to galvanize and guide action in Tennessee to prevent older adult suicide.

An Ecological Model for Prevention

The following diagram illustrates the interaction of psychosocial factors affecting suicide and mental health among older adults, along with suggested counters.



There is a place for state and federal public health agencies within every level of this model. Furthermore, these agencies and their employees have the ability to bridge gaps between these levels to create a cohesive approach to this concern.

Overview of Suicide Risk Factors and Warning Signs in Older Adults

At the individual level, research has identified a number of risk factors for suicide among older adults. These include but are by no means limited to the following:

Loss of self-esteem can result from the losses and stresses that often accompany aging. Older adults may express feelings of uselessness, hopelessness or anger at the aging process. When people can no longer function independently as they did earlier, they may believe that they have no value.

Depression is a major factor in late-life suicides. It is more than just "sadness" that all people experience occasionally. It is a deeper and more long-lasting feeling of hopelessness, helplessness, and despair. Depression is not a natural part of aging. It can be treated successfully.

Abuse of alcohol or drugs is a way that some aging individuals cope with feelings of depression or loneliness. Unfortunately, this self-destructive behavior usually magnifies the feelings from which they are trying to escape and complicates their lives.

Chronic illness afflicts some older adults with serious, painful or debilitating results. Coupled with feelings of hopelessness and despair, such illnesses may lead an older person to contemplate suicide. Diseases that involve organic mental deterioration, such as strokes or Alzheimer's disease, are especially high-risk; people with these concerns not only worry about losing independence or

becoming dependent on others, but may not be able to think rationally. People who expect to die soon from an ongoing illness, regardless of their actual prognosis, are also at risk. Finally, many medications used to treat chronic illnesses common among older adults have depression as a possible side effect, inadvertently increasing the risk of suicide.

Isolation from family and friends may lead to loneliness, depression and possibly substance abuse. This holds true especially for people in nursing homes or assisted living facilities.

Access to lethal means, such as firearms, knives, or medication, may prompt people who are only considering suicide to act on an impulse. Even relatively harmless household objects, like electrical cords or sleeping pills, could be used by actively suicidal people, so they should be temporarily removed from the premises during a suicide crisis.

Warning Signs

Research has also identified warning signs which may signal suicidal thoughts or plans by an older person. Knowing these signals and taking action may save lives. Common warning signs include the following:

- Persistent sadness or depression
- Withdrawal or isolation from family and friends
- Giving away prized possessions
- Increased use of alcohol or drugs
- Acquiring potential lethal means (buying a gun, stockpiling medication, etc.)
- Weight loss or decrease in appetite.
- Change in sleeping patterns, either sleeping significantly more or less
- Frequent accidents, especially falls (These may actually be suicide attempts.)
- Talking about or threatening suicide (This is the most obvious and most serious warning sign of all and requires immediate action.)

Any one of these signals alone does not necessarily indicate a person is suicidal. However, several signals combined may be cause for concern, especially if the person has attempted suicide in the past.

Older Adults and Suicide: Tennessee's Strategic Plan

In the US, persons 65 and over have the highest suicide rates of any age group. Their attempts tend to be well-planned and highly lethal. With the graying of the "baby boom" generation (a group which is already seeing elevated suicide rates), experts expect the number of late-life suicides to increase dramatically over the next 20 to 30 years.

However, these tragedies can be forestalled if risk factors are noted, warning signs are recognized, and prevention and intervention resources are available. Increasing awareness of the problem of suicide and the unique factors involved with older adult suicides is necessary to prevent a national mental health crisis in the years to come. Too many people mistake the thoughts, words, and actions of severely depressed older adults for complications of a physical ailment or, worse, write them off as part of the aging process.

TSPN offers this five-step model for awareness, risk assessment, planning, and intervention. It is our hope that this plan will help guide the mental health response to a vulnerable segment of the population and prevent tragedy on individual and national levels.

Step 1: Defining the Problem

- The Centers for Disease Control and Prevention (CDC) observe that suicide rates increase with age and are among the highest in those 65 and older. In 2013, 7,215 Americans over the age of 65 died by suicide. 84% of these were men; 96% were white.
- According to the Substance Abuse and Mental Health Services Administration (SAMHSA), older adults represent 13% of the population but account for over 18% of all suicidal deaths.
- The rate of completed suicide attempts versus suicide attempts drops with age, to a ratio of 4:1 by late life.
- Suicide rates for white men reach their peak in late life. The 2014 suicide rate for white men in Tennessee aged 65-74 was 30.9. For ages 75-84 it was 40.9, and for ages 85 and over it was 71.1. For comparative purposes, the rate for all men in Tennessee that year was 33.9. For Tennessee in general it was 14.4, and for the nation at large in 2013 it was 13.0.
- Many older adults who die by suicide have recently visited a primary care physician: 20% on the same day, 40% within one week and 70% within one month of the suicide. (National Suicide Prevention Statistics)
- Older suicide victims are more likely to have suffered from a depressive illness than their younger counterparts. They are also prone to more chronic forms of depression.
- The older adult population is the fastest growing population in Tennessee and our nation.

Step 2: Identifying Causes through Risk and Protective Factors Research

Risk Factors for Suicide in Older Adults

As explained earlier, a variety of factors should be considered when assessing suicide risk. Aside from the major factors already listed, the following elements should be considered. The more factors that are present, the greater the risk of a suicide attempt.

Biological, Psychological and Social Risk Factors

- Co-morbid disorders, especially if depression, diabetes, heart disease or stroke are among the diseases involved
- Severe or chronic pain
- Frailty in general and perceived health decline
- Amount and type of medications taken (Greater numbers of prescriptions could allow for stockpiling of pills.)
- Generally inflexible personality (Some people may react poorly to dramatic life changes.)
- Low self-esteem, feelings of loss of dignity or control, sense of being a burden
- Feelings of anxiety or agitation
- Traumatic loss of a spouse, relative, friend, child, etc.
- Widowhood or a marital history that includes divorce
- Family or personal history of suicidality or mental illness
- Previous suicide attempts or a history of violence towards others.

Environmental Risk Factors

- Financial or professional setback
- Residence in a long-term care (LTC) facility
- Caregiver status for an aged parent or other relative
- Desensitized to the violence of suicide
- Availability of lethal agent

Social-cultural Risk Factors

- Inadequate or insufficient social support
- Living alone
- Abuse
- Family conflict
- Loss (of relationship, role, functional capacity or support, health, work, mobility, finances or several of these in succession)
- Barriers to accessing health care, especially mental health and substance abuse treatment

Protective Factors for Suicide

- Effective and easily accessible clinical care for mental, physical and substance abuse disorders
- Easy access to a variety of clinical interventions and supports in a variety of settings
- Restricted access to highly lethal means of suicide, such as firearms
- Support through ongoing relationships with medical and mental health professionals

- Cultivation of skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Readily available social supports, including family, close friends and confidants

Steps 3 and 4: Development and Implementation of Interventions

If properly applied, prevention and intervention efforts can mitigate risk factors and bolster protective factors.

The following principles should be kept in mind when developing suicide interventions for any population and are no less valid for older adults:

- Suicide preventions programs should coordinate and cooperate with other prevention efforts, such as substance abuse.
- Programs should reframe the problem of suicide from a mental health issue to a public health problem.
- Programs must address the needs of people in each stage of life.
- Programs must be culturally sensitive. As such, program planning should represent the community with respect to age, ethnicity, faith, occupation, sexual orientation, social economic status and cultural identity.
- Prevention programs are most effective when they are long-term, with opportunities for reinforcement of attitudes, behaviors and skills.
- Each community must develop a program that meets local needs and builds on local strengths.

Step 5: Concurrent Review and Evaluation of Effectiveness

Each intervention should allow for an evaluation to determine whether the selected intervention will work under local conditions. Determining the costs associated with sustaining programs and comparing those costs to the benefits of the programs is another important aspect of evaluations.

Tennessee's Strategy for Older Adult Suicide Prevention: Goals and Objectives

The Tennessee Strategy for Older Adult Suicide Prevention was developed by TSPN's Older Adult Suicide Prevention Plan Committee in 2009, updated in 2013 and 2015. It is based on the Tennessee Strategy for Suicide Prevention as adopted in 2002 and revised in 2004, 2006, 2007, and 2013.

Goal 1: Promote awareness that suicide is a preventable public health problem.

Cooperation and collaboration between public and private entities is critical to the success of this plan. Stakeholders will work together to organize public education campaigns, plan and sponsor conferences on suicide and suicide prevention programs, and disseminate information on older adults and suicide within presentations to community agencies and through special-issue town hall meetings.

Strategies:

- Development of public education campaigns.
- Creation and/or circulation of educational materials for the community at large, with emphasis on agencies serving seniors and their families, as well as faith-based organizations.
- Organization and sponsorship of statewide conferences on older suicide and suicide prevention.
- Development of informational materials specifically directed to older adults; these should address suicide risk and protective factors, community resources, and specific issues facing older adults such as but not limited to late-life depression, coping with life changes, substance abuse and chronic illness.
- Targeting of organizations that serve older adults, including AARP, area agencies on aging, senior centers, retirement programs, senior high rises, and primary care for training and presentations
- Organization and promotion of regional forums to present the Older Adult Suicide Prevention Plan and provide information and encouragement for outreach and coordinate planning across systems.

Goal 2: Develop broad-based support for suicide prevention.

The Tennessee Strategy for Older Adult Suicide Prevention aims to address the psychological, biological and social factors affecting older adults. It encourages collaboration between aging mental health agencies, institution, private and faith-based organizations. Building such alliances will allow for the blending and merging of resources allowing for innovations such as suicide prevention programs in senior centers and preventative mental health education at retirement planning seminars or AARP-sponsored programs.

The strategies established for Goal 2 focus on developing collective leadership and increasing the number of groups working to prevent suicide. This will ensure that suicide prevention is better understood and that organizational support exists for implementing prevention activities.
Strategies:

- Organization of a statewide interagency committee featuring delegates from the Tennessee

Department of Health, the Tennessee Department of Mental Health and Developmental Disabilities, the Tennessee Commission on Aging and Disability, the Tennessee Medical Association, the Tennessee Psychological Association, and the Tennessee Psychiatric Association.

- Establishment of public/ private partnerships dedicated to implementing the Tennessee Strategy for Older Adult Suicide Prevention including AARP and other retirement programs, county aging offices, mental health providers, primary care physician's offices, hospital discharge planners, emergency room staff, and representatives from the arena of LTC, faith-based organizations and insurance companies.
- Increase in the number of professional, volunteer, and other groups that integrate suicide prevention activities into ongoing projects; these will include area agencies on aging, AARP, senior centers, and senior apartments.
- Increase in the number of faith communities that adopt policies designed to prevent suicide.
- Recruitment of leaders of community groups, such as churches, United Way organizations, and senior centers to secure their support of and participation in the integration of suicide prevention into current programs; this may involve links to existing prevention programs related to substance abuse or other addictions.
- Recruitment of at least one member of each aging county system to be a community organizer for suicide prevention projects.
- Completion of an annual mailing to hospital discharge planners, primary care offices that includes the statistics of suicide in older adults, user-friendly assessment, and community resources.

Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Suicide is closely linked to mental illness and substance abuse. Within older adults, loss, isolation and chronic illness are also critical factors. But the stigma of mental illness and substance abuse prevents many older people from seeking the help they need. The stigma of suicide itself, the idea of suicide as shameful and/or sinful, also keeps people from seeking help.

Historically, the stigma associated with mental illness, substance abuse, and suicide has led to inadequate funding for prevention services and to low insurance reimbursements for treatments. It has also resulted in the establishment of separate systems for physical health and mental health care. This development has led to bureaucratic and institutional barriers between the two systems that complicate and impede the provision of care.

Destigmatizing mental illness and substance use disorders will increase access to treatment by reducing financial barriers, integrating care and increasing the willingness of individuals to seek treatment.

Strategies:

- Develop a public awareness campaign including educational presentations around aging and behavioral health issues.
- Insure prevention activities are culturally and developmentally sensitive.
- Seek to eliminate disparities that erode suicide prevention activities.
- Emphasize early interventions to promote protective factors and reduce risk factors for suicide.

- Utilize wellness models and peer-to-peer programs to normalize the behavioral health aspects of aging.

Goal 4: Develop and implement suicide prevention programs.

Research demonstrates that most suicides are preventable, but effective suicide prevention programs require commitment and resources. The public health approach provides a framework for developing preventive interventions that represent a comprehensive and coordinated effort.

The strategies established for Goal 4 support planning and program development, ensuring the integration of suicide prevention within entities that serve older adults and those who work with them. The objectives also address the need for systematic planning at state and local levels, the need for technical assistance in the development of suicide prevention programs, and the value of continual evaluation.

Strategies:

- Development of technical support centers to build the capacity across the state to implement and evaluate suicide prevention programs.
- Identification of contacts to coordinate an increase in the proportion of local communities with comprehensive suicide prevention plans.
- Identification of contacts to coordinate an increase in the number of evidence-based suicide prevention plans in community service programs, area agencies on aging, primary care sites, senior centers, and senior apartments.

Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm.

Evidence from numerous studies shows that limiting access to lethal means of self-harm is an effective strategy to preventing self-destructive behaviors. Often referred to as "means restriction," this approach is based on the idea that a small but significant minority of suicidal acts are, in fact, impulsive. They result from a combination of psychological pain or despair coupled with the easy availability of the means by which to inflict self-injury. Hence, limiting the individual's access to the means of self-harm may prevent a self-destructive act.

Admittedly, some controversy exists about how to accomplish this goal. For some, means restriction may mean modifying existing lethal means of self-harm currently available (for example, installing trigger locks on firearms and promoting safe storage of medications). Other activists are more concerned with limiting the availability of such means. It is not the intention of TSPN or the Older Adult Suicide Prevention Plan Committee to take sides on this issue. It is, however, our intent to explain the importance of limiting or removing access to lethal means, even if only temporarily, for older adults identified as at risk.

The strategies established for Goal 5 are designed to separate the individuals from the lethal means of self-harm. They include:

- Education of medical personnel, staff and social workers routinely interacting with seniors, aging care managers, and LTC facility staff on regular assessment of lethal means in homes and care facilities, as well as the actions needed to reduce suicide risk in older adults.
- Education of other miscellaneous groups, such as Meals on Wheels volunteers and beauticians, with regular contact with older adults on suicide awareness and prevention.

- Implementation of a public information campaign on lethal means reduction.
- Improving firearm safety design, establishing safer methods for dispensing potentially lethal quantities of medications and safer methods for reducing carbon monoxide poisoning for automobile exhaust systems, and
- Support and promotion of the discovery of new technologies to prevent suicide.
- Education of family caregivers on appropriately storage and security for potential lethal means.

Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment.

Many health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment. Despite increased awareness of suicide as a major public health problem, gaps remain in training programs for health professionals and others who often come into contact with patients in need of these specialized assessment techniques and treatment approaches.

Goal 6 is oriented primarily towards gatekeepers—people who regularly come into contact with individuals or families in distress. Examples relevant to older adult suicide include primary care physicians, health care office staff, caseworkers, senior center or senior apartment staff, social workers and nursing staff working in the arena of LTC, clergy, police officers, emergency health care personnel, and seniors themselves. All these groups need training to recognize suicide risk factors and learn appropriate interventions.

The strategies established for Goal 6 are designed to ensure that health professionals and key community gatekeepers obtain the training that will help them prevent suicide.

Strategies:

- Development and implementation of proactive interventions, such as creation and circulation of “crisis cards” that instruct individuals in a series of action steps to prevent the action of suicide, as well as gatekeeper training for awareness of risk factors with emphasis on monitoring suicide survivors (persons grieving family members of loved ones who have died by suicide).
- Outreach to senior centers, senior apartments, retirement communities and LTC facilities to ensure resident gatekeepers are aware of risk factors of suicide in older adults
- Suicide prevention and crisis intervention training for seniors themselves through senior centers educational programs run by AARP and other retirement organizations.
- Providing educational programs for family members of persons at elevated risk.
- Incorporation of suicide prevention workshops at annual meetings of professional groups and LTC associations.
- Specific targeting of primary care physicians for education about risk factors, identification of depressive symptoms, and effective treatment of depression (medication and therapy).
- Outreach to regional aging agencies for better access to area gatekeepers.
- Encouragement of directors of education at medical and other professional schools to include suicide prevention training in the curriculum.

Goal 7: Develop and promote effective clinical and professional practices.

One way to prevent suicide is to identify high-risk individuals and to engage them in proven treatments for reducing the personal and situational factors associated with suicidal behaviors. Additionally, we can promote and support protective factors such as learning skills in problem solving, conflict resolution, and nonviolent handling of disputes.

Improving clinical practices in the assessment, management, and treatment for high-risk older adults at risk for suicide greatly decreases the risk of these people acting on their despair and distress in self-destructive ways. Likewise, promoting protective factors for these individuals can contribute significantly to reducing their risk of suicide and to improving their general quality of life.

The strategies established for Goal 7 are designed to heighten awareness of risk and protective conditions associated with suicide, leading to better triage systems and better allocation of resources for those in need of specialized treatment.

Strategies:

- Promotion of procedure and/or policy change designed to assess suicide risk and the incorporation of suicide risk screening and suicide prevention training in hospital emergency departments, substance abuse treatment centers, specialty mental health treatment centers, LTC and other institutional treatment settings.
- Provision of training in suicide risk assessment for the aforementioned groups as well as emergency medical technicians, firefighters, police, and funeral directors.
- Promotion of mental health services in emergency departments for persons treated for trauma, sexual assault, or physical abuse.
- Organization of training sessions for family members and significant others of persons receiving mental health and substance abuse treatment.
- Collaboration with hospital associations to develop tracking procedures for mental health follow-up.
- Promotion of the inclusion of geriatric behavioral health issues in medical schools, nursing programs and allied health training programs.
- Distribution of suicide risk posters for emergency rooms.
- Sponsorship of depression screening events at hospitals and other medical facilities in order to promote education among professionals regarding screening and identification.
- Promotion of guidelines for aftercare treatment programs.
- Promotion of strategies for successful aging within agencies mentioned above; this includes providing information on combating depression, maintaining active engagement with life, and increasing social support, nutrition, sleep hygiene, exercise, and resilience.

Goal 8: Improve access to and build community linkages with mental health and substance abuse services.

Suicide prevention, like all aspects of public health is affected by lingering health care disparities attributable to differences of gender, race or ethnicity, education, income, disability, stigma, geographic location, or sexual orientation. But of all these factors, age remains the largest disparity in regards to behavioral health service provision.

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors.

- Financial barriers include insufficient health insurance or inability to pay for services outside a health plan or insurance program.
- Structural barriers include the lack of understanding of age-specific behavioral health needs across disciplines. These originate in a lack of training in age-specific behavioral health needs, unwillingness of mental heath providers to serve older adults, and shortages of health care facilities and/or geriatric specialists.
- Personal barriers include ageism, cultural or spiritual issues, language barriers, concerns about confidentiality or discrimination, lack of transportation, and not knowing when or how to seek care.

Overcoming these barriers is necessary to ensure that older adults receive adequate mental health care and preventative services.

The strategies established for Goal 8 are designed to enhance inter-agency communication and the provision of health services.

Strategies:

- Support for the integration of mental health and suicide prevention services into health and social services outreach programs for at-risk populations.
- Definition and implementation of screening guidelines for primary care, senior centers, and LTC facilities, along with guidelines on linkages with service providers.
- Establishment and facilitation of support programs for people who have been bereaved by suicide, and continued support of existing groups.
- Incorporation of mental health referrals into case management services provided by county health and social service agencies.
- Support for Memorandums of Understanding (MOUs) between the county mental health and aging systems ensuring cross system training, teamwork and case review stressing the need for outreach and education to seniors on suicide prevention.
- Provision of training for group facilitators and community meeting spaces for suicide survivor support groups.

Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.

Changing media representation of suicidal behavior is one of several strategies needed to reduce the suicide rate. Mass media has a powerful impact on perceptions of reality and on behavior. Research shows that media representations of suicide may either spawn and further suicide contagion, or help prevent suicide and encourage consumers to seek help.

Media portrayals of mental illness and substance abuse may also affect the suicide rate. Negative depictions may lead individuals to deny they have a problem or avoid treatment, possibly culminating in suicide attempts.

The strategies established for Goal 9 will help members of the media better consider the impact of their portrayals of suicide, suicidal behavior, mental illness, and substance abuse, with the goal of encouraging media representations that can help prevent rather than increase suicide.

Strategies:

- Promotion of responsible reporting on suicide and mental illness by local newspapers and broadcast outlets, in line with American Association of Suicidology (AAS) guidelines—briefly, coverage that avoids sensationalism, is sympathetic to survivors, and acknowledges the preventability of suicide by including information on available crisis resources
- Promotion of curricula detailing proper coverage of suicide and mental health issues in journalism schools.
- Encouraging survivors and community advocates to monitor portrayals of suicide in general and older adult suicide in television, print, radio, and on the Internet.

Goal 10: Promote and support research on suicide and suicide prevention.

The volume of research on suicide and its risk factors has increased considerably in the past decade and has greatly clarified the interplay between the various factors that influence suicide and suicidal behavior. This research continues to bolster our knowledge base regarding risk and protective factors, thus shaping and refining the intervention process.

The strategies established for Goal 10 support research endeavors focused on the etiology, expression, and maintenance of suicidal behaviors across the lifespan. The enhanced understanding to be derived from this research will lead to better assessment tools, treatments, and preventive interventions. The objectives include:

- Promotion of increased funding for suicide research projects, especially those focused on older adults; this may involve contributing letters of support and assisting with grant applications.
- Encouragement of psychology, social work and counseling departments at Tennessee institutions of higher learning to conduct research on older adult research and share their findings with the Network.
- Establishment of a registry of interventions with demonstrated effectiveness for prevention of suicide or suicidal behavior.
- Development and distribution of user-friendly toolkits on program evaluation.
- Outreach to county medical examiners to encourage better and more timely provision of suicide data.

Goal 11: Improve and expand surveillance.

In this objective, "surveillance" is defined as the systematic and ongoing collection of data. Surveillance systems are key to health planning. They are used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high risk populations for interventions and to assess the impact of prevention efforts.

Data on suicide and suicidal behavior are needed at national, state and local levels. National data draws attention to the magnitude of the suicide problem and reveals phenomena related to groups (e.g., ethnic groups), locales (e.g., rural vs. urban) and settings of care (e.g., primary care, emergency departments). State and local data help drive local program priorities and are vital for evaluation and adjustment suicide prevention strategies on the microlevel.

The strategies established for Goal 11 enhance the quality and quantity of data available on suicide and suicidal behaviors and ensure that the data are useful for prevention purposes.

Strategies:

- Development and implementation of standardized death scene investigation protocols
- Encouragement of local hospitals to code for external cause of injuries
- Support of pilot projects that link and analyze information on self-destructive behavior from various distinct data systems; this includes Tennessee's possible inclusion in the National Violent Death Reporting System (NVDRS) and other reporting systems that collect information not currently available from death certificates.
- Development of a set of community level indicators for progress in suicide prevention.

Looking Ahead

The Tennessee Strategy for Older Adult Suicide Prevention complements TSPN's existing framework for suicide prevention for Tennessee and extends it to reach an underserved population. It is designed to encourage and empower groups and individuals to work together.

This initiative can only succeed through broad support and collaboration with other agencies and the general public. Working together, we can raise awareness of the problem of suicide, demonstrate its highly preventable nature, and engage individuals and groups in prevention efforts.

The comprehensive nature of the Tennessee Strategy for Older Adult Suicide Prevention allows individuals and groups to select objectives and activities that best correspond to their responsibilities and resources. The strategies suggest a number of roles for different groups and have been developed in recognition of the point that people from a variety of occupations and backgrounds are needed for full implementation of the plan. Everyone has a part to play, up to and including the older adults we are trying to protect. No gesture is too small, no idea too unorthodox.

This document articulates the framework for statewide efforts and provides legitimacy for statewide agencies to make older adult suicide prevention a priority. At the same time it is a model for action on the local level that helps communities develop their own older adult suicide prevention plans.

Now is the time for action. We are working to save lives not only among the older adults of today, but for generations to come. Old age is a phenomenon everyone will some day experience, if we are fortunate. We owe it to our parents, grandparents, relatives, and neighbors to make sure that the later chapters of their lives are free of the specters of depression and mental anguish that can bring them to a close too early. And as we age we, too, stand to benefit from the availability of quality mental health care that takes our special needs into account.

This is a living document, in multiple senses of the term. It will change and develop over time as new opportunities, participants, research, and conditions present themselves. Whether you have been involved in the initial development of the plan or are just now joining, you can make a difference in the lives of Tennessee's older adults.

Acknowledgements

Editors

Scott Ridgway, MS, Executive Director, Tennessee Suicide Prevention Network
Vladimir Enlow, MTS, Executive Assistant, Tennessee Suicide Prevention Network

Tennessee Older Adult Suicide Prevention Plan Committee

Members of the workgroup assisted in the writing and development of the plan and engaged community partners in providing input at community forums.

Jennifer Harris, Committee Co-Chair (Hickman Community Hospital, Centerville, jennifer.harris@baptisthospital.com)
Lygia Williams, Committee Co-Chair (Tennessee Department of Mental Health and Developmental Disabilities, Nashville, lygia.williams@tn.gov)
Laurie Cooper (Home Instead Senior Care, laurie.cooper@homeinstead.com)
Gwen Hamer (Tennessee Department of Mental Health and Developmental Disabilities, Nashville, gwen.hamer@tn.gov)
Harold Leonard (Indian Path Pavilion, Kingsport, leonardhb@msha.com)
Angela Thompson (Director, Behavioral Health Services, Metro Nashville Public Health Department, angie.thompson@nashville.gov)
Lucy Utt (Commission on Aging and Disability, Nashville, lucy.utt@tn.gov)
Pam Arnell (Junipers of the World, Pulaski, angel1@surfmore.net)
Sam Bernard (PAR Foundation, Chattanooga, sambernard@comcast.net)
Vickie Bilbrey (Livingston Regional Hospital, Livingston, vickie.bilbrey@psysolutions.com)
Gayle Bradley (FiftyForward, Nashville, gbradley@fiftyforward.org)
Diane Gramann (Alzheimer's Association, Nashville, diane.gramann@alz.org)
Deborah Hardin (Tennessee Department of Health, Nashville, deborah.hardin@tn.gov)
Shirley McGowan (Comprehensive Counseling Network, Memphis, shirleym@ccnmemphis.org)
Kris Moore (Behavioral Health Center, Martin, kmoore@thmgt.com)
Linda Moran (Dale Hollow Mental Health Center, Livingston, lmoran@vbhcs.org)
Nancy Pertl (Mental Health Association of Middle Tennessee, Nashville, npertl@mhamt.org)
Melissa Pippin (HCA, Inc., melissa.pippin@hcahealthcare.com)
Micky Roberts (Blount County Health Department, Knoxville, micky.roberts@tn.gov)
Jana Sevier (Windsor Medicare Extra, Nashville, jsevier@windsorextra.com)
Jackie Talley (Tennessee Department of Mental Health and Developmental Disabilities, Nashville, jackie.talley@tn.gov)
Linda Terrill (Cumberland County Department of Human Services, Crossville, linda.terrill@tn.gov)
Patty Wright (Lincoln County Health System, Fayetteville, pwright@lchealthsystem.com)

Bibliography

Bruce, M. L., et al., (2004). Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: a randomized controlled trial.
Journal of the American Medical Association 291(9):1081-1091.

Injury and Violence Prevention Program, Office of Disease Prevention and Epidemiology, Oregon Department of Human Services. *Oregon Older Adult Suicide Prevention Plan.* Available URL: http://www.oregon.gov/DHS/ph/ipe/esp/docs/plan.pdf

Institute of Medicine of the National Academies (2002). *Reducing Suicide: A National Imperative*. Washington, DC: National Academies Press.

The John A. Hartford Foundation. JAHF 2002 Annual Report. Available URL: http://www.jhartfound.org/pdf%20files/JAHF%202002%20Annual%20Report.pdf

Levkoff, S. E., *et al*. (2004) Design and sample characteristics of the PRISM-E multisite randomized trial to improve behavioral health care for the elderly. *Journal of Aging and Health* 16:3-27.

Pennsylvania Department of Public Welfare. *Pennsylvania Older Adult Suicide Prevention Plan*. Available URL: http://www.dpw.state.pa.us/Resources/Documents/Presentations/PaStrategyForOlderAdultSuicidePrev.pdf

U.S. Public Health Service (2002). *National Strategy for Suicide Prevention: Goals and Objectives for Action (Summary)*. Rockville, MD: U.S. Department of Health and Human Services.

U.S. Public Health Service (1999). *The Surgeon General's Call to Action to Prevent Suicide*. Washington, DC: U.S. Department of Health and Human Services.

Tennessee Suicide Prevention Network. *Tennessee Strategy for Suicide Prevention*. Available URL: http://www.tspn.org/suicide_prevention.htm

Web-based Injury Statistics Query and Reporting System (WISQARS). Available URL: http://www.cdc.gov/injury/wisqars/index.html

Tennessee Suicide Prevention Network

Street and mailing address:
446 Metroplex Drive, Suite A-224,
Nashville, TN 37211

Office phone: (615) 297-1077
Office fax: (615) 269-5413
www.tspn.org

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org