

“It Takes a Community”

**Report on the
Summit on Opportunities for Mental
Health Promotion and Suicide Prevention
in Senior Living Communities**

**October 16-17, 2008
Gaithersburg, Maryland**

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1.

Summit Overview

Against a backdrop of disproportionately high rates of suicide among older adults, in October 2008 a partnership of concerned Federal agencies and private-sector organizations convened “It Takes a Community”: A Summit on Opportunities for Mental Health Promotion and Suicide Prevention in Senior Living Communities.* In recognition of serious public health concerns about suicide among elders, the summit helped to advance discussions and action emerging on multiple fronts intended to improve the mental health, and reduce the suicide risk, of residents of senior living communities.

Burden of Suicide in the United States

- Suicide was the 11th leading cause of death in the United States in 2006 (the most recent year for which statistics are available).
- Older adults have the highest suicide rate of any age group, particularly among men 65 and older.
- While older adults constituted 12.4 percent of the U.S. population, they accounted for 16.6 percent of the suicides.
- Eleven persons per 100,000 in the U.S. population took their own lives, and among persons older than 65, the suicide rate was 14.7 per 100,000.
- Adults over age 65 have a vastly higher suicide completion rate than other age groups: one estimated suicide for every four attempts (Kung, Hoyert, Xu, & Murphy, 2008).
- From 1999 through 2005, the suicide rate in the United States increased for the first time in a decade, mostly among whites ages 40–64. Middle-aged women and middle-aged men experienced the largest annual increases at 3.9 percent and 2.7 percent, respectively (Hu, Wilcox, Wissow, & Baker, 2008).

As the Baby Boom generation begins to age into “elder” status, the impact of this public health problem is anticipated to intensify.

David M. W. Denton, executive director of Asbury Methodist Village in Gaithersburg, Maryland, told the 70 invited summit participants that senior living communities are not insulated from elder suicide: in 2004 and 2005, his community experienced three known suicides—and probably others took place under the radar. “Loved ones and friends left in the wake of suicide find themselves in a state of disbelief, despair, and oftentimes remorse,” Denton stated. A community in “disbelief and grief finds itself asking: ‘What do we do now?’ There are so many tough questions and no simple answers or playbook to guide us out of this dark tunnel.”

* The summit’s sponsors included the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS); National Institute of Mental Health, DHHS; Asbury Methodist Village; Suicide Prevention Resource Center (SAMHSA-funded grant); Sodexo; and Suicide Prevention Action Network (SPAN USA)

In response to these concerns, the summit marked the beginning of a collaborative, interdisciplinary, multistakeholder effort to consider issues related to late-life suicide in senior living communities. Summit participants identified opportunities for action across a range of policy and practice areas. In addition, they explored stakeholder-specific roles and key considerations for decision making in developing and implementing evidence-based policies and practices tailored for senior living communities.

Several principles guided the work of the summit:

- A broad-based approach to emotional health includes promoting positive emotional wellness as well as reducing and preventing mental illness and suicide.
- Promoting emotional health is not solely the job of mental health professionals, but rather is a shared responsibility.
- Effective mental health promotion and suicide prevention efforts typically include the adoption of multiple, coordinated approaches. These approaches incorporate preventive efforts that address whole populations, interventions that target at-risk individuals, and effective responses to crises and suicidal behavior.
- Because every senior living community is unique, approaches to promoting mental health and preventing suicide must be customized to reflect the local context, population, and resources.
- Decisions about the most appropriate and effective approaches for a given facility will be shaped by the evidence in support of that approach, as well as facility-specific and other factors.

Early Summit Outcomes

Meeting organizers anticipated that the summit would set in motion subsequent actions to address suicide prevention in senior living communities. Selected summit outcomes include the following:

- The Center for Mental Health Services/Substance Abuse and Mental Health Services Administration (SAMHSA) contracted with the National Association of State Mental Health Program Directors (NASMHPD) to develop suicide prevention toolkits for selected high-risk populations. The ideas and observations generated by summit participants, and captured in an early version of this report, contributed to the content of *Promoting Mental Health and Preventing Suicide: A Toolkit for Senior Living Communities*. The resource targets administrators, professionals, and paraprofessional staff of senior living communities—including nursing homes, assisted living, independent living, and continuing care retirement communities, as well as residents and their family members. Scheduled for release in early 2010, the toolkit offers tools to teach staff to recognize and take steps to help someone at risk for suicide and to learn how to

put policies and actions in place that could improve the mental well-being of the residents.

- Conference participants and planners Carol Podgorski, Ph.D., Linda Langford, Sc.D., and Jane Pearson, Ph.D., along with Yeates Conwell, M.D., collaborated on a journal article submitted for review to *PLoS Medicine*.
- Linda Langford, Sc.D., and Jerry Reed, Ph.D., MSW, presented a session entitled “Opportunities for Mental Health Promotion and Suicide Prevention in Senior Living Communities” at the American Association of Suicidology Annual Conference on April 16, 2009.
- Jerry Reed, Ph.D., MSW, presented a session entitled “Bringing Opportunities for Mental Health Promotion and Suicide Prevention Efforts to New Communities like Older Adult Living Facilities” (co-authored by Linda Langford, Sc.D.) at the XXV World Congress on Suicide Prevention sponsored by the International Association for Suicide Prevention in Montevideo, Uruguay, on October 28, 2009.
- Conference planners and participants David Denton, Jane Pearson, Ph.D., and Richard McKeon, Ph.D., M.P.H., presented at the American Association of Homes and Services for the Aging’s annual meeting in November 2009. Speaking on “Promoting Mental Health and Preventing Suicide in Senior Living Communities,” they described experiences that inspired the summit, discussed the framework for suicide prevention in senior living communities, and announced the forthcoming release of the toolkit.

Organization of this Report

Following this overview of the summit and its early outcomes (Chapter 1) and a presentation of the conceptual framework for the summit (Chapter 2), this report presents the remarks of A. Kathryn Power, Director, Center for Mental Health Services, who set the context for the summit in her keynote address (Chapter 3). Two first-person accounts illustrate the human cost of untreated mental illness (Chapter 4), and another presentation summarizes preliminary findings from focus groups exploring senior living community residents’ attitudes and opinions about emotional health and mental health issues (Chapter 5).

Summit presenters shared research and professional experience about the extent and nature of suicide among older adults (Chapter 6), suicide prevention and intervention approaches, and recommendations for intervening in suicide-related crises and coping with the aftermath of a suicide (Chapters 7 through 9). In their presentations, these experts also offered recommendations for interventions across the summit’s three focal categories: whole-population approaches, approaches for populations at risk for suicide, and crisis response and postvention. Two additional experts on aging shared their perspectives: one on aging and mental health (Chapter 10), and the other on successful aging (Chapter 11). Chapter 12 summarizes the opportunities for promoting health and preventing suicide generated by small-group discussions. A matrix lists participants’ suggestions for activities by which senior living communities can

promote both wellness and suicide prevention, and the subsequent narrative lists proposed actions that specific stakeholder groups can take to move suicide prevention efforts forward.

2.

Framework for Mental Health Promotion and Suicide Prevention in Senior Living Communities

Linda Langford, Sc.D., Evaluation Scientist, Suicide Prevention Resource Center, Newton, Massachusetts, presented an overview of basic concepts in suicide prevention and an explanation of the summit's structure. She described a public health approach to suicide prevention and then introduced the framework for the summit, a schematic created to provide a common reference point to blend the expertise of summit participants who work in suicide prevention with those employed by senior living communities. She concluded her remarks by describing best practices for planning suicide interventions.

Public Health Approach

Langford explained that the public health model focuses on promoting health and preventing disease in whole populations. While originally focused on infectious diseases, the public health model has been broadened to address problems such as suicide and self-harm. This approach extends beyond the medical notion of treating individual cases of disease by studying risk factors for diseases in populations, with the aim of intervening to prevent new cases. The public health approach consists of the following steps:

- Define and understand the problem in a population (or in a specific setting such as senior living communities).
- Identify contributing factors that increase the likelihood of the problem (risk factors) and reduce the likelihood of the problem (protective factors), envisioning the chain or constellation of events that result in the problem.
- Institute measures to intervene in that chain of events. Interventions may involve a combination of program, policy, services, and systems changes.
- Evaluate to examine whether problems were prevented—and use that information to design better efforts.

The concept of *prevention* consists of reducing risk factors and promoting protective factors in order to change the underlying conditions that lead to suicide, thereby decreasing the number of new cases. Also important for addressing suicide comprehensively are early intervention and responding after a crisis. Langford asserted that the concept of suicide prevention is not confined solely to the prevention of suicide deaths, but rather encompasses multiple goals, including enhancing emotional wellness, creating health-promoting environments, addressing risk and

protective factors, intervening early in mental health problems, addressing suicidal behavior, and conducting postvention (working with individuals and communities following a suicide death.)

Langford noted that while mental illnesses and substance abuse play a role in suicidal behavior and suicide deaths, they are not in themselves a sufficient explanation for suicide. Many people with mental health problems do not engage in suicidal behavior, while some people in treatment for mental health conditions do engage in suicidal behaviors—which makes it imperative to look beyond a simple treatment model for solutions to suicide.

Research finds that suicide is complex, with a variety of causes and contributors. These factors may be conceptualized according to a social ecological model, which recognizes that causes occur at multiple levels:

- Individual factors (e.g., biology, individual beliefs)
- Group/family factors (e.g., family and/or peer influences)
- Institutional factors (in this context, the policies and structures of the senior living community, and the programs or services it offers)
- Community factors (attributes of the community in which the facility is located, for example, community-based resources or services)
- Public policy and societal factors (factors outside the immediate community, including State or Federal policy and larger cultural forces)

Contributors to suicidal behavior also vary in their temporal relationship to a suicide, that is, some risk factors are closer in time to the suicidal event (proximal factors or immediate triggers), while others are more distal factors (biological or predisposing factors) that heighten vulnerability to more immediate risks. Comprehensive suicide prevention efforts will address multiple causes and contributors and incorporate efforts across the continuum of prevention, intervention, and response.

Summit Framework

Developed by Langford, the conceptual framework that guided summit presentations and discussions (see Table 1) outlines goals and objectives for mental health promotion and suicide prevention among residents of senior living communities. The framework includes three categories of approaches by which to address suicide prevention:

1. **Whole population approaches** that build health-promoting environments and address risk and protective factors across the whole population, regardless of risk status or behavior
2. **At-risk approaches** that provide assistance with symptomatic illness or higher risk, or greater risk factors in the environment

3. **Response to crises and suicidal behaviors**, which includes responding to acute crises, including suicidal behavior, and providing support to the community after a suicide death

Table 1. Summit Framework

<p>Category 1: Whole-Population Approaches</p> <ul style="list-style-type: none"> ▪ Focus on reducing risk factors and increasing protective factors across the whole population, regardless of risk status or behavior. ▪ Include building a health-promoting environment for individual residents and also for the campus as a whole. ▪ Acknowledging that residents also have a role in promoting their own emotional wellness, focus on what <i>institutions</i> can do.
<p>Goal 1. Promote effective coping and functioning. Provide and promote opportunities for residents to cope positively with the circumstances and challenges of aging.</p>
<p><i>Objectives:</i></p> <ol style="list-style-type: none"> 1.1 Promote coping with loss and bereavement. 1.2 Promote coping with decreased functioning and role changes. 1.3 Promote problem-solving skills. 1.4 Provide assistance with financial or other matters.
<p>Goal 2. Promote social networks and social support. Promote relationship building and foster a feeling of connectedness and belonging.</p>
<p><i>Objectives:</i></p> <ol style="list-style-type: none"> 2.1 Encourage connections among residents. 2.2 Promote a sense of community on campus. 2.3 Provide or facilitate regular “check-ins.” 2.4 Facilitate contacts with family members.
<p>Goal 3. Promote engagement in positive activities. Promote participation in on- and off-campus activities to increase positive feelings, engagement, and meaning.</p>
<p><i>Objectives:</i></p> <ol style="list-style-type: none"> 3.1 Provide access to spiritual or faith activities. 3.2 Promote involvement in volunteer activities. 3.3 Provide recreational activities. 3.4 Promote engagement in physical activity.

<p>Goal 4. Decrease access to lethal means. Limit access to potential sites, weapons, and other agents that may facilitate dying by suicide.</p>
<p><i>Objectives:</i></p> <ul style="list-style-type: none"> 4.1 Limit access and/or erect fences on roofs of buildings. 4.2 Replace windows or limit size of window openings. 4.3 Restrict access to stored chemicals and prescription drugs. 4.4 Restrict access to firearms.
<p style="text-align: center;">Category 2: At-Risk Approaches</p> <ul style="list-style-type: none"> ▪ Focus on assisting residents who are suicidal, have symptomatic mental health problems, or are at higher risk for suicide. ▪ Include instituting facility-specific systems and practices, and also working collaboratively with off-campus providers, services, and systems.
<p>Goal 5. Increase help-seeking behaviors. Provide residents with knowledge and motivation to encourage them to seek help with emotional issues, and to lower the barriers that impede help seeking.</p>
<p><i>Objectives:</i></p> <ul style="list-style-type: none"> 5.1 Increase residents' knowledge of treatable risk factors, potential treatments, and available services. 5.2 Decrease local barriers to help-seeking. 5.3 Implement efforts to reduce stigma and normalize help seeking.
<p>Goal 6. Identify and refer distressed or at-risk residents. Identify and appropriately refer residents who are experiencing emotional distress or who are at risk for suicide.</p>
<p><i>Objectives:</i></p> <ul style="list-style-type: none"> 6.1 Increase the ability of other residents, staff, and families to identify and refer residents for help (i.e., by gatekeeper training). 6.2 Increase identification of depression, substance abuse, and suicidality among residents (i.e., by screening). 6.3 Increase clinicians' capacity to identify and refer appropriately.
<p>Goal 7. Increase access to mental health and substance abuse services. Help residents in need of services to obtain them.</p>
<p><i>Objectives:</i></p> <ul style="list-style-type: none"> 7.1 Create linkages with community-based mental health and substance abuse services. 7.2 Provide mental health and substance abuse services or supports.

Goal 8. Promote effective treatment and management of mental health and substance abuse disorders.

Promote the accurate diagnosis and appropriate treatment of residents with emotional problems, including assessing and managing suicide risk.

Objectives:

- 8.1 Adhere to geriatric-specific treatment guidelines.
- 8.2 Utilize effective models of geriatric care management.
- 8.3 Assess for suicidality.
- 8.4 Increase regular monitoring of at-risk residents.

Goal 9: Effectively address medical conditions and pain.

Reduce physical and emotional consequences and impairment from medical conditions and pain.

Objectives:

- 9.1 Employ treatment regimens designed to reduce symptoms and pain.
- 9.2 Help ill residents deal with specific types of disability and functional impairment.

Category 3: Response to Crises and Suicidal Behaviors

- Focus on responding to suicidal behavior and deaths by suicide.
- Create and implement protocols, procedures, and systems for responding appropriately to crises, including suicidal acts.
- Provide support for communities following a suicide death.
- Create policies, procedures, and systems proactively, in advance of a crisis.

Goal 10. Develop protocols and procedures to promote the safety of distressed or suicidal residents and to respond to crises using institutionalized procedures.

Develop processes that promote systematic and effective responses to crises, including suicidal behavior.

Objectives:

- 10.1 Implement protocols and systems for responding effectively to acutely distressed or suicidal residents.
- 10.2 Utilize decision-making protocols and procedures regarding mental health issues and the need for additional care (e.g., hospitalization, transition to assisted living).
- 10.3 Ensure that emergency contact notification protocols are appropriate to mental health crises.
- 10.4 Institute procedures for creating and implementing post-crisis follow-up plans.
- 10.5 Utilize standardized procedures for appropriately documenting interactions with distressed or suicidal residents.
- 10.6 Train appropriate personnel in relevant protocols and procedures.

Goal 11. Respond to suicides with a comprehensive postvention program to identify survivors, assess level of trauma and risk among survivors, support survivors, and prevent suicide contagion.

Reduce physical and emotional consequences and impairment from medical conditions and pain.

Objectives:

- 11.1 Develop postvention protocols and procedures prior to need.
- 11.2 Ensure that all appropriate individuals within the community are identified as survivors.
- 11.3 Assess all survivors for level of trauma and risk.
- 11.4 Ensure that support is offered/provided to all survivors.
- 11.5 Work appropriately and effectively with the media.
- 11.6 Implement postvention strategies that discourage suicide contagion.

Best Practices for Planning Suicide Interventions

According to the literature, Langford asserted, more comprehensive interventions use approaches that address objectives across all three categories. Evidence-based interventions often combine multiple components across different categories, for example, contact with a counselor, problem-solving treatment that also promotes coping skills, increased physical activity and socialization, antidepressants when indicated, and attention to medical conditions. For best effect, multilayered program elements reinforce and support one another.

Langford explained key concepts in prevention planning for organizations such as senior living communities. Data-driven planning enables the nature of the problem to inform and guide appropriate solutions. Since no one-size-fits-all program or set of interventions will work in every facility, programs will be more effective when guided by an institution-specific assessment of its own issues and resources that is then used to create a plan tailored to its specific circumstances. Better plans include focused aims that specify which factors will be modified (using “change language” such as “increase” and “decrease”). These changes—the goals and objectives—state the desired result, while activities (e.g., training, helpline, policies) represent the actions to take to achieve the goals and objectives. More effective planning processes establish the desired changes first, then select appropriate activities capable of achieving those changes. Each activity should be linked with an objective, for example, “Train clinicians *in order to* increase knowledge of evidence-based treatments.”

Successful implementation of prevention programs entails several key processes, including:

- **Leadership** to place emotional health and wellness on the agenda and to champion and provide support to the efforts
- **Collaboration** within an institution and with the community
- **Review of data and research** to define and understand problems both nationally and locally, and to identify evidence-based programs and best practices

- **Strategic planning** to tailor plans based on local data and thoughtfully choose multiple, reinforcing initiatives that respond to local circumstances
- **Evaluation** to determine whether efforts are achieving their desired results
- **Sustainability planning** to ensure that efforts are ongoing

In terms of safety, Langford reassured summit participants that asking people directly whether they are contemplating suicide does not increase their risk. But because some well-meaning messages *may* increase suicide risk among vulnerable individuals, it is important to abide by established Safe and Effective Messaging Guidelines (see Suicide Prevention Resource Center, n.d.).

3.

Keynote Address

A. Kathryn Power, M.Ed., Director, Center for Mental Health Services/Substance Abuse and Mental Health Services Administration, began her remarks by recognizing summit participant James T. Clemons, a pioneering suicide prevention leader,^{*} faith leader, and Asbury Methodist Village resident, who initially posed the suggestion to address suicide prevention for older adults in senior living communities. Power stated that it indeed “takes a community to save lives and ensure that mental health is viewed as part of our overall health,” and noted that the New Freedom Commission on Mental Health (2003) established, as its number one goal, the aim to “reduce suicide through education, awareness, conversation, and dialogue.”

The highest rate of suicide in America occurs among older adults, and fully 58 percent of elders who die by suicide have visited their primary care practitioner within the last month of their lives. Power suggested that visits to the doctor present an opportunity for prevention. Emphasizing that the mind/body connection is a key tenet of mental health, she stated that “everything a provider does in a primary care visit should focus on the holistic status of the individual.” This approach is important especially since older adults’ suicide attempts are “more likely to be deliberate and fatal.” She highlighted the need to embrace every opportunity to “prevent and treat” and to provide effective interventions for those left behind after suicide occurs.

Several Federal policy documents issued in recent years have focused attention on suicide prevention among older adults. The National Strategy for Suicide Prevention (U.S. Department of Health and Human Services [DHHS], 2001) identified specific goals and objectives to meet the needs of older adults, and called for wider awareness that suicide among older adults is a preventable public health problem (see sidebar). In line with the National Strategy, Power noted, the Federal Government recently has begun to treat veterans with mental health problems. The Nation’s defense sector has begun to recognize that “it takes a warrior with courage to face a mental health problem” and that “people should not be discriminated against because they recognize they need to talk with someone.” Power also stated that the 2005 White House Conference on Aging issued a recommendation to “improve recognition, assessment, and treatment of mental illness and depression among older Americans” (DHHS, 2005).

Power emphasized that depression is not a normal part of aging:

There is much we know and much we can do to ensure that all our citizens, young and old, can enjoy the quality of life they so richly deserve. Treatment works. Episodes of depression and untreated mental illnesses should not be allowed to detract from the true potential for each of us to enjoy our lives.

^{*} James T. Clemons, D.D., Ph.D., founded and served as executive director, Organization for Attempters and Survivors of Suicide in Interfaith Services. An author and professor emeritus, he was instrumental in convening the first national conference on survivors of suicide attempts.

Power called the summit a “hallmark effort to address unmet needs around mental health problems among older Americans” that will serve as a catalyst for continued national efforts. “With our older adult population expected to double by 2030, no time is better than the present to accept this challenge.”

***National Strategy for Suicide Prevention:
Goals and Objectives to Meet the Needs of Older Adults***

- Promote awareness that suicide in older adults is a public health problem that is preventable.
- Develop and implement strategies to reduce the negative aspects associated with aging and with being a senior consumer of mental health substance abuse and suicide prevention services.
- Implement training for recognition and assessment of at-risk behavior and delivery of effective treatment to older adults.
- Encourage and support research on late-life suicide and suicide prevention.
- Support interventions that improve social relations and decrease isolation in older adults.

(DHHS, 2001)

4.

Human Cost of Untreated Mental Illness

To illustrate in human terms the cost of untreated mental illnesses and suicide, two summit participants told their personal stories.

Victoria Graham shared her experience and perspective as a survivor of loved ones' suicides. A volunteer program director with ACTS/HelpLine in Prince William County, Virginia, Graham developed and facilitates depression awareness support groups, including one for older adults.

Graham explained that when her grandfather took his life in 1965 at age 64, she, then a child, became a suicide survivor. At that time, her family "experienced despair, depression, and anxieties as they tried to come up with a logical explanation for what had happened."

This was her first experience with death, and Graham remembered vividly all the events that led up to it: Her grandfather sat at the table on a beautiful fall day when she sat down on his lap and put her arms around his neck. He had a huge black eye, which Graham's mother explained away with, "Grandpa fell down the basement steps." The little girl said to him, "Take care of yourself, because I don't want anything to happen to you, because I love you."

Later that day, Graham remembered, sirens blared and her mother cried, "He's killed himself! He's hung himself! He's dead!"

Everyone entered into their own separate grief. No one said anything to the children. But the death of Graham's grandfather changed the family irreparably. Her grandmother became a widow—and she still had a child in the house to raise. Her grandmother had to "carry for the rest of her life the memory of having found her husband hanging in the basement."

No support for suicide survivors was available in those days in that community. Graham's mother and her siblings had lost their father, and six grandchildren lost their Grandpa. She and her mother's youngest sister, who lived with them, returned to school immediately. Graham remembered:

It was odd. My grandfather had been the groundskeeper and maintenance man at school, having retired from his career. But no students, faculty, or administrators offered any kind of condolences. They probably didn't want to say the wrong thing. We went to school with no one saying anything. My mother's youngest sister and I didn't say anything. No one was talking about a man who had lived for 65 years.

One of the most profound effects of his suicide occurred almost two decades later, when Graham's grandfather's only son took his life. Just one week after that, his youngest daughter fatally shot herself. Suicide had reverberated full force into the next generation.

“Now we all are watching our children,” Graham said. “When we are able to prevent or intervene, we are ensuring something for the next generation.”

Her grandfather’s death led to Graham’s subsequent involvement over more than two decades in suicide prevention efforts. It’s like “chipping away at the mountain,” she stated. But a sign on a wall at work reminds her and her colleagues that

Suicide does not end the pain.
It merely lays it on the shoulders
of those left behind.

Graham concluded her remarks by saying, “Our willingness to turn our pain to action and pain to hope makes a difference in the community.”

• • •

Mildred Reynolds, Ph.D., a psychiatric social worker for 30 years until her retirement, also shared her personal story. Reynolds decided to specialize in mood disorders as a result of her own experience with clinical depression. She has served as vice president of the Depression and Bipolar Support Alliance (DBSA) and as a member of its advisory board. She also has served on the executive committee of the National Coalition on Mental Health and Aging and the board of the Center on Global Aging.

Reynolds told summit participants that her willingness to talk about her suicidal ideation was tinged, “in the deep recesses of my mind,” with stigma. She explained that older adults

used to think that there was a stigma around anyone with a mental problem. They were described as “lazy,” “ne’er-do-wells,” “lost their marbles,” “off their rocker.” Maybe they were ready for the “loony bin.” Some people in asylums were actually shackled. Stigma reigned supreme when we grew up.

Despite her residual feelings of stigma, Reynolds recounts her story in “hopes that maybe somehow it will make a difference.”

At age 15, doctors told her that her too-rapid heartbeat would render her an invalid by age 25. She didn’t want to be a burden, and she wondered whether her siblings would care for her after their parents died. She tried to search for a way out of her predicament, and she had heard that rat poison would kill a person. But her church believed that suicide was a sin against God and that a person who took his or her own life would go to hell—a fiery furnace. “I surely did not want to go to hell, but the alternative of being an invalid for the rest of my life was no good either. A teenager should not have to make that choice alone. I told no one.” Slowly, fortunately, she recovered from her ailment.

Fifteen years later, she experienced what most people would now recognize as clinical depression. As Reynolds explained:

No one said anything about it in those days. Very little was known about it or how to treat it. The days seemed dark, dreary, and dismal. I tried counting my blessings, being grateful for all the good things, and I tried everything else I could think of, but I couldn't rid myself of depression. I no longer thought it was a sin; my view of suicide had changed. Now I thought that surely God would not do that to a person. It just didn't make sense to me. But I was in deep despair. I felt I wanted to go outside, lie down under the tree in the snow, and slowly freeze to death.

Another time I felt like a rat was gnawing on my brain and that the only thing that could give me relief was to put a gun to my head and pull the trigger. But I had no gun and didn't know how to get one. . . . It seemed too complicated.

Then I remembered that in this small university town, people had jumped off a bridge. I planned to write a suicide note and put it in the campus mail so it would arrive shortly after I jumped. I walked across the bridge to size it up to see how it might work. But then I began to think of the impact it would have on my parents. I knew they would be devastated. I simply could not do that to them, so I consulted my doctor, who recommended a psychiatrist and psychoanalysis—not what I needed then, but what I needed was not available. Slowly I felt better. I found that my analytical skills would help it never to happen again.

Another 15 years later, Reynolds held a position as a social worker at George Washington University Medical School's Department of Psychiatry. She had acquired a doctoral degree and had published scholarly papers in professional journals. Despite these accomplishments, she explained, she began to feel inferior, inadequate, and incompetent. "Depression had wreaked havoc" with her self-esteem, and she saw herself "sliding down the slippery slopes again. Neither my professional knowledge that I had gained from my work nor my analytical skills could lift the depression. Again I thought of suicide." Her parents were no longer living, "so they were not a deterrent, but I had my husband. I couldn't do it because I knew he would be devastated." This time she saw another psychiatrist, who said, "You have major depression, and I think medication would help."

It had taken more than 25 years from the time she first sought help until she received a correct diagnosis. "Psychotherapy was helpful, but the medication made the big difference." Yet it took still another 9 years after her diagnosis before she was able to find a medication that worked really well for her.

Reynolds was hopeful that she would enjoy smooth sailing from then on, but suddenly and unexpectedly her husband died. She stated that one of her first thoughts was, "Oh, I don't have to stay alive anymore!" She feared that losing him would send her into a downward spiral once again, but "fortunately, it did not. I knew I had good coping skills, and this time I had good medications and a support group that was effective." Reynolds considers the interventions that worked for her to be proper diagnosis and proper treatment—psychotherapy, instead of psychoanalysis, combined with effective medications and a support group for mood disorders.

"Am I home free?" she asks.

Only time will tell. Depression frequently recurs, and medications can stop working. These are the realities that I live with, but I do not dwell on them. Instead, I want to do as much as I can for as long as I can for as many as I can, to see that others don't have to go through this.

So when I speak, I often remind people that help is available. And with help, there is hope.

I know. I've been there.

5.

Hearing the Voices of Residents: Findings from Focus Groups on Emotional Health in Senior Living Communities

A number of older adults participated directly in the summit's activities. In addition, in order to incorporate the voice and perspectives of a broader representation of senior living community residents, planners organized a series of facilitated focus groups around the country prior to the gathering. In six facilities—three continuing care retirement communities and three affordable housing communities—a total of 52 residents responded to a series of specific questions about emotional wellness, emotional problems, suicidality, and available and needed resources and supports. Focus group participants reflected diversity in geographical location, length of residency, gender, race, ethnicity, gender orientation, and other dimensions.

Dr. Linda Langford presented findings of her preliminary analysis of the focus group responses, summarized here for confidentiality, brevity, and readability. Dr. Langford introduced the results with a reminder that focus groups help to understand how people think *about* issues, particularly their context and meaning. She noted that group dynamics and differences among focus groups affect responses to specific questions, and she cautioned against generalizing the findings to all older adults or all senior living communities.

Defining Emotional Health and Well-Being

Participants were asked first to define emotional health and well-being. Acknowledging individual differences, some residents characterized the concepts as an attitude or state of mind, such as feeling good about oneself, being happy with life as it is, or feeling a sense of community. Others described well-being in terms of certain actions, for example, being friendly, pursuing an active social life, or participating in activities. Some associated emotional health with certain skills, such as communicating, handling emotions, and coping with change, especially issues related to aging, role changes, and mortality. A few residents described emotional well-being as “avoiding depression.” Some cited the security of residential living as a contributor to their well-being.

Senior Living Community Supports for Emotional Health

Focus groups were asked what supports available at their facility help them to be emotionally healthy. Most responses fell into three broad categories: qualified and caring staff and professionals, access to formal activities and other services, and especially the nature of the social environment, for example, socializing with other residents, neighbors checking in on each other, and getting emotional support.

Senior Living Communities' Formal Role in Promoting Emotional Health

When asked what else their facility might do to promote well-being, many participants recommended that facilities coordinate and promote a broad menu of activities that appeal to residents. Specific suggestions included exercise and wellness programs, social activities, and “uplifting experiences,” with an emphasis on encouraging interpersonal connection and communication. Participants highlighted the need for communication between residents and management and staff, while also respecting the preference of some residents to keep to themselves.

Emotional Challenges and Problems Faced by Residents

Common concerns perceived by focus group participants included the emotional impact of changing or failing health and related decisions about moving to a higher level of care, loneliness and isolation, contact (or lack thereof) with family members, and loss of a sense of purpose. Focus group facilitators noted widespread agreement that depression is a problem. Some participants observed the need for both staff and residents to identify problems and to take appropriate action to help.

When asked specifically if they had heard anyone saying or sounding like they did not want to live, participants related poignant stories about serious emotional challenges they or others have faced regarding ill spouses, bereavement, being alone, financial difficulties, and loss of function. Some participants indicated that suicidal thoughts are normal, or at least understandable, at their age. The extent to which participants had direct knowledge of suicidality among other residents appeared to vary across facilities.

Available Resources to Address Emotional Problems

Participants identified a number of resources their facilities offer to help residents deal with emotional challenges. These included medical and mental health professionals, pastoral care providers, care management professionals, service coordinators, and informal caregivers. Community resources included suicide hotlines, medical facilities, support groups, and friends and family members. When asked whether primary care physicians are good sources of help for emotional problems, many said they can be helpful because of their familiarity with their patients and their ability to make referrals when necessary; however, they noted many limitations, including variability in physician-patient rapport, accessibility issues (including timely appointments, insurance coverage, and proximity to campus), and, especially, limited expertise in mental health issues.

Barriers to Help Seeking

Focus group participants identified several obstacles that keep older adults from seeking help for emotional problems, including stigma and embarrassment, unawareness of the need for help, unwillingness to reach out for help, fear, language difficulties, and insufficient availability, accessibility, and affordability of resources.

Whether Facility Promotional Materials Should Address Emotional and Mental Health Issues

Most participants said they would have felt positive or neutral if their facilities' promotional materials had highlighted the importance of promoting emotional wellness and addressing mental health problems. Some observed that such a focus would appeal to prospective residents' children. Others noted that typically people are healthy when they look for a senior residence and this concern is not on their radar screen.

6. Suicide in Older Adults

Carol Podgorski, Ph.D., MPH, LMFT, presented an overview of the current state of knowledge on suicide in older adults. A medical sociologist and licensed family counselor, Podgorski serves as assistant professor of psychiatry and medicine at the University of Rochester School of Medicine and Dentistry, and associate director of the Senior Health and Research Alliance (SHARE), a partnership between the University of Rochester and Eldersource Care Management Services, Inc.

Podgorski quoted the short suicide note left by Kodak founder George Eastman, who took his own life at age 77 in 1932: “My friends, my work is done. Why wait?” She explained that Eastman had long suffered from spinal stenosis and had watched his mother become crippled with the same condition. He was losing his functionality, was in pain, and was depressed and lonely. “You might see [such] a suicide note,” Podgorski noted, “but so many other [unsaid] things are going on.”

Healthy People 2010, the Nation’s target for the health of its population, set a goal to reduce the suicide rate to 4.8 suicides per 100,000 persons (CDC, n.d.). Females have been reaching that target, but the risk for males remains extremely high. In looking at suicide by age, race, and gender, the rate for white males ages 60–85, for example, is “astronomical”—approximately 40 per 100,000—while for black males, the rate is approximately 15 per 100,000 (National Center for Health Statistics, n.d.). Suicide rates vary by state across all ages, from 6.0 to 22 per 100,000, with uneven distribution by region (American Foundation for Suicide Prevention, n.d.).

Podgorski enumerated major risk factors for suicide among elders:

- Depression, both major depression and other categories
- Prior suicide attempt
- Co-occurring general medical condition
- Often experience pain and decline of role function
- Social dependency or isolation
- Family discord
- Losses
- Personal inflexibility, rigid coping
- Substance use
- Access to firearms

Suicide rates are higher with the co-existence of medical illness. For example, people with seizure disorders are more than twice as likely, and people with severe pain are more than four times as likely, to attempt suicide (Jurlink, Herrmann, Szalai, Kopp, & Redelmeier, 2004).

Podgorski presented findings regarding methods people use to take their own lives in the United States. The use of firearms, the most lethal means of suicide, is 57 percent for all ages but 73

percent among older adults, while suicides by hanging and by poison are lower among elders. Among females, however, rates of suicide by firearms differ little from age 10 to 65-plus, but the use of poison increases with age, including rat poison, medication overdoses, alcohol, and toxins of any kind. High rates of firearm use by males over age 65 increases the lethality of attempts in this age group: In the general population, one death occurs for every 66 suicide attempts, but among elders, one death occurs for every four attempts (CDC, 2008) In a study examining lifetime prevalence of suicidal behavior, 2.9 percent of the population over age 65 had serious suicidal ideation (Moscicki et al., 1988).

Podgorski suggested that the work of the summit may promote additional research regarding suicide and older age. Patterns of suicide methods among elders who live in various settings—senior living communities or nursing homes, for example—may vary due to different environments and access to lethal means.

Late-life suicide attempts are more lethal because older people are more frail, more isolated (and thus less likely to be rescued), and more deliberate and determined to end their lives. Therefore, interventions must be aggressive and prevention strategies must be implemented for older adults.

People typically consider risk factors to be modifiable and protective factors to be in place consistently, but Podgorski cautioned that protective factors might *not* always be available to people. Protective factors against suicide include:

- Restricted access to highly lethal methods
- Family and community support. Elders’ family members may move away or die or just not “be there,” and organized activities may not always be available.
- Effective and appropriate clinical care
- Easy access to a variety of clinical interventions and support for help-seeking behaviors
- Support from ongoing medical and mental health care relationships

(American Psychological Association, 2007)

Podgorski identified points of access where members of the community might intervene with older adults (see Table 2).

Table 2. Intervention Points of Access for Older Adults

Domain	Point of Access
Community	<ul style="list-style-type: none">▪ Banks▪ Utility companies▪ Pharmacists▪ Mail carriers▪ Senior living communities
Health care	<ul style="list-style-type: none">▪ Primary▪ Specialty▪ Long term▪ Home
Social services	<ul style="list-style-type: none">▪ Senior centers▪ Nutrition▪ Transportation▪ Peer support▪ Outreach
Mental health services	<ul style="list-style-type: none">▪ Wherever services are offered
Religion	<ul style="list-style-type: none">▪ Churches▪ Temples▪ Other houses of worship

Podgorski’s overview set the stage for a series of three presentations based on the summit’s conceptual framework (discussed in Chapter 2). Speakers described state-of-the-science evidence on which senior living communities might base future efforts to prevent suicide.

7.

Whole-Population Approaches in Suicide Prevention

Dr. Carol Podgorski transitioned from her overview of suicide prevention among older adults to a description of how whole-population approaches can reduce risk factors and increase protective factors for suicide, as well as to create health-promoting environments. The term *whole population* refers to approaches that address an entire population, regardless of risk level or individual behaviors. Whole-population approaches include efforts to reduce risk factors for suicide and to promote protective factors among individual senior living community residents, as well as initiatives designed to create a health-promoting environment for the campus as a whole. While residents have an important role in attending to their own emotional wellness, institutions also can play a key role by creating conditions that facilitate emotional health and wellness among their residents.

Podgorski explained multiple interrelated domains of suicide risk that may occur in later life, including social (for example, loss and life change), psychological (personality and coping), psychiatric (depression and other disorders), biological (aging and environmental factors), and medical (illness and treatment) (adapted from Blumenthal & Kupfer, 1986). Another model of suicide in elders, the Stair Step Model, illustrates that risk factors develop over time. Personality factors, social ecology, cultural values, and perceptions represent a baseline of risk. By adding role changes, medical illnesses, and/or stressors to that baseline, the risk of suicide increases. When symptoms increase and resiliency declines, and when depression and hopelessness increase, and/or if a person is in a “peri-suicidal” (pre-suicidal) state, the risk of suicide increases or moves from a less likely to a more imminent possibility. When a mental illness is involved, risk is heightened further (Caine & Conwell, 2001).

In a report on the MacArthur Foundation’s longitudinal study of successful aging, Rowe and Kahn (1998) present a Venn diagram with three interlocking circles labeled “avoiding disease,” “maintaining high cognitive and physical function,” and “engagement with life.” Over the course of their 7-year project, the investigators followed approximately 2,000 reasonably healthy people, ages 70–79, to predict successful aging—which they found to occur among individuals who experience all the conditions at the intersection of the three circles.

Table 3 presents the whole-population category of the framework for suicide prevention that structured the balance of Podgorski’s presentation.

Table 3. Whole-Population Approaches in Suicide Prevention

Whole-Population Approaches: Overview	
<ul style="list-style-type: none">▪ Focus on reducing risk factors and increasing protective factors across the whole population, regardless of risk status or behavior.▪ Include building a health-promoting environment for individual residents and also for the campus as a whole.▪ Acknowledging that residents also have a role in promoting their own emotional wellness, focus on what <i>institutions</i> can do.	
Goal 1. Promote effective coping and functioning.	Provide and promote opportunities for residents to cope positively with the circumstances and challenges of aging.
Goal 2. Promote social networks and social support.	Promote relationship building and foster a feeling of connectedness and belonging.
Goal 3. Promote engagement in positive activities.	Promote participation in on- and off-campus activities to increase positive feelings, engagement, and meaning.
Goal 4. Decrease access to lethal means.	Limit access to potential sites, weapons, and other agents that may facilitate dying by suicide.

Goal 1. Promote effective coping and functioning.

Podgorski identified a number of factors that contribute to or hinder effective coping and functioning. Effective coping includes the following skills and behaviors:

- Problem solving and goal setting that involve appraising problems and challenges, and generating alternatives to deal with them
- Social skills that enable a person to express feelings and choices effectively and to get along with other people
- Cognitive skills that enable a person to modify how he or she looks at situations and to avoid making mountains out of molehills
- Stress management, including such skills as relaxation and meditation

Studies have shown a number of factors to predict suicide in later life, including, for example, personality and level of functioning. Duberstein, Conwell, Conner, Eberly, and Caine (2004) found that two factors on personality inventories—high neuroticism and low openness to experience—are more predictive of people likely to commit suicide. People with high neuroticism typically are anxious, angry, sad, fearful, and self-conscious. Individuals with low openness to experience typically follow a routine, prefer the familiar to the novel, have a constricted range of intellectual interests, and have blunted affective and hedonistic responses.

A lower level of functioning predicts mortality in nursing home residents, according to Draper, Brodaty, Low, and Richards (2003). Functional disability along with depression predicts suicidal ideation. Self-neglect in the basic activities of daily living and higher levels of functional

disability have been correlated with suicidal behavior and suicidal ideation (Nelson & Farberow, 1980; Zautra, Maxwell, & Reich, 1989). A number of factors affect functioning:

- Physical health. Suicide risk increases with number of medical illnesses, and persons with seven illnesses are 15 times more at risk of suicide than persons who are healthy (Juurlink, Herrmann, Szalai, Kopp, & Redelmeier, 2004).
- Emotional well-being.
- Sensory function.
- Coping and problem solving.
- Social support.
- Supportive services.
- Fears. Research has shown that a number of specific fears play a significant role in limiting one's ability to cope with life's challenges and to function effectively.
 - Fear of Alzheimer's disease. People fear Alzheimer's disease more than death (Kleinfield, 2002), and one third of well-educated older adults have this fear (Dark-Freudeman, West, & Viverito, 2006). Fear prevents active living, restricts the use of resources and choices—"just in case something would happen"—and leads to isolation. But, Podgorski advised, fear of Alzheimer's is modifiable. It is valuable to help people understand that that memory is complicated, and if one of the many types of memory should weaken, it is not in itself an indicator of impending Alzheimer's. The Alzheimer's Association's (2006) Maintain Your Brain campaign offers activities to help older people maintain their cognitive functioning.
 - Fear of falling. One in three adults over age 65 experiences a fall, and 30 percent require medical treatment. Fear of falling reduces physical activity, keeps people in their homes and increases isolation, reduces function and increases frailty, and decreases pleasure and participation in previously enjoyed activities. But fear of falling is modifiable by such means as environmental safety features (banisters, no throw rugs), medications that do not cause dizziness, assistive devices, exercises to increase balance, education on how to fall, and tai chi.
 - Fear of losing sensory function. Almost half of the population between ages 48 and 92 have hearing loss, including 30 percent of persons over age 60 and 50 percent over age 85 (Cruickshanks et al., 1995). In addition, 21 percent of people over age 65 have some vision impairment, another factor that can lead to isolation and depression.

Hearing Loss as Risk Factor: Case in Point

Podgorski described an 88-year-old married man who came to her with his wife for couples counseling on their 65th wedding anniversary following a serious suicide attempt. He told her, “I’m not sure why I’m here,” but his psychiatrist had cited communication problems with his wife. The couple seemed to be a model for a successful marriage of 65 years.

But the husband had experienced progressive hearing loss. When people are blind, Podgorski explained, people go out of their way to help them understand, but when they are deaf, they still can see the frustration on people’s faces when they try for the third and fourth time to communicate. The man had just stopped trying to communicate.

But after just two sessions, the wife told their therapist:

We’re doing better now because we make time during the day to plan our agenda and to check in face to face with each other to see what we have to do. I used to talk to myself, and I didn’t realize that he thought I was talking to him—and he was missing what I was saying. I try hard not to do that anymore.

Lighthouse International has asserted that most Americans with vision loss do not benefit from a multitude of available assistive services and resources. But hearing and vision loss are modifiable.

- Fear of loss of independence. Older adults fear losing their driver’s license, financial security, control over their mobility, and control over their finances. Anticipation of nursing home placement, especially among married older adults, has been linked to increased suicidal ideation (Loebel, Loebel, Dager, Centerwall, & Reay, 1991). A number of measures may be implemented to minimize risk of the loss of independence. Senior living communities can explore driving and transportation alternatives (for example, using senior shuttles, scheduling planned activities, facilitating people attending activities), invite a lawyer to present a workshop on durable power of attorney, and work to dispel myths about nursing homes as the only option for long-term care. Although older adults typically think that 50 percent of people over age 65 are in long-term care, the reality is closer to 4 percent. Podgorski suggested that retirement communities with multiple levels of care can integrate their levels of care better, so that people in independent living are not so fearful of entering assisted living facilities, and people in assisted living are not so fearful of nursing care.

Risk factors for suicide among nursing home residents include major losses and situational cues (Rosowsky, 1993). Major losses include loss of function to perform activities of daily living and the instrumental activities of daily living that foster independence, cognitive loss, self-esteem, and sense of purpose. Situational cues include the death of someone close, diagnosis of a major

illness, and an unwanted move or change (such as gaining a roommate or moving from a single to a double room).

Researchers have developed extensive evidence on the effects of loss and bereavement on suicide risk:

- Bereavement greatly increases the risk of depressive episodes (Bruce, Kim, Leaf, & Jacobs, 1990).
- Complicated grief and depression in bereaved older adults increases suicidal ideation (Szanto, Prigerson, Houck, Ehrenpreis, & Reynolds, 1997).
- The oldest old men experience the highest increase in suicide risk (15 fold) immediately after the loss of a partner (Erlangsen, Jeune, Bille-Brahe, & Vaupel, 2004).
- Older adults who have experienced stressful losses are significantly more likely to drink excessively than those who have not (Jennison, 1992) and to use indirect self-destructive behaviors in long-term care (Nelson & Farberow, 1980).
- The suicide rate in older adults is highest for divorced and widowed people (CDC, 1996).

Evidence on problem-solving skills related to suicide risk includes the following findings:

- Difficulties with interpersonal problem solving have been associated with hopelessness and suicidal behavior (Arie, Apter, Orbach, Yefet, & Zalzman, 2008; Roskar, Zorko, Bucik, & Marusic, 2007; Jeglic, Sharp, Chapman, Brown, & Beck, 2005).
- Suicide attempters were poorer, more passive problem solvers even when their mood improved (Pollock & Williams, 2004).
- Promising interventions include problem-solving therapy (Arean, Hegal, Vannoy, Fan, & Unützer, 2008). Problem-solving therapy, which is *not* a form of psychotherapy, examines an individual's problems and helps develop concrete approaches for how to solve them. Another promising intervention is care management, whereby care managers work with community-based elders in providing assistance in problem solving.

A growing national and international evidence base demonstrates that connections to support services can reduce depression and suicidal ideation, primarily for females. In addition:

- The Link-Plus study found improved social contact, fewer unmet needs, less depression, and less suicide risk (Morrow-Howell, Becker-Kemppainen, & Lee, 1998). The study added social workers to suicide hotlines who were able to address a variety of unmet needs in addition to suicidal ideation.

- Community agencies with specialized programs reduced hopelessness, but the programs did not necessarily impact on measures of depression or life satisfaction (Fiske & Arbore, 2000–2001). Hopelessness, Podgorski noted, is a serious risk factor for imminent suicide.
- Care management.

A highly successful 10-year study of more than 18,000 service users in Padua, Italy, found that a “telehelp/telecheck” intervention for the elderly, which included twice-weekly support with a needs assessment via telephone calls, could reduce the standardized mortality ratio for older adults. Although the expected observed suicide rate was 20.9 per 100,000 persons, the observed number was actually 6 per 100,000 (De Leo, Dello Buono, & Dwyer, 2002). A study of the prevalence of suicidal ideation in care management clients at SHARE Alliance—people in their own homes who call on the provider for a variety of services—found that almost a third of the participants felt that life was not worth living at a time in the last year; a quarter felt that they wished they were dead; 11 percent thought of taking their own life; and 7.5 percent had ever made an attempt on their life (Richardson, Conwell, et al., submitted for review). Another SHARE Alliance study investigated the effects of training elder care managers in Question, Persuade, Refer (known as QPR), a simple manualized program for staff and groups of residents in senior living communities. All 13 elder care managers who participated in the study improved their self-efficacy, increased their average thoughts and feelings about asking about suicidal ideation, and increased preparedness and average knowledge (Von Bergen, Podgorski, King, Pisani, & Conwell, manuscript in process).

Goal 2: Promote social networks and social support.

Social networks and social support reduce the risk of suicide and increase protective factors. In fact, they have been shown to improve health outcomes related to such illnesses as breast cancer, heart disease, and depression. In addition, social relationships are beneficial to memory. MacArthur Foundation studies reveal that isolation is a powerful risk factor for poor health and that no one “right” kind of social support exists (Rowe & Kahn, 1998). Examples of the profound effect of social connections on health include:

- Resistance to colds. A statistically significant study by Cohen, Doyle, Skoner, Rabin, & Gwaltney (1997) found that among healthy adults exposed to a cold virus, 62 percent of persons with three or fewer (of a dozen possible) relationships developed colds. Of persons with four or five relationships, 43 percent developed colds. Among persons with six or more relationships, only 35 percent developed colds.
- Prolonged life in illness. A study of women with breast cancer showed that the more relationships they had, the more protection they enjoyed. Women with nine or more social contacts had 60 percent less chance of recurrence of the cancer, compared to a group of women with six or fewer relationships.
- Protection against depression.

- Protection against heart disease.
- Delay of onset of AIDS in people who are HIV-positive.

Considerable data indicate potential mechanisms for the association of social relationships with health. Social relationships increase motivation to take better care of oneself because of enhanced feelings of self-worth, sense of responsibility, control, and meaning in life. In addition, connections may alter mood and cause changes in levels of hormones that regulate the immune system. According to Rowe and Kahn (1998), social support may be defined as information leading one to believe that he or she is cared for, loved, esteemed, and a member of a network of mutual obligations. In the socio-emotional dimension, expressions of affection, respect, and esteem assure a person that he or she is valued. Social support also manifests as acts of direct assistance, such as giving physical help and helping with chores, transportation, financial assistance, and meals. Evidence shows that the supportive resources of a spouse, family, friends, and religious institutions appear to have a stress-buffering effect that reduces excessive drinking in response to a life crisis. But older persons are vulnerable to the magnitude of losses they experience as they grow older. As they lose more of their family, friends, and peers, the buffering effect diminishes (Jennison, 1992).

Podgorski explained that social connections bolster memory by keeping many regions of the brain stimulated and by keeping people active. Swedish longitudinal studies (1987–96) examined types of activities (productive, mental, social, physical, and passive recreational) engaged in by 1,375 subjects in Stockholm. Investigators found that persons with a rich social network cut their risk of dementia by half. Those who lived alone, watched television, and avoided contact with others had twice the dementia risk (Crowe, Andel, Pedersen, Johansson, & Gatz, 2003). The investigators found a link between more leisure activities and less chance of developing dementia in a 7-year study that followed 1,700 volunteers over age 65 who participated in 12 leisure activities. The activities included knitting, walking, movies, classes, sporting events, reading magazines and newspapers, visiting friends, playing cards, and attending church or synagogue. Persons who engaged in multiple leisure activities on a regular basis had a 38 percent less risk of dementia, and each additional leisure activity equated to 8 percent less risk. Persons who preferred intellectual activities had better outcomes than those who engaged in mainly social or physical options.

In a caveat related to social support, Podgorski stated that “silent collusion” may take place in communities. Silent collusion refers to assistance from others for the achievement of death. People may stop observing neighbors who worry them, or they may start to understand why one might want to take one’s own life, or they may understand and not intervene. The cultural system—goals, attitudes, values, and beliefs—affect risk in senior living communities (Rosowsky, 1993).

A sense of community offers comfort and protection, and it serves as the litmus test for one’s own pain, alienation, and invalidism. A group activity program (social, voluntary, recreational, exercise) was shown to be effective in reducing suicide risk in women (Oyama et al., 2005). Some interventions benefit women, and few benefit men more than women.

Another factor that impacts on one's risk of suicide is contact with family members. While older adult/adult child relationships are generally good and families are generally there when needed, family discord predicts suicidal ideation (Duberstein, Conwell, Conner, Eberly, & Caine, 2004). Feelings of family rejection also predict suicidal ideation (Osgood, 1992), and contact with family members decreases after nursing home admission (Gaugler, 2006). Nevertheless, people in long-term care sometimes develop bonds with staff members and form surrogate families. Many strategies are available to help nursing home residents when families stop visiting, some of which make it more enjoyable for families to visit in long-term care facilities.

Goal 3. Promote engagement in positive activities.

Rowe and Kahn (1998) ascribed value to maintaining relationships with others, including achieving a balance between providing and receiving support, in long-term care facilities where people often have no outlets for giving. Engaging in productive activities also is good for people.

Spirituality is another well-documented protective factor. Nelson and Farberow (1980) found that intentional self-destructive behaviors increase in the absence of religious commitment among nursing home residents who are chronically ill. Osgood (1992) found, however, that self-destructive behaviors occurred more often in church-affiliated nursing homes than in public/private facilities. (Summit speaker Joel E. Streim, M.D., commented that in his research experience, residents of a Catholic nursing home who are depressed are careful to say, "I'd never take my life. It's a sin." But sometimes they will not eat, and they refuse medications. Often they become frail and often on the verge of death because of failure to thrive. He found this situation to be "very common" and visible in places where it is not acceptable to express more directly "I wish I were dead.")

Sense of purpose also impacts on risk of suicide. Butler (1963) discussed the concept of life review. Consistent with Erickson's stages of human development, as individuals realize that limited time remains to them, they examine the kind of life they have lived and whether they feel it was a success or failure. The life-review process often manifests as reminiscence and can lead to personality reorganization in old age. A life-review intervention in a nursing home population resulted in less depression, more life satisfaction, and more self-esteem compared to a group that received a friendly-visit control (Haight, Michel, & Hendrix, 2000). Life-review activities include scrapbooking, journaling, and writing life stories. One study revealed that when people in long-term care communities had a story to tell about their accomplishments, large or small, their self-esteem served as a protective factor in that they experienced less depression and increased life satisfaction (Chiang, Lu, Chu, Chang, & Chou, 2008). Podgorski noted the challenge to find opportunities for congregate housing residents to share personal stories.

Developing protective factors may be achieved with a program aimed at the realization of personal goals using a cognitive-behavioral approach. Lapierre, Dubé, Bouffard, and Alain (2007) studied a group of older adults who set, planned, pursued, and realized concrete, meaningful personal projects. Compared to a control group, program participants improved significantly on the dimensions of hope, goal realization, serenity, flexibility, and attitude toward retirement. Levels of depression and psychological distress significantly decreased, and participants maintained their gains 6 months later. Eighty percent of the experimental group

reported the absence of suicidal ideation at 6-month follow up, compared to 36 percent in the control group.

Physical activity is associated with improvements in depression, reduced falls and fractures, increased function, reduced stress, improved health, and reductions in risk factors for major illnesses. The fear of physical activity is modifiable: It is important to overcome the myth of “I’m too old to exercise” and to understand the value of starting with even just 5 minutes of exercise.

Podgorski explained that fitness guru Jack LaLanne asserted at age 89 that the things most hazardous to wellness are habit and routine—people should change some aspect of what they do every 2 weeks, even if it is driving a different way to an accustomed destination or changing hands to brush one’s teeth.

Goal 4. Decrease access to lethal means.

Little is known about suicide in long-term care, but very old individuals are more likely to use indirect, intentional life-threatening behaviors such as refusing to eat or drink (43 percent), taking medications (40 percent), wrist slashing (49 percent), shooting (18 percent), and asphyxiation (13 percent) (Rosowsky, 1993). Nearly 27 percent of old-old persons are apt to refuse food (Draper, Brodaty, & Low, 2002).

In a recent study of means of suicide in New York City residents over age 60, the highest prevalence was in falling (30 percent) and use of firearms (16 percent) (Mezuk, Prescott, Tardiff, Vlahov, & Galea, 2008). Podgorski noted that handguns are used more often than long guns, and when the guns are locked and loaded, the percentage of completed suicides rises. She also pointed out that suicides and attempts often take place in garages at senior living communities, perhaps because they are relatively isolated places. Garages and similar locations warrant consideration for resident safety.

Closing Remarks

Podgorski suggested that senior living communities survey residents’ fears in addition to their strengths. It is important to know what people are afraid of, because those fears affect their active engagement, disease avoidance, and cognitive function.

She pointed out that older adults often enjoy having information about themselves that can be provided as part of a series of wellness courses, for example, that test physical strength, flexibility, and other personal characteristics. Data on their baseline functioning may empower people to assume responsibility for their health and well-being.

Podgorski urged that communities:

- Conduct environmental assessments that incorporate rooftops, size of window openings, and safety of garages in terms of solitude and remoteness.

- Examine policies on alcohol, medications management, and firearms.
- Consider implementing gatekeeper approaches such as QPR.
- Consider integrating transitions between levels of care and taking steps to avoid negative stereotypes inherent in escalating care.

Discussion

Summit participants discussed a range of issues:

- Suicides are vastly undercounted, and capturing data on deaths that are possible suicides is difficult. If “suicide” is not noted on a death certificate, a death is hard to categorize as suicide. Suspicious deaths include, for example, deaths due to long falls. Neither vital statistics nor the suicide literature deals with the “Willy Loman solution”—suicide by car—which has the benefit of sufficient ambiguity that life insurance companies pay on claims. The National Institute of Mental Health’s (NIMH) Jane Pearson, Ph.D., noted that as coroners become more comfortable with determining suicide by car, rates of accidental deaths will decline and suicide rates will rise. States take different approaches to data collection, and most lack good data for deaths that result from driving under the influence.
- Neurological conditions, such as seizures and loss of brain function, increase risk of suicide.
- People’s perceptions are important:
 - The misperception that a person will die from a specific medical condition can serve as a catalyst to consider suicide.
 - People believe that mortality rates are lower at senior living communities. Nevertheless, emergency room mortality data, which do not distinguish between senior living communities and nursing homes, show that suicide occurs at much higher rates in individual dwellings than in senior living communities.
- It is especially difficult to intervene with at-risk men, who typically do not seek help. It is important, therefore, for physicians to initiate discussions with their male patients about what a risk factor may or may not mean and to understand a patient’s fears.

Some in society believe that suicide in older adults is not as devastating as in younger people—and in fact some believe it might be appropriate for some people. Podgorski asserted the need to change cultural values to counter that belief.

8.

At-Risk Approaches in Suicide Prevention

Joel E. Streim, M.D., highlighted the knowledge base related to approaches to assist senior living community residents who are suicidal, have symptomatic mental health problems, or are at higher risk for suicide. In his presentation, Streim, who serves as professor of psychiatry, Geriatric Psychiatry Section, University of Pennsylvania, and is affiliated with the Philadelphia VA Medical Center, described the concepts and evidence germane to each of the summit goals related to at-risk approaches (see Table 4).

Table 4. At-Risk Approaches in Suicide Prevention

At-Risk Approaches: Overview
<ul style="list-style-type: none">▪ Focus on assisting residents who are suicidal, have symptomatic mental health problems, or are at higher risk for suicide.▪ Include instituting facility-specific systems and practices, and also working collaboratively with off-campus providers, services, and systems.
<p>Goal 5. Increase help-seeking behaviors. Provide residents with knowledge and motivation to encourage them to seek help with emotional issues, and to lower the barriers that impede help seeking.</p> <p>Goal 6. Identify and refer distressed or at-risk residents. Identify and appropriately refer residents who are experiencing emotional distress or who are at risk for suicide.</p> <p>Goal 7. Increase access to mental health and substance abuse services. Help residents in need of services to obtain them.</p> <p>Goal 8. Promote effective treatment and management of mental health and substance abuse disorders. Promote the accurate diagnosis and appropriate treatment of residents with emotional problems, including assessing and managing suicide risk.</p> <p>Goal 9. Effectively address medical conditions and pain. Reduce physical and emotional consequences and impairment from medical conditions and pain.</p>

Goal 5. Increase help-seeking behaviors.

Streim stated that addressing the goal to increase help-seeking behaviors requires answering a number of specific questions.

Who Needs Help?

The presence or absence of specific risk factors helps to determine one's vulnerability to certain conditions. Multiple modifiable individual risk factors indicate vulnerability for suicide:

- Clinical depression (including unipolar depression, bipolar depression, and anxiety disorders)

- Alcohol and substance abuse
- Social isolation
- Chronic pain
- Physical disability
- Access to lethal means, especially gun possession

What are the Barriers to Help-Seeking?

Several myths and misconceptions pose barriers to help-seeking.

Myths and Misconceptions

- Depression is inevitable with aging.
- Depression is really laziness or weakness or a character fault.
- Treatment for depression does not work because it does not change or eliminate the depressing circumstances.

People commonly believe that depression is inevitable with aging. After all, later life brings inevitable losses and possibly suffering. Older adults retire and/or relocate, sometimes to a nursing home. They lose the companionship of friends who are becoming disabled and dying. They may suffer from bereavement, loss of health, chronic pain, and/or physical disability. Each of these losses might lead to grieving and depression.

“It may seem logical” that depression is inevitable under these circumstances, Streim acknowledged, “but it ain’t so. Most older adults are resilient.” Studies show that only 1 to 2 percent of persons over age 60 have a major depressive disorder. Not only is depression *not inevitable* with aging; chronic illness, disability, or even nursing home placement also are *not inevitable*.

But clinically significant depression symptoms—more broadly defined than major depressive disorder to include minor depression and other conditions—represent a major problem in that clinical depression causes distress and disability and leads to suicide and higher mortality rates. Studies show that 15–20 percent of elders who reside in the community and 25–35 percent of residents in long-term care facilities have depression (Koenig & Blazer, 1992; Fabacher, Raccio-Robak, McErlean, Milano, & Verdile, 2002; Koenig, George, Peterson, & Pieper, 1997; Parmelee, Katz, & Lawton, 1989).

Other misconceptions are themselves stigmatizing, Streim pointed out. Some people equate depression with laziness or weakness, and some consider depression to be a character flaw. But decades of rigorous research (much of it sponsored by NIMH) debunks these myths by demonstrating that depression is an illness associated with disturbances of neurochemistry that cause physical symptoms. Similarities between depression and diabetes are shown in Table 5.

Table 5. Depression and Diabetes: Both Are Illnesses

Common Characteristics	Diabetes	Depression
Involve chemical abnormalities in the protein insulin, which regulates blood sugar	. . . in the proteins serotonin and norepinephrine, which regulate the central nervous system
Affect regulation of appetite and energy	✓	✓
Have psychological impact	✓	✓
Is a chronic condition	✓	✓
Cause disability	✓	✓
Affect family members	✓	✓

The mistaken belief that treatment will not help alleviate depression—because it cannot change or eliminate the depressing circumstances—constitutes another myth that interferes with seeking help. But abundant evidence shows that depression is treatable “even among elders with chronic medical conditions that cause pain or physical disability, including those in nursing homes without real prospects of ever being discharged home,” Streim explained. Research on frail nursing home residents with depression, for example, shows a positive response to treatment for depression.

What Conditions Place Persons at Risk for Suicide?

The confusing distinction between normal sadness and clinical depression represents a reason why clinical depression is so misunderstood. *Everyone* experiences mood changes, and grief and bereavement are *normal* reactions. But clinical depression is a *treatable illness*. “Normal sadness may result from a transient loss for a couple of hours or a difficult bill to pay that causes you to become demoralized only until you figure out what to do about it, and later this afternoon you feel better,” Streim explained.

By contrast, people with clinical depression have persistent (for at least 2 weeks), pervasive symptoms, including low mood, sad mood, intense feelings of loneliness, and loss of interest or pleasure in normal activities. “Most of the time the person is under a cloud.” Clinical depression is associated with changes in appetite, energy, sleep, feelings of excessive guilt out of proportion to the real situation, excessive feelings of worthlessness, impaired concentration, and impaired memory. Clinical depression also is associated with thoughts about morbid situations and death, including suicidal ideation. “This is not normal sadness or changes in mood, or even just normal bereavement,” but rather, Streim stated, “with these symptoms, you know you have clinical depression.”

In suicide prevention, mood symptoms and clinical depression are important targets for treatment. Streim presented several examples:

- Unresolved grief or bereavement may become complicated and lead to depression-the-illness.
- Minor depression (diagnosed by the same symptoms as clinical depression, but not as numerous, severe, or pervasive) increases the risk of developing major depression. Long-term care facilities have a 7.4 percent annual incidence of minor depression, which in itself is a risk factor for suicide (but a less immediate risk than major depression).
- Nearly 10 percent of residents in long-term care settings experience *new* onset of clinical depression.
- Hopelessness correlates highly with suicide, but hopelessness is prevalent even in conditions other than major depression. For example, untreated panic disorder and its constant terror about having another panic attack can make a person feel trapped in the condition, and the perception of no possible escape often leads to hopelessness. Hopelessness, then, represents a major risk factor along the spectrum of depression and anxiety.

Prevention Target

An appropriate target for prevention/intervention, according to strict diagnoses, might be someone who experiences grief with associated loss of appetite, failing nutrition, and suicidal ideation for more than 2 weeks. After 2 weeks, unresolved issues, especially guilt and suicidal thoughts, even during a period of bereavement, should raise a red flag regarding a person's need for extra professional attention. Many people experience these symptoms in the first few weeks after a loss, but most work through that aspect of grief with family or the community and do not need a therapist.

“Depression of all types is important to address, because depression kills—and not just major depression,” Streim asserted. Minor depression, especially in men, is associated with higher all-cause mortality rates (Penninx et al., 1999).

Why Should People at Risk Increase their Help-Seeking Behaviors?

Evidence shows that depression of all types results in a variety of adverse outcomes. Depression causes distress, including increased complaints about pain or decreased pain tolerance, loss of appetite that can lead to compromised nutrition, insomnia, and anxiety and agitated behaviors.

Medical complications also arise from depression. In the course of diabetes, for example, or diabetes, emphysema, pulmonary disease, or heart failure, medical outcomes are worse with co-occurring depression. Depression also interferes with individuals' participation in their own nursing and rehabilitation care. People with depression do not reliably do their exercises or take

medications or engage in other health promotion activities. Depression may negatively impact physical functionality and lead to disability beyond what might be medically expected.

Following a heart attack or stroke, people with depression have substantially increased mortality rates for all causes (Frasure-Smith, Lesperance, & Talajic, 1993, 1995; House, Hackett, Anderson, & Horrocks, 2004). Studies show that among people with depression who live in long-term care facilities, mortality rates increase by 60 percent to 300 percent (Katz, Leshner, Kleban, Jethanandani, & Parmelee, 1989; Rovner et al., 1991; Ashby et al., 1991). As Streim noted, “This is evidence that depression kills in nursing homes more than in other settings.” Suicide mortality related to “giving up” in older adults—those who refuse food, fluids, or medications—may be captured in some all-cause mortality rates. Nevertheless, “many patients who give up at home are not recognized as suicides. The death certificate does not record these as suicide, so researchers cannot capture them,” Streim noted.

What Can Be Done to Increase Help-Seeking Behaviors?

The evidence to support objectives aimed at increasing help-seeking behaviors resides principally in marketing, communications, and educational research. These objectives include increasing residents’ knowledge of treatable risk factors, potential treatments, and available services; decreasing local barriers to help-seeking; and implementing efforts to reduce stigma and normalize help-seeking. A robust literature suggests the following effective strategies to increase help-seeking behaviors:

- Raising awareness. Guided observation enables people to look at their neighbors and relatives and realize that people experiencing mental difficulties “are just like you and me. Sometimes it’s our own neighbors and families. Sometimes it’s me.” A way to raise awareness surreptitiously is to show films and other media that portray real people who make mental illnesses “look like something we can recognize because we have seen it in people we know.”
- Increase knowledge and debunk myths. Educational activities such as health fairs, seminars, and mental health workshops provide opportunities for people to learn about the signs, symptoms, consequences, and treatment of depression and other mental disorders.
- Reduce negative stereotypes associated with mental disorders and seeking help for them. Public service announcements (PSAs) and ad campaigns have been used effectively to reach many people in a community, beyond solely a particular at-risk population. Testimonials by respected leaders and role models also can mitigate the negative connotations of seeking help: After all, treatment worked for them.

Goal 6. Identify and refer distressed or at-risk residents.

In addressing this goal, Streim posed the following questions:

- What methods are available to identify distressed or at-risk residents?
- What are the preconditions for screening programs?
- Who should be responsible for case identification and referral?

Screening tools, as well as a variety of unstructured strategies, serve effectively to identify at-risk elders. A variety of well-validated, structured screening instruments have been adapted for use in various office settings, shopping malls, and health fairs. Some are easy and quick, including the self-reporting Geriatric Depression Scale, which elicits reliable results even with mild to moderate cognitive disability. Others include the PHQ-9, CES-D (used in many primary care settings), and the Paykel Suicide Scale (a hierarchy of questions for suicidal ideation that helps with risk assessment).

Streim cautioned that screening is ethical, however, only if:

- It can be done without causing harm.

It's OK to Ask

People are afraid to ask others if they are depressed or if they have considered suicide, because they think the question will make the other person depressed or suicidal. This is not what happens. Most people in distress are relieved when you ask them, because they see that someone “gets it.” But it is important for the interviewer—especially nonprofessionals—to be prepared to respond to the information in a way that is helpful and not become overwhelmed.

- A positive screen is followed up with appropriate, definitive diagnostic evaluation.
- Effective treatment exists for the condition to be identified.
- Treatment is available and readily accessible to the individual being screened.

Otherwise, Streim asks, “What’s the point in screening?”

A variety of professionals in health care disciplines may administer screening questionnaires, including primary care providers, visiting nurses, physical and occupational therapists, social workers, dietitians, pharmacists, and mental health care providers. In addition, many nonprofessionals are capable of administering screening tools with proper training.

Proper Preparation and Training Are Essential

“At one clinic, the audiologist was always the first one to see a person. If the subjects cannot hear, they are totally isolated. They may nod their head, and you may think you’re communicating, but they may not know what you’re saying, and they’re just nodding their head to yes-and-no questions. We want to make sure that the administration of these screening tools is done carefully and by people who are trained well.”

Identification of at-risk residents also may be accomplished by unstructured methods. Family and friends can simply observe older adults, as long as they have been educated on what depression looks like. “How do you know when someone’s in trouble? A person who has always been fastidious and tucked in his shirt and shaved, but now is looking slovenly, hasn’t showered in three days—that should raise some concerns,” Streim explained. Health professionals also can ask direct questions about depression, anxiety, and suicidal thoughts or behaviors. Studies show that simple yes-or-no questions can serve as an effective screening tool in primary care settings. “Sometimes just ask. It’s as simple as that. You don’t need fancy scores.”

Community gatekeeper programs have been used for approximately a decade to identify at-risk individuals. The prototype gatekeeper program trained people in the community who had frequent contact with older adults. The gatekeepers may not have known the elders intimately, but they would see them on a regular basis and knew how the elders looked, how they dressed, their demeanor, and whether they typically were verbal or quiet. Gatekeepers included bank tellers, cashiers, grocers, pharmacists, meter readers, letter carriers, and other delivery personnel. If the gatekeepers sensed that elders were having difficulties, they referred them to aging and/or mental health service providers, which then followed up with a visit from a case manager. The successful study has been replicated and shown to be effective with the right design and the right training.

Training to identify and refer at-risk individuals involves learning to:

- Recognize depression’s signs and symptoms. “It’s not checking off all those symptoms of major depression to make a diagnosis. It’s learning to notice that something’s different that might be an early indicator of trouble.”
- Administer formal screening tools.
- Respond to immediate distress.
- Make referrals and support the referral process.

Goal 7: Increase access to mental health and substance abuse services.

In order to increase access to mental health and substance abuse services, it is important to know the answers to the following questions:

- What services need to be accessible?
- What is known about increasing access to mental health and substance abuse services?
- How can we increase engagement of senior living community residents in services and programs?
- What is the evidence for programs that are acceptable to elderly health care consumers?

Appropriate Services

Will older adults continue to participate in a program? Do they like it? It is a problem when an 85-year-old woman shows up in the waiting room of a community mental health center and sits next to a 22-year-old person with schizophrenia who is hallucinating, or a heroin abuser who has not bathed in days. That elderly woman will not feel comfortable in that waiting room, so it is important to figure something else out.

As people reach age 55 and older, major depression becomes a major risk factor associated with suicide. In addition, for people in that age group, substance abuse disorders still represent potent risk factors. Consequently, older adults need to be able to access mental health and substance abuse services, a complicated feat in many jurisdictions that administer the services in different systems by people trained in different skills.

Streim asserted that elders tend to resist accepting referrals for specialty mental health care provided by psychiatrists, community mental health clinics, or treatment by addictions counselors. By contrast, research consistently shows higher rates of engagement when mental health treatment and substance abuse services are integrated into the primary care setting. Several large-scale national studies (including PRISMe, PROSPECT, and IMPACT) employed models that provided mental health assessment and support for treatment within the primary care practice setting in which the elderly patient already received care. (See more on this subject under Goal 8.)

Goal 8. Promote effective treatment and management of mental health and substance abuse disorders.

Consideration of how to promote effective treatment and management of mental health and substance abuse disorders prompts the following questions:

- What methods have been shown to promote adherence to clinical practice guidelines?
- What models are established for monitoring at-risk residents?
- What is the evidence that treatment of depression reduces suicide risk?

As demonstrated in the PROSPECT and IMPACT studies, depression care managers take on a number of tasks. They:

- Assess individuals, including for suicide risk
- Provide information to individuals on treatment options
- Support and empower individuals to participate in their own treatment
- Monitor treatment adherence (are they taking medications and appearing at appointments?), response (are they feeling better?), and tolerability (is the medication making them sick to their stomach and they are flushing their medication down the toilet?)

- Monitor symptoms on a continuing basis, including suicidal ideation
- Solve problems with individuals
- Provide feedback to providers who can adjust treatments to accommodate individual differences

Care managers can sort through details and provide feedback to providers. For example, they can inform a prescribing physician that a patient is not doing well, suggest changes, and generally work in alliance with primary care providers. The IMPACT study was shown to lower rates of suicidal ideation and death thoughts significantly in an intervention group, compared to usual treatment at 6, 12, 18, and 24 months (Bruce et al., 2004). The PROSPECT study showed a significant decline in major depression compared to treatment as usual.

Suicidal and morbid thoughts diminish upon using effective treatment that combines psychotherapy and drug therapy. Evidence (Szanto, Mulsant, Houck, Miller, et al., 2001; Szanto, Mulsant, Houck, Dew, & Reynolds, 2003) has emerged about treatment of depression that reduces suicidal ideation:

- Short-term depression treatment (12 weeks).
- Pharmacotherapy.
- Interpersonal psychotherapy sessions.
- Outcome measures for suicidal ideation and depression.
- After 12 weeks of treatment, suicidal ideation had resolved in all treated patients, although 4.6 percent still reported death thoughts.

Goal 9. Effectively address medical conditions and pain.

Addressing this goal involves answering the following questions:

- What medical conditions and distressing symptoms are associated with depression and hopelessness?
- What options can be made available to address functional impairment and physical disability?
- How can one effectively address medical conditions, especially pain, chronic dizziness, and chronic shortness of breath?

Streim explained that high rates of depression are associated with some conditions to a greater degree than others. For example, people with highly lethal pancreatic cancer have “sky-high

incidence of major depression.” Depression also regularly accompanies cardiac disease, rheumatoid arthritis, diabetes, hypothyroidism, infectious diseases, COPD/emphysema, nutritional deficiencies, and medications that depress central nervous system function. Depression also is common in many neurodegenerative diseases and neurological disorders, including stroke, cardiovascular disease, Alzheimer’s disease, Parkinson’s disease, Huntington’s disease, and others.

Among people who care for persons with depression, rates of caregiver depression also are extremely high. Considerable research has found that treating depression in both care recipient and caregiver generates better outcomes. This finding is particularly important in that nursing home placement may be delayed with ongoing caregiver support. With prevention efforts that target depression, rates are reduced for suicide mortality, institutional placement, nonsuicide mortality, and disability and distress.

Streim noted that people with Alzheimer’s disease have high rates of depression. While specific diagnostic criteria are designed for people with cognitive impairment, if someone who is apathetic and less functional because of Alzheimer’s develops depression, it is difficult to know how much depression and how much dementia causes a loss of function, flat affect, or disengagement from activities.

Integrated care must include mental health and general medical care. Considerable evidence confirms reciprocal relationships between depression and pain and between depression and disability. Chronic pain must be optimally managed, in some cases by a specialist with high-tech, nonpharmacological approaches. In addition, hospice offers options for people with terminal conditions. Streim asserted that people in the later stages of Alzheimer’s disease should receive treatment—but that even before late stages, people become depressed and suicidal and need treatment as well.

Medical care must address medications, some of which cause central nervous system depression. These medications include certain types of beta blockers for hypertension and certain antihistamines used in ulcer disease. Antihistamines are readily available over the counter, but few individuals pay attention to medication labels; anyone can use them to induce sleep, and this practice may evolve into psychological dependence. Antihistamines taken in higher doses may interfere with memory and concentration, may make people feel like they are getting Alzheimer’s disease, and may lead to depression.

Streim asserted that access to rehabilitative care is essential for residents with disabilities. Assessments may be provided, for example, by psychiatrists (physicians who care address bones and muscles, which are important to mobility), and physical, occupational, and speech therapists who implement the treatments that psychiatrists prescribe. Accommodations for hearing and vision loss are essential to promote communication and avoid isolation, an important risk factor for depression and suicide. Treatment plans should aim to promote independence to the extent possible, identify impairments that require assistance, and match needs and resources.

Summary

In summary, Streim asserted that:

- Depression is a leading risk factor for suicide in older adults.
- Depression is a treatable illness.
- Alcohol and substance abuse are leading risk factors for suicide in older adults, and these disorders are treatable. At-risk drinking for older adults may be two drinks daily.
- At-risk individuals can be identified and referred for help.
- Help can be designed to optimize engagement and increase chances of better outcomes.

Discussion

A participant noted the need for proper dental care for elders. People who lack proper dentition cannot eat properly, which is likely to impact nutritional status and add to risk of depression. In addition, people may become embarrassed about their dental problems and isolate themselves. Another participant identified the need for long-term treatment for autoimmune disorders, which may be highly associated with depression.

9.

Response to Crises and Suicidal Behaviors

Mary Livingston Azoy, LPC, CPT, posed a series of questions that senior living communities should consider in developing policy and protocols related to crisis response and postvention. Azoy serves as Director of Community Education and Crisis Response at CrisisLink, Arlington, VA, a nonprofit social services agency that operates the leading crisis, suicide, and referral hotline for the Washington, DC, metropolitan area. Azoy stated that Goal 10 of the framework relates to responding to crises and Goal 11 suggests ways to promote resiliency in survivors of a suicide (see Table 6). In her discussion of Goal 11, she explained and stressed the importance of the often overlooked concept of postvention.

Table 6. Response to Crises and Suicidal Behaviors

Category 3: Response to Crises and Suicidal Behaviors
<ul style="list-style-type: none">▪ Focus on responding to suicidal behavior and deaths by suicide.▪ Create and implement protocols, procedures, and systems for responding appropriately to crises, including suicidal acts.▪ Provide support for communities following a suicide death.▪ Create policies, procedures, and systems proactively, in advance of a crisis.
<p>Goal 10. Develop protocols and procedures to promote the safety of distressed or suicidal residents and to respond to crises using institutionalized procedures. Develop processes that promote systematic and effective responses to crises, including suicidal behavior.</p> <p>Goal 11. Respond to suicides with a comprehensive postvention program to identify survivors, assess level of trauma and risk among survivors, support survivors, and prevent suicide contagion. Reduce physical and emotional consequences and impairment from medical conditions and pain.</p>

Goal 10. Develop protocols and procedures to promote the safety of distressed or suicidal residents and to respond to crises using institutionalized procedures.

Azoy posed questions and provided guidance related to each of the objectives associated with Goal 10.

10.1. Implement protocols and systems for responding effectively to acutely distressed or suicidal residents.

- Who creates the protocols and how? Senior living communities must determine who is responsible for the response and then enlist as many of those people as possible to develop the protocols. Protocols are needed for emergencies during daytime hours as well as emergencies that arise at night and on weekends and holidays.

- Who is in charge of implementing the protocols? The people who create the protocols need not be the same people who implement them. A chain of command should be determined.
- Who is informed of a resident's mental health crisis? Decisions should balance safety issues with confidentiality.
- How and to what extent is confidentiality maintained throughout the entire crisis situation? It is important to provide appropriate information about the situation to residents. Research on safe and effective messaging has produced guidelines to inform information sharing. If no information is provided to residents, a rumor mill inevitably fills the vacuum. Confidentiality must not be violated.

10.2 Utilize decision-making protocols and procedures regarding mental health issues and need for additional care.

- Under what circumstances is a resident in crisis to be hospitalized?
- In the case of a nonfatal suicide attempt where follow-up care is provided offsite, how is confidentiality protected? How much information is released to the community and in what manner?
- What protocols and protections should be in place for a resident's return to the community? As they develop protocols and protections, communities should decide how collaborative—or directive—to be with such a resident.

10.3. Ensure that emergency notification protocols are appropriate to mental health crises.

- Do contact-notification protocols for other medical emergencies apply to a mental health crisis?
- If not, what special provisions or caveats should be put into place? Mental health and physical health are inextricably linked. Nevertheless, communities should be sensitive to other people's understandings of differences between mental and physical health. Those understandings should shape the protocol for notification about emergency services.

10.4. Institute procedures for creating and implementing post-crisis follow-up plans.

- How, by whom, and how often will the resident's well-being be assessed upon his or her return to the community?
- How will confidentiality be protected throughout the process?

10.5. Utilize standardized procedures for appropriately documenting interactions with distressed or suicidal residents.

- What form will documentation take? Is a template available, or must the senior living community create one?
- Who collects and is in charge of the documentation?
- What confidentiality protocols are needed for the collected information? Who sees the information, how is it stored, and how is it used? Creation of these protocols is not straightforward, but they must be set in place in advance of the need for them.

10.6. Train appropriate personnel in relevant protocols and procedures.

- Who are the appropriate personnel to be trained?
- Who develops the training?
- Who presents the training?
- How often are initial trainings and refresher trainings conducted? Refresher trainings are essential to renew perishable skills, especially when they are not used often, in dealing with such sensitive subjects.

Goal 11. Respond to suicides with a comprehensive postvention program to identify survivors, assess level of trauma and risk among survivors, support survivors, and prevent suicide contagion.

Azoy discussed the often overlooked but crucial concept of “postvention,” which Edwin Shneidman, founder of the American Association of Suicidology, referred to as “prevention for future generations.” Postvention in this context pertains to individuals who have lost someone to suicide. Research suggests that survivors of suicide loss have between one-and-a-half and five times greater risk of suicide than the general population—including members of families that have experienced multigenerational suicide. Azoy also pointed out that role modeling may prompt imitative, or “copy cat,” suicides in a given community, especially in families and schools.

Active postvention efforts can help prevent such future suicides within a family or a community. Using suicidologist Frank Campbell’s model (Cerel & Campbell, 2008), Azoy differentiated between passive and active postvention. With a passive model of postvention, a community may offer survivors of suicide a support group and other services, but service providers wait for people to come to them. In most communities, survivors at the scene of a death are assumed to be suspects until the death is ruled a suicide. First responders and the coroner or medical examiner may arrive to investigate, and the traumatized survivors may be questioned and made to wait and undergo interrogation for hours—a traumatizing experience in itself. Survivors might

later stumble on existing mental health services, but the average time between a suicide and the point when survivors seek resources is four and a half years, a long time to suffer without support.

In active postvention, the model is similar to passive postvention until the coroner or medical examiner rules the death a suicide. Under an active postvention model, new responders are added to the cast of characters: a LOSS Team trained to serve as a resource for survivors immediately following a suicide. The team's primary goals are to support survivors at the scene, provide them with as much pertinent information as possible, and notify them about resources available to help them. Law enforcement officials may appreciate this team's ability to support the survivors—who often are highly emotional and highly traumatized—leaving investigators free to do their work.

Azoy offered guidance related to each objective related to Goal 11.

11.1. Develop postvention protocols and procedures prior to need.

- Select a team to devise the protocols and procedures. This team may include the same people who developed protocols and procedures related to ongoing crises, but not necessarily. Media guidelines are a useful resource in protocol development. Azoy cautioned against use of such terms as *committed suicide*, *successful suicide*, or *failed attempt*, and instead suggested *died by suicide*, *attempted suicide*, or *took his or her life*.
- Research similar protocols and procedures used by other institutions.
- Develop appropriate protocols and procedures according to a facility's unique resources and needs.

11.2. Ensure that all appropriate individuals within the community are identified as survivors.

Suicidologists have estimated that every suicide leaves six survivors. But, Azoy asserted, this is a major underestimate. Campbell has identified as many as 45 unique relationships to the deceased who have sought support in the aftermath in a community, including, for example, spouses, close friends, casual friends, eyewitnesses who may not have known the person, caregivers, administration, and other staff.

Communities should decide to whom to offer postvention services—whether to include anyone outside the community, such as the resident's family and/or first responders. First responders may include clergy, volunteers, emergency medical technicians, and law enforcement officers. The decision-making process on inclusion might warrant consideration of the health and mental health staff of a facility and anyone else exposed to the scene, such as a maid employed to clean a resident's home, bystanders, or witnesses.

11.3. Assess all survivors for level of trauma and risk.

- How will assessment tools be selected or developed, and by whom? In the aftermath of a suicide, the identification of suicide survivors, particularly those who have been in close proximity to the suicide as it took place, often is overlooked. Suicide survivors are traumatized and bereaved simultaneously, and sudden and traumatic loss leaves people psychologically unprepared for life's challenges; psychological vulnerability represents a risk factor.
- Who will perform trauma and risk assessments, and with whom will results of the assessments be shared? Confidentiality issues must be considered.
- When will the assessments be administered?
- What other assessment protocols need to be in place? Senior living communities should recognize that it is almost impossible for people to grieve fully until they have first processed their trauma.

11.4. Ensure that support is offered or provided to all survivors.

- What types of support will be offered or provided, in what sequence, and to whom?
- Who will provide that support?
- How will support be offered and publicized within the community?
- How long will support continue?
- How will the type and quality of support be evaluated to ensure the community did the right things and to learn how to improve?

Types of support may include the following:

- Crisis debriefings by internal or community loss teams. If a community loss team is to be involved, ensure that the team and the senior living community are prepared to work together.
- Memorial service. Decisions must be made about whether to hold a religious or nonreligious service; whether to involve the family and/or residents in planning; and whether the suicide is to be mentioned explicitly or not. Azoy advocated for “telling like it is” as a way of diminishing negative connotations, but sensitivity is critical to balance family confidentiality with a sense of providing an opportunity for mental health education. She suggested reviewing the Suicide Prevention Resource Center's recommendations for public memorial observances.

- Individual counseling for both trauma and grief. Who will provide the counseling and how? Is pastoral counseling available onsite or not? Should a support group for suicide survivors be established, or can residents join an ongoing community group? Should support be time limited or ongoing, and provided in open or closed groups? What sorts of educational materials, workshops, or reading resources should be offered? How can negative stereotypes be avoided? How can the facility educate people about the link between depression and suicide, and engage in associated prevention activities? The number one symptom of depression and suicidal thinking among men is anger and irritability, which often are missed among the signs and symptoms of depression.
- Because everyone grieves differently, one response does not fit all. Individuals need to be made aware of the options and then make their own choices.

Crisis Response in a Senior Living Community

Mary Azoy described her LOSS Team's response to a homicide/suicide in a senior living residence. With the help of people in the community in identifying survivors, the team conducted four crisis response groups. The team worked with initial witnesses and people who worked with police to secure the perimeter of the scene and were in visual contact with the bodies; these were mostly staff and maintenance personnel. "The people were so glad to have had the opportunity to talk through what the experience was like for them." The LOSS Team also met that day, in separate groups, with administrators and the couple's closest friends. Finally, the LOSS Team provided an opportunity for members of the entire community to come together, whether or not they knew the couple.

"In every group, people were shaken and confused, and very grateful for the opportunity to be recognized as people in need of support."

11.5. Work appropriately and effectively with the media.

Addressing media interest represents an inevitable aspect of the postvention process. Senior living communities can educate the media, and by extension, if the suicide is publicized, the general public.

- Develop protocols for handling onsite media to protect the confidentiality of victims and survivors.
- Decide to what extent family members should be involved in deciding on responses to media inquiries.
- Distribute safe reporting guidelines to onsite and offsite media to enable reporters to report responsibly without sensationalizing the event.
- Encourage media to include the toll-free National Suicide Prevention Lifeline telephone number (see below) at the end of the coverage as part of responsible reporting.

11.6. Implement postvention strategies that discourage suicide contagion.

The opportunity to talk openly about suicide, particularly among people at risk, may be welcomed as a relief. Discussing suicide does not encourage or induce thoughts about suicide. In developing a postvention program, it is important to consider the following:

- Decide on the advisability and nature of a candid discussion about depression, late-life suicide, and suicide pacts within the community. If knowledge of a suicide pact is revealed, deal responsibly with the issue rather than pretend that does not exist.
- Develop protocols to encourage anonymous reporting of suicidal individuals by other community members. If residents feel assured that their communications will remain confidential, they are more likely to report on someone about whom they have concerns. Protocols should address strategies to educate and broaden the perspectives of community members who might think that there is nothing wrong with suicide by demonstrating suicide's far-reaching impacts. Workshops to discourage suicide imitation should be part of any postvention strategy.
- Develop and implement other protocols or strategies to discourage imitative suicides within the community.

Azoy encouraged summit participants to ensure that any suicide prevention or depression materials they produce and/or disseminate should include the toll-free National Suicide Prevention Lifeline telephone number, 800-273-TALK (8255). The Lifeline is available around the clock to anyone who wants to talk about a real crisis. "It's an important part of prevention, intervention, and postvention," Azoy asserted.

10.

Perspectives on Aging and Mental Health

Erlene Rosowsky, Psy.D., a leading clinical geropsychologist, offered her perspective on aging and on coping with the inevitable changes that accompany aging. Rosowsky, a fellow of the Gerontological Society of America, is a licensed psychologist and past president of Needham Psychotherapy Associates in Massachusetts. She is an assistant clinical professor in psychology, Department of Psychiatry, Harvard Medical School, and on the Core faculty of the Massachusetts School of Professional Psychology (MSPP), where she also serves as Director of the MSPP Center for Mental Health and Aging.

Rosowsky began her remarks on aging with a prayer attributed to an anonymous 17th-century nun:

Lord, Thou knowest better than I know myself that I am growing older and will someday be old.

Keep me from the fatal habit of thinking I must say something on every subject and on every occasion.

Release me from the craving to straighten out everybody's affairs.

Make me thoughtful but not moody; helpful but not bossy. With my vast store of wisdom, it seems a pity not to use it all, but Thou knowest, Lord, that I want a few friends at the end.

Keep my mind free from a recital of endless details; give me wings to get to the point.

Seal my lips on my aches and pains. They are increasing, and love of rehearsing them is becoming sweeter as the years go by. I dare not ask for grace enough to enjoy the tales of others' pains, but help me to endure them with patience.

I dare not ask for improved memory, but for a growing humility and a sureness when my memory seems to clash with others. Teach me the glorious lesson that occasionally I may be mistaken.

Keep me reasonably sweet; I do not want to be a saint—some of them are so hard to live with—but a sour old person is one of the crowning works of the devil.

Give me the ability to see good things in unexpected places and talents in unexpected people.

And give me, O Lord, the grace to tell them so. Amen.

Rosowsky asserted that an overarching meaning of aging is that of change. How one historically has responded to change serves as a good indicator of his or her relationship to change throughout life, whether proactive or reactive or resistant. She explained:

People who are proactive look ahead, see the blips down the road and try to anticipate those things. People who are reactive respond to the knock or press for change. People who are resistant to change are the ones who scare me as a clinician, because they come into my office and say they're the same at age 75 as they were at age 35, and I wonder what they have been doing for 40 years.

Many people who enter senior living communities, particularly staged communities, take a proactive approach to life. But, Rosowsky noted, a “conflict often gets played out between honest intention and a hidden wish,” a conflict that communities often support and reflect and market. “The honest intention is to look ahead, to know what can come down the road as one gets older, and to not be a burden—to be independent—and to plan that proactively.” But when new residents arrive, “their hidden wish is to stay exactly the same—not to change at all.” The way communities support and reflect this dichotomy is to promote a culture of “live well, live long, live actively, remain young (at least for your chronological age), and live in a community with others *just like you*.”

Rosowsky stated that this mindset engenders the “I and thou” phenomenon. She pointed out that no wheelchairs or walkers are permitted in some communities’ dining rooms, and that such rules may represent a reason why residents choose to join these communities. The reaction to the “thouness,” or to the “less than fully intact,” is avoidance of persons seen to decline, or “measured altruism,” where people enter skilled nursing facilities for a measured period of time. Altruism is recognized as one of the “loftiest of defenses,” Rosowsky stated, “but when the ‘thou’ in the community is seen to have a mental illness, there develops often a synergistic effect leading to a double social stigma of being old *and* having a mental illness or not being mentally healthy.”

Negative stereotypes affect the responses and resources that are both available and *not* used within a community. Rosowsky asserted that “fostering mental health builds on the twin pillars of recognition and transparency.” Recognition refers to information from others about general age-appropriate behavior and what is known about a specific individual. This information can come from clinical sources, family, or other residents, and is based on both knowledge and observation. Transparency is self-revealed information “based on trust and questions.” Both pillars are supported by “what we know to be normal and what we know to be *not*.” To counter stigma, Rosowsky stated, “we need to minimize the *risk* of identification and disclosure and maximize the *benefit* of identification.”

The entire community must buy in to a culture of recognition and transparency in a process that obeys the laws of what Rosowsky terms “trickle down” and “parallel process.” Trickle down refers to the core values, beliefs, and assumptions that start at the top of a system and trickle down to the residents. “If a mental illness is regarded even tacitly as an affront to the system, as being inconsistent with its image, then staff and residents pick it up—and that undoes the very best formal training that is introduced.” Parallel process has the same effect, but is bidirectional. “It posits that the different strata within a system will tend to run parallel with others with regard to values, attitudes, and beliefs—and therefore behavior.” Consequently, attitudes and beliefs about mental health and mental illnesses in a senior living community can be expected to infuse the entire community. For any single clinical condition presented by any single individual in the community, it is necessary to understand the problem objectively—but also subjectively. Senior living communities need to know several important bits of information, especially in the context of bereavement and grief:

- Who is the person who appears to be in trouble?
- How does the world look to him?
- What is being asked of her?
- What challenge is she facing?
- How does he feel he can address this challenge?
- Does he feel he can address the challenge?
- And, what about the relationships in her world, including sustaining, paining, and missing relationships?

Rosowsky invited participants to take a developmental view of mental illness and to consider aspects of the ways by which college campuses address mental health challenges may translate into practice in senior living communities (see Table 7).

Table 7. College Campus and Senior Living Community Approaches to Mental Health

	College Campuses	Senior Living Communities
Premise	Mental or emotional signs or symptoms are considered real, relevant, treatable, and worthy of treatment. They are in no way considered a normal part of life, and they always imply pathology.	Signs and symptoms of mental difficulties are attributed to normal aging or dismissed as a normal response to the challenges of aging.
Awareness	College students have an awareness of what pathology looks like. Outreach is present to inform the eyes and ears of the community—and oneself—to recognize it.	The current cohort of older adults does not share familiarity with mental health signs and symptoms, although this situation may change for the rising cohort of older adults. Remedial education is needed to counter the abundant misinformation passed along in communities of older adults, much of which holds a negative, ageist bias. Community-wide education needs to normalize the frequently occurring, age-related changes and to debunk myths about what should <i>not</i> be attributed to these changes and challenges.

	College Campuses	Senior Living Communities
Access	Access to evaluation and access to care are available.	Senior living community residents need concrete, real access to evaluation and care. How user friendly is it to disclose one's distress to a trusted other, who can then facilitate a connection to trusted services? How easily and how timely can the service be accessed? And what is the temporal distance between identification and service delivery, as well as the physical distance?
Acceptance	Typically, college students accept the premise that an individual <i>has</i> pathology rather than the individual <i>is</i> the pathology. College students come to their mental health appointments with friends and classmates, and they often meet afterward for study sessions or go for beer and pizza.	In senior living communities, shame is a barrier to securing mental health services.
Coordination and integration	Multiple aspects of care and integration factor into the treatment plan or intervention.	Recognition, treatment, and maintenance plans need to be coordinated and integrated into the community, in the context of life for the residents. Suffering from social distress is at the same time inter-individual, intra-individual, and trans-systemic. The ultimate example is when someone in a community of elders takes his or her own life.
Efficacy	Students are offered care most effective for the conditions they present.	Is the treatment of choice available, or is the treatment defined by what is available? Because the evidence and beliefs constantly change, it is important for the community to keep up to date on current evidence-based treatment. This process is more challenging for older adults than for college-age young people, because most research is skewed toward the younger age on the life spectrum.

	College Campuses	Senior Living Communities
Reentry	Students expect to reenter the campus community after an event, an episode, or a course of treatment.	Older adults may experience a “potent triad of shame, discomfort, and fear of contagion—there but for the grace of God go I”: <ul style="list-style-type: none"> ▪ The older adult who is hurting, who is painfully lonely and isolated, experiences profound shame and often does nothing The staff associate who does not know what to say or do, does not want to make things worse, does not want to get in the bad graces of that resident—and, out of genuine concern, does nothing ▪ Community colleagues—friends and neighbors—who strongly identify with the older adult and feel acutely uneasy with the changes they observe, and also do not want to alienate their friend, avoid their uneasiness—and therefore do nothing It is the “do nothing” that so often has tragic consequences.

Rosowsky discussed the challenging roles played by caregivers, administrators, and other stakeholders in senior living communities. “How we care, how we manage, how we participate in programs, how we design—it’s difficult work.” Stakeholders in elder care engage in several “overarching, big struggles.” Regarding “distance regulation,” she noted, “we have to be close enough to do this hard work, but not so close as to eliminate a necessary objectivity.” And concerning professional boundaries, “Where do we leave off and the care recipient begin? Where do other professional boundaries fit the system and individuals? Professionals’ perception is that work is *part* of our life, not the *sum* of our life.”

Rosowsky emphasized the special importance of taking care of the care provider and suggested ways to optimize one’s contributions:

- Accept your uniqueness: who you are and who you are not. Aging, delightfully, gives us time—a little bit—for self-integration.
- Observe, center, and ease into new situations. We often try too hard.
- If your legs move, walk. Walk any way you can—and walk tall. Sometimes confidence starts on the outside, and confidence and purpose help make it real. Yes, even if you’re not absolutely sure. Who knows? You may be right.
- Take a chance. Practicing to live with uncertainty is pretty good practice for getting older.

- Savor what you value, and what you most value, savor the most. In our busy world, savoring is often dismissed as extraneous. It isn't.
- Change something about yourself you don't like. We're powerful agents of change. Look at the work we do. We need to remember to use some of that power on ourselves.
- Advocate for what you believe in, and start with believing in yourself.
- Graciously demur, decline, or just plain refuse when it makes sense for you not to do something. It is hard to say no and to stick to it.
- Revitalize a passion or two and discover a new one. It's especially important if you're starting to feel burned out or flattened out.
- Seek to maintain balance in your life—mind, body, and spirit. Give yourself a regular balance check-up. It may be as important as a dental check-up—maybe more.
- Make a new friend and extend your reach a little. Choose someone different from yourself. The more advanced we get in our fields, the more we may travel in tighter, more insular circles, which does not provide creativity and novelty.
- Complain parsimoniously. Express appreciation liberally.
- Splurge and indulge yourself. Show a little self-love.
- Allow yourself to rest when you need to. The miraculous thing is that the world will still be there after a nap.
- Plan time out *before* you need to. If time out can soothe a cranky toddler, think how effective it can be for overworked professionals—maybe preemptively to avoid becoming cranky.
- Smile broadly and often.

Start now. If not now, when?

11.

Changing Aging

Colin Milner, chief executive officer, International Council on Active Aging, spoke to summit participants about how residents of senior living communities can unlock their potential within the wellness model and, in doing so, improve their mental health. A popular motivational speaker, Milner is recognized as one of North America's foremost visionaries, original thinkers, and advocates regarding the health and well-being of older adults.

Milner began his presentation by introducing the National Wellness Institute's definition of wellness: an "active process through which people become aware of, and make choices towards, a more successful existence." He echoed that organization's assertion that people get the most out of life by becoming engaged in all six dimensions of wellness—physical, social, vocational, intellectual, spiritual, and emotional—and he discussed ways to engage senior living community residents in each dimension.

Physical Dimension

To begin with, Milner asserted, physical activity is good for mental health and in fact influences all the dimensions of life. He quoted American Medical Association president Ronald Davis, who claims that "if we had a pill that contained all the benefits of exercise, it would be the most widely prescribed drug in the world." But that pill does not exist. An AARP survey revealed that 98 percent of adults over age 50 know that physical activity is good for them, but only about 30 percent of that population is physically active.

Milner explained the dramatic loss of strength that can come with age. Between ages 35 and 70, people lose 50 percent of their strength, and by age 80, 48 percent of the population finds it difficult to lift 10 pounds. But strength training can reduce the burden on the body and, in turn, can impact one's disposition and outlook on life. In addition, improved strength can help prevent 50 percent of falls. Adults may be characterized by five levels of functioning—elite athlete, fit, frail, independent, or dependent. Because each group has a different ability and different need, a one-size-fits-all approach does not work to engage people in activity. Most of the population fits in the independent category; at minimum, they can say, "I have enough strength to function, but not as much as I need." That situation, though, is reversible with basic strength training, cardiovascular workouts, and balance training. Improved strength can help prevent 50 percent of falls.

Social Dimension

Milner noted that incorporating the social dimension into senior living communities emphasizes the creation and maintenance of healthy relationships, which also impact positively on mental health. Engaging in the social dimension also enhances interdependence with others and with nature, and encourages the pursuit of harmony within the family. It also furthers positive

contributions to one's human and physical environment for the common welfare of one's community.

The social dimension links with physical activity in the context that 58 percent of women over age 50 say they would be more likely to exercise if they had a friend to exercise with, and 33 percent say they would be much more likely.

Senior living communities benefit by offering meaningful programs to foster social interaction. Examples include the Red Hat Society, buddy programs that offer mentoring, group fitness classes and personal training, group travel opportunities, intergenerational and family programs, mentoring and volunteering, outings to sporting attraction and socials, art classes, and book and current events discussions. Milner acknowledged that although programming ideas may be plentiful, their implementation may prove challenging—but engaging in meaningful activities can result in individuals feeling better about themselves.

Vocational Dimension

Engagement in the vocational dimension emphasizes the process of determining and achieving personal and occupational interests through meaningful activities, in addition to goal setting for one's personal enrichment. The vocational dimension is linked to the creation of a positive attitude about personal and professional development.

Activities related to this dimension include recognizing abilities, identifying a personal mission and goals, learning new skills, developing new interests, considering roles and life plans, hobbies, volunteering, and helping others. It is important to empower the growing population of older adults to use fully their life experiences, skills, cultural and spiritual wisdom, creativity, and energy.

Milner commented that enabling elders to remain independent can have a dramatic impact on their lifestyle. When older adults lose their license to drive, for example, they often become socially isolated—a serious hardship. But he recalled a time when a man approached him at a Florida retirement community and said, “Colin, I’m the sexiest guy in this community! Guess why! I have a car. It’s like when I was 17. I get all the chicks!” Milner later encountered a driving simulator in a fitness club geared to adults over age 50, where they use it to improve response time, to improve physical activity, to enhance cognitive ability to respond—and to help people prepare for their upcoming driver’s license test.

Intellectual Dimension

The vast majority of older adults believe that taking care of their health is very important, but they do not feel knowledgeable about how to prepare for a healthy old age (National Council on the Aging, 2002). Individuals need to be shown what they need to do, particularly to take care of their mental health. A recent seminar at a Montreal community center on “Discover What’s Next for You” drew 500 people to explore next steps after retirement. Organizers anticipated that the program would draw people between 50 and 65 years of age—but the average age was 80, and many of the attendees still worked and still were deciding on how to retire and what to do then.

Milner noted that great demand for a variety of programs that promote brain activity has placed the sector on entrepreneur.com's 2008 Hot List. Over the next 2 years, 41 percent of continuing care retirement communities around the country anticipate purchasing brain fitness products, and 60 percent will buy Wii for its social and intellectual connections.

It is important for senior living communities to consider how to educate their residents to challenge their minds' ability to learn and process information quickly, while exploring new topic areas that require judgment and decision making. Intellectual stimulation may be promoted by seminars, workshops, new experiences; games and GPS; debate clubs about current events; book clubs; lending library; access to computers; and involvement with younger adults and sharing the past.

It is important to help people regain a sense of the identity they may have lost upon retirement. Senior living communities can consider how to help people learn new skills and become proficient at something meaningful to them. A community can offer residents opportunities to learn how to cook, particularly for men, to foster their sense of being able to take care of themselves and to feel empowered.

Spiritual Dimension

Empowering the senior population to give back—for example, to work in mentoring programs or to participate in other volunteer programs—has a role in helping them derive meaning in life. Apart from religion, spirituality involves realizing and connecting with a higher power. As an example, Milner suggested, “Walk through the forest or community and enjoy the sunlight, taking time to smell air that is not filled with fumes. Smell the plants, connecting in that moment, and take time where nothing else matters. Be in the moment.”

Retirement communities can provide opportunities for people to engage in this type of activity on their own or in groups. Some senior living communities now do tai chi at sunrise, and if an area on their campus seems appropriate, they transform it into a sanctuary where residents can meditate, connect with themselves, and work on their own being. Labyrinths—natural or purchased—can provide such an experience.

Emotional Dimension

Milner acknowledged that many summit participants whose work involves mental health typically focus on the emotional dimension, emphasizing awareness and acceptance of one's feelings. The emotional dimension reflects the degree to which individuals feel positive and enthusiastic about themselves and life.

The World Health Organization projects that depression will be the second greatest cause of premature death and disability worldwide by 2020. Communities may address depression through exercise, mind-body exercise classes, spa services (e.g., massage and acupuncture), and complementary alternative medicine. Surveys have shown that the number one-ranked complementary alternative medicine is prayer: 43 percent of the population use prayer, and

prayer for someone else ranks second in alternative medicine use. Other ways to address depression include stress management workshops, counseling, behavior modification classes, humor, support groups, and social events. Milner commented that all these elements dovetail to engender a lifestyle that helps residents and clients have a better life.

Yale University researchers have found that the effect of positive self-perception of aging on survival is greater than the physiological measures of low systolic blood pressure and cholesterol, as well as the independent contributions of a nonsmoker’s lower body mass index and exercise. Research also shows that persons with a positive outlook live 7.6 years longer than those with negative perceptions of aging.

“It’s all about the experiences,” Milner asserted, especially in combining the six dimensions of wellness into one’s life experiences. “It makes a big, big difference.”

For each of the six dimensions, Milner offered a selection of related concepts (see Table 8).

Table 8. Concepts Important to the Six Wellness Dimensions

Wellness Dimension	Concepts			
Physical activity	Independence self-reliant attributes fun movement functionality healthy	mobility work freedom engaged endorphins five senses mental health	strength flexibility perfection fitness abilities attraction	disability disease management pleasure appearance self-image
Emotional	feelings purpose support well-being maturity friendship	compassion acceptance content satisfied empathy balance	harmony laughter humor joy apathy	powerless stability valued emotional self-control
Social	family recreation friendships relationships belonging	entertainment clubs connection work/employment support	intergenerational engaged pets fun social butterfly	food belonging community status happy hour
Spiritual	self- actualization serenity well-being meditation oneness reconciliation	giving service forgiveness strength wholeness growth personhood	transformation hope peacefulness fulfillment introspection relaxation love	soul purpose charity/ charitable journey destiny seeking

Wellness Dimension	Concepts			
Intellectual	learning self-actualization brain fitness vitality analyzing entertainment	educational level creative engaged problem solving artistry contribution	communication memory growth curious scholarly willing	innovative reassuring respect cognitive status intelligence
Vocational	skills volunteering purpose responsibility productivity education	training experience self-worth creative role	change financial reward security independence challenge	career hobby job ability value

12.

Summit Discussion Summaries

Following the presentations on state-of-the-science content and context for late-life suicide, summit participants put their knowledge to work in a series of two small-group exercises. First, multidisciplinary groups brainstormed activities, approaches, and ideas that might enable senior living communities to achieve the summit's suicide-prevention goals and objectives (as delineated in the framework in Chapter 2). Taken together, the framework's three categories—whole-population approaches, at-risk approaches, and response to crisis and postvention—represent a comprehensive approach to suicide prevention.

Second, participants convened in stakeholder-specific groups to discuss ideas related to their unique roles in advancing work in mental health promotion and suicide prevention.

Proposed Approaches to Suicide Prevention: Interdisciplinary Discussion Groups

In each multidisciplinary group, a facilitator led discussions that were loosely organized around the stated goals and objectives; an expert served as a resource person on suicide prevention and mental health issues; a recorder captured the group's ideas and key discussion points; and a reporter presented highlights to summit participants convened in plenary session. Participants amplified many of their ideas by noting factors that would facilitate implementation of the approaches, as well as challenges and barriers they might encounter.

In general, opportunities identified for promoting health and preventing suicide among **whole populations** related to the following themes:

- Educate residents about wellness, healthy aging, and signs of depression. Mental health is essential to overall health.
- Be aware of mental health and other resources within the senior living community and in the broader local area.
- Make timely referrals to mental health and/or substance abuse services when and where indicated, in accordance with ethical standards.
- Reduce negative stereotypes in order to increase help-seeking behaviors.
- Recognizing that suicidality may relate to struggles with life circumstances and not just mental illness, emphasize overall wellness.
- Aim to limit social isolation using planned activities and engagement strategies.
- Consider risk and protective factors in suicide prevention.

- Recognize considerable overlap in the strategies appropriate for whole populations and for persons at risk for suicide, reflecting a continuum in mental health.

Opportunities for intervention with **at-risk populations** included these themes:

- Enlist senior living community residents and staff in identifying residents' at-risk life circumstances and/or behaviors.
- Be aware that major impediments to help-seeking behaviors among people at risk include lack of awareness of the signs and symptoms of depression and suicidality, the presence of modifiable risk factors, and negative stereotypes associated with mental difficulties.
- Emphasize “back-door” approaches to prevention and early intervention.
- Understand that discussing suicide as a prevention strategy does not cause suicide.

Opportunities addressing **crisis intervention and postvention** included these themes:

- Develop comprehensive protocols in advance to address the needs of the resident-in-crisis and the broad range of people connected to that individual.
- Train staff on how to implement the protocols.
- Promote mental health awareness and implement assessment strategies.
- Establish links in advance with a community crisis team, if available.
- Incorporate media guidelines into the community's communication protocols.
- Publicize the National Suicide Prevention Lifeline phone number wherever appropriate.

Tables 9, 10, and 11 summarize the opportunities identified by summit participants. Some descriptions are more detailed than others.

Table 9. Opportunities for Senior Living Communities: Whole-Population Approaches

<p>Goal 1. Promote effective coping and functioning.</p> <p>Objectives: 1.1 Promote coping with loss and bereavement. 1.2 Promote coping with decreased functioning and role changes. 1.3 Promote problem-solving skills. 1.4 Provide assistance with financial or other matters.</p>
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Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
As an organizational priority, consistently monitor residents' health status, including mental health, both formally and informally.	Involvement of <i>all</i> staff (and interested residents) creates a safety net.		
-Train residents to recognize the signs and symptoms of depression in themselves and others in the community. -Train all staff to conduct routine, informal depression screens. -Train marketing staff to identify potential mental health challenges as they talk with prospective residents.		-Determine the effectiveness of the training. -Determine the frequency of training workshops.	-Provide certificates of completion to individuals who participate in gatekeeper (and other skills) workshops. -Nonprofessional staff may become more engaged if the terminology <i>equip</i> or <i>empower</i> staff is used, rather than <i>train</i> .
-To identify residents potentially at risk due to illness, loss, or other life challenges, train residents and nonprofessional staff as "gatekeepers." Gatekeepers actively observe behaviors and report any physical/mental health concerns. -Model gatekeeper training on the Community Watch or the campus resident advisor program.	-Provide thorough training in depression and suicide prevention. -Adopt standard forms on which staff and residents report their concerns.	-Protect residents' privacy/anonymity. -Educate residents on how to circumvent instinctive boundaries and respect for autonomy, which may act as barriers to approaching a distressed or depressed friend or other resident.	-One resident per floor (for example) is trained to be aware of the status of everyone on that floor. This person could be the "go to" person for other residents to express concerns about neighbors who seem depressed or suicidal. -Enlist community residents (e.g., retired social workers). -Engage and empower transportation, food service, security, housekeeping, maintenance, recreation, and other staff. -When warranted, a staff member completes and submits a "concerned associate report" to the care management department, which investigates and follows up. Residents can submit a similar form to care management, which follows up with a visit. -Many senior living communities conduct formal and informal gatekeeper training.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Educate new and continuing residents on supports available in the senior living community.	-Prior to move-in, distribute resident manuals and materials on supports and resources. -Marketing staff review materials with residents at some interval after move-in. -Provide periodic refreshers and reminders about resources.	New residents typically experience overload due to massive amounts of documentation and the stress of their move. Even if residents receive materials on available resources, they may not take time to review them.	
As part of residents' transition into the community, schedule initial and follow-up visits with a social worker.			-Expectations of interactions with a social worker can mitigate negative connotations of mental health concerns. -Greater access to mental health assessment and effective treatment among more recent (and future) residents will diminish associated negative connotations. -The terms <i>stress test</i> instead of <i>mental health screening</i> , and marketing mental health-oriented consultation as something other than <i>counseling</i> , may increase buy-in to a holistic approach that highlights the importance of mental health..
Establish (peer) support groups for bereavement, economic distress, chronic health conditions, topics of expressed interest to residents, and/or other common circumstances.		-Resources and facilitator training are needed. -Creative recruitment may be necessary.	-Take care to identify groups by names that lack negative connotations. -"Back-door" approaches may foster attendance at programs designed to boost coping skills and provide opportunities for mental health check-ups by trained staff or other residents.
Make problem-solving therapy available to residents.		Resources to train providers may be scarce.	
Enlist residents to serve as mentors for other residents.	-This is a cost-effective strategy. -Marketing and other staff become aware of residents' skills and interests and pair residents with other residents.		Establish a buddy system.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Use the National Council on Aging's <i>Get Connected</i> toolkit (SAMHSA, 2006), developed with SAMHSA to increase awareness of coping skills.	Staff are familiar with implementation of the process described in the toolkit.		<i>Get Connected</i> includes a public awareness campaign. Training is needed (via the toolkit's DVD) to implement prevention activities.
Reach out to the broader community for help in educating residents and staff on available resources (e.g., engage local mental health association volunteers to lecture on a variety of topics).			Attendance at an existing community-based program is increasing because participants learn how to connect to services.
Inform residents on how to access "warm lines," similar to lifelines or hotlines; residents may telephone for support even when their concerns do not approach crisis intensity.			-Local warm lines may be modeled on warm lines operated by mental health consumers. -Some organizations may (soon) provide support using Internet technologies.
Introduce an intergenerational approach to social networks in nursing home settings.	Senior living community department directors	Nursing homes typically do not support social networks because of budget and policy considerations.	-Connect with professional schools (e.g., medical, social work) to implement activities for residents. -Nursing home residents can mentor at-risk high-school students and thus themselves contribute to society. -Enable staff to attend professional conferences.
Population-wide approach	-Master trainers from Stanford train peer leaders. -Licenses are purchased so training can occur within a State. -Some peer trainers receive stipends.		Kate Lorig model: residents support each other with setting goals. Gets people started.
Partnership with a psychiatric hospital		Availability and awareness of staff about mental health problems.	-Large institutions find it not cost-effective for hospital social workers to go into homes. -Psychiatrists in private practice work with a nursing home to provide services to residents.
Develop a protocol to evaluate and refine the policies and activities set in place.			

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Develop/implement wellness-related prevention (educational) activities that involve primary care physicians.	<ul style="list-style-type: none"> -Most seniors who have Medicare coverage see a primary care provider. -Care management takes responsibility to do a periodic assessment. -Build providers' (e.g., social workers) capacity to provide mental health assessments and sustain private practices through Medicare. -Training is needed on evidence-based protocols to educate clients on depression and managing symptoms. 	<ul style="list-style-type: none"> -Primary care physicians lack time and/or training to address multiple, complex concerns. -Providers may not know where to refer residents for mental health problems. -It is difficult to coordinate care for residents who receive services in the broader community. -Residents may view depression screens as intrusive. -Some depression screens lack validity. -Care managers may be reluctant to inquire about depression. 	<ul style="list-style-type: none"> -If physicians have a way to identify and then solve a mental health problem, they often are willing to participate in an access-enhancing program. -Use a valid care-management assessment tool during regular check-ins. Private practices can use (psychiatric social workers to administer) the PHQ-9, a brief self-assessment for depression. Alternatively, they can use a depression scale similar to a pain scale. -Survey/consult with the residents on a screening instrument's content. -In order to eliminate negative stereotypes associated with depression screens, incorporate them into a wellness program. -Geriatric psychiatrists can use telemedicine to provide assessments in consultation with primary care providers.
Establish a full calendar of wellness programs.	Use social marketing to promote wellness and reduce negative stereotypes about mental health problems.		<ul style="list-style-type: none"> -Include programs that emphasize general wellness, physical activity, problem solving, and happiness. -Help residents understand if/when they are at risk.
Build capacity in the workforce by establishing links with universities and other professional educational institutions to offer training opportunities to serve older adults.		Most of the people who will constitute the future practices of today's medical students will be older adults.	<ul style="list-style-type: none"> -All health care disciplines—medicine, nursing, psychologists, social workers, occupational therapists, physical therapists, other allied professions, and peer supporters—must prepare students to care for older adults. -Senior living communities need to team with local universities and schools to offer training opportunities, including using depression-screening tools.
Senior living communities work with universities to offer courses with Continuing Education Units (CEUs) to mental health practitioners to help them better serve older adults.			Most universities have the ability to confer Class I CEUs automatically; senior living communities' partnership with such a university is beneficial to both parties.

Goal 2: Promote social networks and social support.

- Objectives:** 2.1 Encourage connections among residents.
 2.2 Promote a sense of community on campus.
 2.3 Provide or facilitate regular “check-ins.”
 2.4 Facilitate contacts with family members.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Create a culture of neighborliness.			
Promote social networks and supports in social settings.	<ul style="list-style-type: none"> -Staff members recruit and organize volunteers to run activities. -Social marketing is used to involve as many people as possible. -Buy-in of residents and administrators is needed. 	<ul style="list-style-type: none"> -This program requires resources. -Identification of positive, effective volunteers requires care. -Program generates a sense of community only where effective volunteers are active, not necessarily on the entire campus. -Some residents may find the approach intrusive. 	Establish a buddy or other person-to-person system that makes resident contact routine.
Create opportunities for shared experiences.			For example, enable residents to watch sporting, news, or cultural events together.
Establish newcomer programs to welcome new residents.	<ul style="list-style-type: none"> -Base connections on mutual interests. -Provide training in outreach and social marketing. 	Recognize that some residents prefer to be alone.	<ul style="list-style-type: none"> -A caring neighbors program encourages a volunteer on each floor of each residence to take a new resident to dinner, provide support if a spouse dies, make hospital visits, etc. -Connect new residents with community leadership (e.g., members of governance board, unit officers, floor leaders, committee chairs, interest group leaders) and other interested residents.
Engage residents to conduct telephone outreach and wellness checks to encourage peer support and social networking.	<ul style="list-style-type: none"> -In-house staff runs the program. -Seek guidance from a community-based crisis hotline. 		Callers place a friendly call every day to elderly or housebound persons. To mitigate loneliness, calls last as long as needed. When an individual does not respond to three calls made at a predetermined time, the caller alerts designated emergency contacts.
Implement peer telephone reassurance program.		Funding for the program may prove challenging.	Volunteers in a community-based seniors group came to a senior living community and called every resident who wished to be contacted.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Host annual holiday celebrations.			Welcome family members.
Enable residents to invite family members to Sunday night dinners.		Contacts with family members can be negative.	Staff can facilitate communication with family members at the discretion of the resident.
<p>-Connect waitlisted individuals to campus activities and amenities (e.g., dining, physical fitness, lectures, classes) <i>before they move in</i>, to create new social networks and facilitate a smooth transition into the community.</p> <p>-Train marketing staff to promote the senior living community's expectations for healthy aging.</p>	<p>-Marketing staff identifies ways to connect prospective residents with services on campus.</p> <p>-A marketing team can identify prospective residents' potential challenges, if trained to know where and what to look for, and whom to call when an issue arises.</p>		<p>-One marketing department connects prospective residents to the facility during their (typically long) wait for an opening. For a fixed fee, individuals may use the facility's amenities before they move in.</p> <p>-Connecting prospective residents to staff in departments in addition to the marketing department is critical.</p> <p>-Marketing messages promote engagement in meaningful pursuits.</p> <p>-Transition team involved in the sales process (e.g., care management, nursing, assisted living, pastoral care) demonstrates that the community collectively speaks to the needs of the individual.</p>
Engage natural helpers. Train interested high school or college students to serve as natural supports at the senior living community and to identify residents' at-risk behaviors.			The activity promotes interpersonal relationships. It may have the serendipitous effect of increasing the self-esteem of the natural helpers who participate.
Establish a pet program, such as community pets, pet therapy, or allowing residents to own pets.	Establish (some) pet-friendly residences.	Some residents do not like pets.	A sense of community arises from the pet-therapy effect. Pet therapy can help individuals who do not necessarily want to relate to other people.

Goal 3: Promote engagement in positive activities.

- Objectives:** 3.1 Provide access to spiritual or faith activities.
 3.2 Promote involvement in volunteer activities.
 3.3 Provide recreational activities.
 3.4 Promote engagement in physical activity.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Promote spiritual wellness.	Pastoral care providers serve as supports to residents, facilitate access to spiritual resources in the broader community, and make referrals to services when needs are identified.		
Establish interest-based outreach efforts. Target particular efforts toward engaging men.	Marketing, recreation, and activities staff take the lead.	Identifying and establishing programs that interest and attract men may prove challenging.	<ul style="list-style-type: none"> -Tailor activities to traditional male interests. Survey residents on activities that interest them. -Sponsor activities led by men. -Establish table(s) in the dining room for single individuals who wish to socialize. -Establish a program of resident-led discussion groups or lectures. -Engage outside organizations to present programs to residents.
Promote opportunities for social contact with the broader community.	Recreation and activities staff serve as coordinators.	<ul style="list-style-type: none"> -Transportation may be challenging. -Funding for special activities may be needed. 	<ul style="list-style-type: none"> -Raise funds for a specific activity; use the fundraiser itself to engage participation by residents. -Use Wii (interactive gaming system), which offers an opportunity for residents to support each other's cognitive abilities.
Promote opportunities to enjoy fresh air and exercise.	<ul style="list-style-type: none"> -Volunteers and staff assist residents to go outdoors. -Create walkways and gathering areas. 	-Limited mobility of some residents must be addressed.	

Goal 4: Decrease access to lethal means.

- Objectives:** 4.1 Limit access and/or erect fences on roofs of buildings.
 4.2 Replace windows or limit size of window openings.
 4.3 Restrict access to stored chemicals and prescription drugs.
 4.4 Restrict access to firearms.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Assess the community's safety risks.			-Limit access and/or erect fences on roofs of buildings. -Replace windows or limit size of window openings. -Improve safety in high-rise buildings, including balconies. -Schedule to coincide with smoke detector checks and air filter changes.
Engage the local mental health authority to tailor protocols to ensure that nursing home environments are safe for persons with mental disorders.	Create/implement safety policies.	Store medicine carts when staff visit residents who are not mobile.	Educate grounds and environmental staff in all precautions.
Establish a suicide prevention education program.	Safety department takes the lead.		
Prohibit firearms.			New York State, for example, bans guns in nursing homes.

Table 10. Opportunities for Senior Living Communities: At-Risk Approaches

Goal 5: Increase help-seeking behaviors.

- Objectives:** 5.1 Increase residents’ knowledge of treatable risk factors, potential treatments, and available services.
 5.2 Decrease local barriers to help seeking.
 5.3 Implement efforts to reduce stigma and normalize help seeking.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
<ul style="list-style-type: none"> -Address negative stereotypes about mental health problems. -Raise awareness of and normalize mental health disorders. -Take a “back door” prevention approach. 	<ul style="list-style-type: none"> -Impart mental health information along with wellness/physical health information. -Actively seek opportunities to embed mental health information in <i>all</i> activities and communications. -Depression awareness education of staff and residents can facilitate open discussion. -Target at-risk persons to participate in positive mental health activities. -<i>Positive mental health</i> terminology circumvents negative stereotypes. -Enlist community experts to give presentations that incorporate mental health education. 	<ul style="list-style-type: none"> -Negative stereotypes related to mental health disorders impede help seeking. -Staff over-workload. 	<ul style="list-style-type: none"> -Incorporate questions on both physical and mental health on the same health assessment forms. -Encourage residents to seek depression screening from their primary care provider. -Host a discussion session on a maintain-your-brain theme—instead of general mental illness—to address the fear of losing one’s memory or concentration or of depression. This serves to avoid isolation. -A stroke support group has evolved into a depression support group—but is not called a depression group. -Discuss pain at meetings. -Market mental health messages (e.g., posters in restrooms: “If you have this issue, call _____”). -Establish a community garden. A successful program with a male “gardening guru” enjoys participation by both men and women. The program aims to decrease symptoms of depression and incidence of diabetes. It not only engages seniors in working in the garden, it trains them to cook and market the produce. The program offers meaningful, productive activity—and hope. -Chaplains offer guidance to residents perceived as at risk.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
<p>Make presentations/hold discussions on general health, current events, and other topics—and embed information about depression and suicide.</p>	<p>-Experts help residents understand if/when they are at risk. -Facilitators should be trained on suicide risk and able to intervene, if necessary. -Publicize events well. -If the technology is in place, run closed-circuit TV programs on depression and suicide.</p>	<p>It is difficult to reach residents who isolate themselves.</p>	<p>-This suggestion addresses people’s reluctance to attend talks on <i>depression</i> or <i>suicide</i>. -Suggested topics include stress, pain, insomnia, preventing depression, how to help your neighbor, improving memory, phase of life problems and how they affect you, changing economics, and mental wellness, Growing Wiser program, holiday blues. -Tailor message for specific cultural groups (LGBT, ethnic minorities). -Establish an insomnia support group. Sleep problems represent an acute risk factor for suicide. -Make recorded programs available to other facilities.</p>
<p>Create and distribute a set of flash cards on sensitive health issues that residents can hand to their doctors as conversation starters.</p>			
<p>Provide training to primary care providers to encourage them to raise the topics of depression and suicide.</p>	<p>Primary care providers need trustworthy mental health professionals to whom to refer their patients.</p>	<p>Develop curricula and materials.</p>	
<p>Conduct ongoing awareness campaign.</p>	<p>-Incorporate mental health information in brochures, newsletters, and other internal communications. -Distribute flyers, brochures, and/or cards about depression and suicide prevention. Place them periodically in residents’ mailboxes.</p>		
<p>Establish a veterans (support) group.</p>			

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Host community suppers to discuss a specific topic. Print placemats with printed information about depression and suicide.	Aging agency may fund the cost of dinner.	-The event may be costly. -Transportation may be needed for residents (and the broader community, if invited).	
Develop a protocol to evaluate and refine the policies and activities set in place.			
Play Feel Good Bingo.			Feel Good Bingo is distributed by Screening for Mental Health, Inc. (mentalhealthscreening.org), the founders of Mental Health Screening Day.

Goal 6: Identify and refer distressed or at-risk residents.

- Objectives:** 6.1 Increase the ability of other residents, staff, and families to identify and refer residents for help (i.e., by gatekeeper training).
 6.2 Increase case identification of depression, substance abuse, and suicidality (i.e., by screening).
 6.3 Increase clinicians' capacity to identify and refer appropriately.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Create and sustain a culture of mutual caring and responsibility.	<ul style="list-style-type: none"> -Administrative (and staff) buy-in and support are needed to train staff and empower residents to help each other (see discussions of gatekeeper training in Whole-Population Approaches). -Use resource kits and educational opportunities to empower residents. -Encourage residents to work out problems on their own and contribute their own skills to solutions. 	Long-standing negative stereotypes.	<ul style="list-style-type: none"> -In a campus community, most information is shared via peer-to-peer interactions. -Members of wellness councils share the value of the mind-body-spirit connection.
Target depression and suicide awareness campaigns for specific times of the year, especially prior to major holidays.	<ul style="list-style-type: none"> -Publicize information about helpful resources (e.g., warm lines, lifelines, hotlines) with posters, magnets, brochures. -Equip social workers, chaplains, and other appropriate staff with phone numbers for referrals and other supports. 		Address suicidal ideation in the context of holiday blues or intractable pain.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Consider every staff and resident interaction to be an opportunity for an informal mental health check-up.	<ul style="list-style-type: none"> -Medicare reimbursement for depression screenings. -<i>Mental health check-up</i> may have more positive connotation than <i>screening</i>. 	<ul style="list-style-type: none"> -Residents may perceive screenings as a tactic to move them into assisted living. -Resources to conduct screenings may be limited. 	<ul style="list-style-type: none"> -Regular screenings become part of the culture. -Depression frequently indicates impending dementia, and such a check-up may in fact precipitate moving to stepped-up care. -In fair housing situations, make screening voluntary and normalize it: “We do this annually”; in these settings, asking questions about depression violates Federal regulations.
Educate every staff member on how depression presents in older adulthood.	<ul style="list-style-type: none"> -In facilities where contact with staff is infrequent, use “inspections” to note changes in residents’ health/mental health status. -Provide information on depression symptoms exhibited especially by men (e.g., irritability, anger, substance abuse). 	<ul style="list-style-type: none"> -Independent-living residents may fall through the cracks because they have less access to clinical staff. -In some facilities, residents can isolate themselves almost completely. 	<ul style="list-style-type: none"> -Provide training at staff orientation and (at least) annual refresher sessions. -In trainings, address attitudes towards late-life suicide to ensure the understanding that depression is not a normal part of aging.
Link education about depression and suicide risk with emergency preparedness (e.g., Citizen Corps).	<ul style="list-style-type: none"> -Contact the Department of Homeland Security’s Citizens Corps to engage mental health providers in senior living communities’ activities. -Access Federal resources for emergency preparedness. -This strategy could provide entrée into Federal housing facilities. 	Resources may be lacking.	
Use targeted approaches.			Provide information on the National Suicide Prevention Lifeline for veterans.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Develop programs in which residents can volunteer to receive mental health care designed to help keep them in independent living.	Facility must decide that this program is worth doing.	This strategy is costly.	
Pre-Admission Screening—Annual Resident Review PAS-ARR			

Goal 7: Increase access to mental health and substance abuse services.

- Objectives:** 7.1 Create linkages with community-based mental health and substance abuse services.
7.2 Provide mental health and substance abuse services or supports.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Offer mental health services onsite by independent providers (e.g., psychiatrists, nurse practitioners, psychologists, licensed counselors)	Most geriatric providers accept Medicare. -Secure approval of private insurers. -Some localities lack access to mental health providers. -The mental health parity law offers opportunities. -Mental health providers can see clients in their own residences. -Care must be available, accessible, and affordable. -Co-locate mental health/substance abuse services to allay privacy concerns.	This strategy depends on payer source (e.g., Medicare).	By 2014 Medicare co-insurance for beneficiaries will be equal for mental and physical health visits. Nevertheless, practitioners assert that Medicare reimbursements are insufficient to sustain independent practices.
Take steps to coordinate residents' mental health services. For example: -Hire a depression management care staff or team. -Hire a geriatric case management team and establish links to care.		-Residents may not want mental health services. -It is difficult for a primary care provider not located in the senior community to recognize residents' mental health needs.	
Facilitate Alcoholics Anonymous and Narcotics Anonymous meetings onsite.			

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Residents should have a choice of behavioral, pharmacological, or both forms of treatment.			
Inform residents about Friendship Line for Elderly Suicide Prevention (San Francisco) , a toll-free warm line			
Research community resources and develop relationships with mental health providers in the broader community.			
Use IMPACT and other primary care-based mechanisms to provide evidence-based treatment to elders.		Limited transportation may be available to access community-based services.	-The best way to increase access to care is to provide integrated care. To see a primary care provider, residents can organize travel .

Goal 8: Promote effective treatment and management of mental health and substance abuse disorders.

- Objectives:** 8.1 Adhere to geriatric-specific treatment guidelines.
 8.2 Utilize effective models of geriatric care management.
 8.3 Assess for suicidality.
 8.4 Increase regular monitoring of at-risk residents.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Establish a depression care-management or wellness-management team to set and oversee standards of care.		All residents may not be linked into medical or mental health care systems.	
Collect and process evaluation data on implemented strategies.			
Use programs with demonstrated effectiveness.		Some programs in use may not have been evaluated for effectiveness.	
Devise strategies to communicate with in-patient treatment facilities after a resident's suicide attempt.	Frame this approach as "coordination of care."		
Offer training to local mental health providers on treatment for older adults to ensure appropriate care for referred residents.	Award CEU credits as incentives for training.	Funds are required.	Invite experts to provide training.
Apply for grants targeted to attract providers to underserved areas.			
Use the National Council on Aging's peer-led, chronic disease self-management program.			
Match (especially male) residents with supports and activities shown to be effective for them.	-Provide training to counselors/consultants on problem-focused therapy. -Survey residents to determine their preferences for activities.		-When men are caregivers, they gravitate to problem-focused support groups. -Research from the Alzheimer's Association shows that men relate better to "how to" than "how do you feel?" -Promoting activities that appeal to men's competitive nature may attract more men to activities. -Internet-based services and Web sites may attract and help men. -When men are trained and serve as activity leaders, more men are drawn into the group and engage in social networking.

Goal 9: Effectively address medical conditions and pain.

- Objectives:** 9.1 Employ treatment regimens designed to reduce symptoms and pain.
 9.2 Help ill residents deal with specific types of disability and functional impairment.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Ensure that professionals to whom residents are referred are affordable and competent.			
Establish a standard that physicians who see residents onsite must assess and treat pain.			
Provide opportunities for residents with disabilities to feel like an important part of the facility—despite their impairments.			
Be aware of other physical risk factors for suicide (e.g., poor dental health, vision deficits, decreased mobility, incontinence, insomnia, hearing loss).			Train staff to recognize these risk factors and empower residents to seek help.
Provide education to eliminate negative connotations associated with taking pain medications.			
Identify practitioners who provide palliative care.			
Refer residents to hospice as early as possible, as appropriate.			
Provide targeted education to residents known to suffer from chronic pain.			

Table 11. Opportunities for Senior Living Communities: Response to Crises and Suicidal Behaviors

Goal 10: Develop protocols and procedures to promote the safety of distressed or suicidal residents and to respond to crises using institutionalized procedures.

Objectives: 10.1 Implement protocols and systems for responding effectively to acutely distressed or suicidal residents.
 10.2 Utilize decision-making protocols and procedures regarding mental health issues and the need for additional care, such as hospitalization or transition to assisted living.
 10.3 Ensure that emergency notification protocols are appropriate to mental health crises.
 10.4 Institute procedures for creating and implementing post-crisis follow-up plans.
 10.5 Utilize standardized procedures for appropriately documenting interactions with distressed or suicidal residents.
 10.6 Train appropriate personnel in relevant protocols and procedures.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Engage a staff team to develop protocols for crisis response.	Team should include the administrator, medical director, nursing director, chaplain, social worker, resident, and mental health professional, at minimum.		Consider including a resident representative.
Protocols should address: -Who makes the initial contact with a distressed individual (e.g., nursing director or social worker) -Who contacts the family about a crisis and when -Confidentiality protections -Referral to a mental health professional or emergency room, as appropriate -Procedures and content of post-crisis contract or follow-up plan for an individual who has experienced a crisis (e.g., mental health services) -Documentation of events related to the crisis	-Policy formulation should take place in advance of a crisis, not in its midst. -A knowledgeable individual trained in suicide risk should evaluate suicide prevention protocols and plans.	-Legal consequences of nonadherence to the adopted protocols. -Judgment must be exercised. -Residents, leaders, and associates change frequently, which impedes continuity in adhering to protocols. -Residents who do not understand the magnitude of the potential for suicide may not recognize the need for protocols.	-Protocols should not mandate automatic transport to an emergency room, except for medical treatment or as a last resort if no other resources are available. -HIPAA does not constrain information exchange during a crisis; it is important to be familiar with its provisions to avoid the dangers of over-interpretation.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Develop a protocol to evaluate and refine the postvention effort after a crisis.			
Establish a training program in crisis response for the entire community.			<ul style="list-style-type: none"> -Incorporate discussions of mental health issues into the community's general health and wellness program. -Encourage residents to report their neighbors' unusual, worrisome behavior that may indicate a problem—without feeling they are betraying their neighbors. -Only clergy well trained in suicide prevention, suicide response, and depression should engage in this process.
Focus particular attention on monitoring the health/mental health of residents following a crisis.			
Use multiple communication strategies to educate the community about mental health awareness.	<ul style="list-style-type: none"> -A community television station and/or Web site can broadcast PSAs and raise awareness. -Holiday-time newsletter can address emotional issues residents might experience. 	Resistance among seniors to electronic communication (e.g., use of computers) may pose a barrier to information dissemination.	
<ul style="list-style-type: none"> -Build mental health and suicide assessment into annual staff training to enable staff to identify signs of depression. -Make identification of depression a part of the community's culture. 	Enhance knowledge among staff of available resources.		Depression is an indicator that something is going wrong; activities are needed that focus on depression, not just suicide.
Train at least one individual to arrange suicide-prevention contracts.			

Goal 11: Respond to suicides with a comprehensive postvention program to identify survivors, assess level of trauma and risk among survivors, support survivors, and prevent suicide contagion.

- Objectives:**
- 11.1 Develop postvention protocols and procedures prior to need.
 - 11.2 Ensure that all appropriate individuals within the community are identified as survivors.
 - 11.3 Assess all survivors for level of trauma and risk.
 - 11.4 Ensure that support is offered/provided to all survivors.
 - 11.5 Work appropriately and effectively with the media.
 - 11.6 Implement postvention strategies that discourage suicide contagion.

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Implement crisis-response protocols.			
Identify mental health providers in advance of a crisis to work with all survivors, both at the facility and in the broader community.			Go beyond obvious survivors to who else may be affected. Make help available to anyone in the community who needs it.
When a resident is identified as at risk, include a higher-level decision-maker in the assessment process.			This strategy helps protect senior living community staff.
Provide access to religious services for suicide survivors.		Not all residents are interested in religious participation.	Ensure that supports are helpful.
Incorporate media guidelines and crisis protocols into existing communication protocols to be ready to explain a crisis situation appropriately to the media.	-Media guidelines posted online		
-Proactively distribute media guidelines to editors of local print and broadcast media. -Prevail upon reporters to include the National Suicide Prevention Lifeline (800-273-TALK) in any media coverage.	-Develop an appropriate vocabulary to provide media with information.	-Comments by residents may be more interesting to reporters than a corporate response. -Media sensationalization.	

Approach/Activity/Idea	Facilitators	Challenges	Discussion Notes
Train community members in media guidelines and protocols.	-Staff can role-play a suicide scenario to educate community and media about relevant response issues and methods. -Use suicide as an opportunity for education of residents and staff.		
Restrict media from roaming the community after a crisis.			
-Develop an annual mental health assessment of all residents. Create a baseline to facilitate identification of indicators of mental health problems.	-Increase communication between residents and staff to enable staff to know residents' current (and past) mental wellness status.	-Securing resources may be difficult. -Compliance with HIPAA provisions is necessary.	-California's assessment model uses an electronic record. -Students involved in oral history projects might serve as resources to collect histories of residents. -Enable use of electronic medical records.
Offer survivors long-term follow-up support and counseling after a suicide in the community.	Support groups may be helpful.		People feel numb after a crisis and need outreach to get in touch with their hidden emotions.
Establish a confidential resident communication/complaint line.			
Maintain open communication among residents and staff so suicide and depression are non-taboo topics.		Not all people are, or wish to be, good neighbors.	
Decide how to present information about a suicide or suicide attempt to the community.	-Acknowledge suicide as a traumatic event. -Use the police report to guide revelation of details. -Be as honest and timely as possible, but consider legalities.	HIPAA and other legal considerations may pose challenges to communication about a suicide.	HIPAA issues: -When a death is ruled a suicide -How and when to reveal the event to residents
Plan and implement a post-crisis community education program.			Incorporate discussion of the suicide into activities already ongoing in the community.

Proposed Stakeholder Group Actions: Stakeholder Discussion Groups

Successful initiatives depend on the input and efforts of a wide variety of stakeholders. With an eye to introducing mental health promotion and suicide prevention into senior living communities, summit participants met in small groups to brainstorm roles and approaches appropriate to specific stakeholder groups.

In addition to proposing concrete actions, the groups considered necessary inputs and identified additional information they might need in decision making related to implementing the approach. Each participant joined one of six groups:

- Residents
- Clergy and social workers
- Wellness lifestyle and programming professionals
- Senior facility leadership and public relations and marketing professionals
- Public health practitioners, community educators, academics, and gerontologists
- Geropsychiatrists, geriatric pharmacologists, and psychologists.

The following discussion summarizes summit participants' thinking in the following areas:

- General roles stakeholders might play
- Particular initiatives to develop or support
- Challenges that may impact progress
- Inputs necessary to implement their activities
- Additional information that might be needed in decision making

This narrative reflects the unique discussion flow in each group.

Residents

Residents of senior living communities identified a number of issues that raise concerns about mental health, and they discussed approaches for individuals and their communities to promote mental health and suicide prevention.

Senior Living Community Residents' Concerns: A Sampling

"I am watching a couple of folks who don't know I am watching, and they are showing signs of distress or depression."

"It's difficult to get over the loss of a loved one. How can we intervene with folks who are showing signs, get reluctant people out of their apartments and rooms?"

"I remember hearing about the people who took their own lives after the Great Depression. Most of the people here lived through that."

“Many people are moving for financial reasons. It impacts their quality of life. They’re moving to smaller rooms and apartments. All change involves loss and a grieving process. Here they call it ‘right-sizing.’”

“Sometimes help from fellow residents is not that helpful—like when they share all the bad news about living in these communities.”

Whole-Population Approaches

- Provide peer support.
- Engage in the gatekeeper program, formally or informally.
- Attend new resident meetings, facilitated by care management and social workers, and offer input.
- Reach out and help other residents in a natural, organic process.
- Take along an advocate to medical appointments.
- Teach residents listening skills to transform “unhelpful helpers” into effective helpers.
- Establish guidelines and education for accessing care management—or other residents—for assistance.
- Post residents’ names prominently on their doors.
- Invite chronic complainers to join a committee charged with improving conditions.
- Survey residents regarding their interests and needs.
- Attend to privacy protection issues.
- Accommodate documentation overload for new residents in scheduling follow-up welcome visits.
- Make special efforts to engage men in activities.
- Acknowledge and address the fear of being moved to more intensive care settings.
 - Sponsor open houses to visit assisted-living apartments.
 - Host a panel of assisted-living residents to discuss their success stories.
 - Share positive stories in newsletters or a closed circuit TV system.

- Establish a benevolent care fund to help with the costs of assisted-living facilities.
- Address residents' unanticipated financial challenges.
 - Hold small-group financial workshops; discussion groups on general financial issues that may prompt sharing about personal anxieties. Offer a continuing education class on making sense of financial uncertainty.
 - Facilitate financial planning.
 - Inform residents about the community's policy if they exhaust their funds. If positive, advertise it: "Did you know that no one has ever been moved from Community X because of lack of money?"
 - Consider subsidizing residents' micro enterprises.
 - Participate in planting, maintaining, and harvesting resident gardens.
 - Consider informal barter programs in dealing with financial situations.
- Devise a strategy to notify residents that a neighbor seems to be having difficulty; consult with the person who observes a problem prior to reporting to care management.
- Urge residents to carry their personal medical information when they leave their homes.
- Implement a campus caller program.
- Post the resident handbook online.
- Teach residents how to set boundaries with their neighbors.

At-Risk Population Approaches

- Address issues related to pain.
 - Most people want to be alone when in pain, though some welcome reaching out.
 - Residents can provide some level of intervention.
 - Determine whether people who want to be alone are depressed.
- Secure mental health and substance abuse services for residents.
 - Help friends recognize they may be experiencing a problem.
 - Use a concerned resident reporting system.

- Promote the use of self-disclosure and recovery stories.
- Investigate the content of training for resident advisors in college residences.
- Focus on mental wellness around holidays.
- Consider teaching computer literacy.
- Address mental health concerns of residents whose spouses are depressed or suicidal.

Postvention Approaches

- To address grief associated with suicide, educate residents that survivor guilt, confusion, and relief are normal.
- Offer support groups. Name the support group “Dealing with Changes”—but anticipate low attendance. Train multiple residents to lead grief and loss groups for survivors.
- Offer pastoral care.
- Address the issue of negative stereotypes in dealing with loss to suicide.
- Recognize the particular difficulties men may experience.

Clergy and Social Workers

Words such as *meaning*, *purpose*, and *hope* connote spirituality. Participants asserted the importance of tempering the medical model with a spiritual perspective in mental health and suicide prevention. Clergy, pastoral counselors, and social workers can engage in the following work:

- Educate and empower natural helpers to participate in planning programs to move initiatives forward.
- Think strategically to develop programs that are coherent, comprehensive, integrated—and eventually institutionalized.
- Increase outreach to faith- and community-based organizations to maximize resources and open opportunities to provide support to older adults.
- Participate in local interagency councils and boards to increase information sharing and information acquisition.
- Identify and assess crisis intervention programs.

- Educate local clergy about the signs of depression and when it is appropriate to refer individuals for mental health services. (This knowledge can be a gift to the clergy and to their older congregants.)
- Team pastoral counselors with social workers to provide an institutional safety net for residents who might resist counseling perceived to be religious—or *not* religious.
- Encourage elders to engage in life reviews to help them see their lives in perspective.
- Remember to care for oneself to promote personal well-being (e.g., Detroit’s Healthcare Chaplains Organization offers support within the discipline).
- Help develop or implement a gatekeeper program.
- Survey professional resources available in local communities.
- Serve on the crisis-response team. Well-trained clergy can help to plan protocols, consult on local resources for crisis counseling, make referrals, provide crisis and/or post-crisis counseling, and consult with residents on their lives’ meaning and purpose.
- Incorporate spirituality into discussions of depression and suicide.
- Foster ongoing relationships between the senior living community and the larger mental health community.

Community Interactions

An interagency council on aging can provide speakers on services for the elderly, share innovative ideas, ease referrals, and stage such events as an annual caregiving conference, senior art show, dance, or senior fair. A local social worker interagency council might focus a meeting on suicide. A senior living community might invite local congregations to attend a conference/training led by social workers about signs of depression. Local clergy may interact with trained pastoral counselors to facilitate religious and nonreligious support.

- Recognize that suicide is a spiritual matter that is not addressed by the medical model. Everyone who interacts with residents should consider ways to help give residents meaning and hope. To accomplish this objective, identify and facilitate meaningful activities (e.g., volunteer service projects, such as sending used playing cards donated by local casinos to deployed troops or participating in a toy donation campaign, or following local sports teams).
- Look for ways that suicide prevention efforts can connect to activities already in place.
- Open the community to intergenerational experiences.

- Connect residents with limited mobility to the outside world by inviting in the broader community. Offer space for high school practices and rehearsals to enable residents to attend. Auditoriums, meeting rooms, and swimming pools may serve as venues for such connections
- Create a partnership with a nonprofit childcare daycare center.

Wellness Lifestyle and Programming Professionals

Participants noted that individuals in the multiple disciplines of the wellness field—for example, fitness, recreation, and occupational therapy—take on the following roles:

- Help people move from illness to wellness.
- Encourage the integration of mind and body in approaches to providing care.
- Promote the use of alternative, evidence-based interventions, and articulate their value in terms of both health outcomes and on senior living communities’ return on investment. (Wellness programs often are regarded as “add-ons,” not as a primary intervention to promote wellness, and they typically are not reimbursed.)
- Promote preventive care.
- Empower staff and residents to make choices based on their own preferences and passions, and to understand what wellness means to them.
- Encourage a mindset change to focus on proactive adoption of health-promoting behaviors, rather than reacting to adverse health conditions as they emerge.
- Educate the community about all aspects of wellness.

Whole-Population Approaches

- Encourage practitioners in the wide spectrum of disciplines to provide an educational series on topics related to wellness (e.g., insomnia, pain, stress). Presentations could focus on the integration of mind and body. Publicity for these discussions would not announce overtly the message that “this is for your mental health.”
- Focus on promoting wellness programs that involve “meaningful” activities (e.g. gardening, tutoring).
- Recognize that wellness means different things to different people; clarify each resident’s understanding of wellness. Consider use of the Wellness Inventory or similar tool to get an idiographic picture of how residents define wellness. (See International Council on Active Aging for good wellness tools.)

- Include problem-solving training and resilience training in wellness programs.
- Target public health campaigns to inform older adults how to develop wellness lifestyles.
- Provide education and support about loss.
- Promote a culture of caring by encouraging residents to reach out to each other. Educate residents about what to say and how to say it (e.g., “it is okay to ask people if they are okay”). Pursue this strategy formally (with wellness checks, telephone check-ins, “buddy” programs) or informally.
- Schedule activities regularly. Many residents find it comforting to know that each week they can participate in an activity of interest to them.
- Survey residents on their interests and help them develop programs.
- Focus on involving men in activities (e.g., billiards groups, competitive activities, food) that could be enhanced by wellness educational efforts.
- Enlist residents to contribute their skills (e.g. medical, social work, counseling). Partner staff with residents to run groups. Provide residents with opportunities to harness the power of helping someone else.
- Focus on helping interest group members feel productive by encouraging them to take responsibility for completing specific tasks.
- Facilitate residents’ participation in activities sponsored by community organizations (e.g., ethnic groups, Red Hat Society, Service Corps of Retired Executives, other volunteer opportunities).
- Consider offering meeting space to outside organizations to facilitate resident involvement.
- A facility with more extensive resources may consider forming partnerships with fair housing facilities.
- Consider implementing a time management group that offers problem-solving strategies and encourage residents to engage in activities.
- Consider implementing groups that focus on physical activities (e.g., exercise, swimming).
- Consider using a Wii or another gaming system for activities.
- Consider implementing sensory-based activities/interventions (e.g. essential oils, music, massage, water).

- Consider implementing support groups related to the economy.
- Consider enabling residents to develop a newsletter or TV station.
- Consider establishing a café or coffee shop where people can congregate.
- Educate physicians on the importance of integrating mind and body when they provide information to residents.
- Provide physicians and other health care practitioners with the health information given to residents to enhance opportunities to discuss issues.
- Consider providing residents with information about how to communicate with their primary care providers.
- Empower staff to raise issues and provide venues for them to express their concerns.
- Evaluate programs' effectiveness with (multidisciplinary) outcomes research. Offer feedback to residents on findings.

At-Risk Population Approaches

- Develop programs specifically for people with identified depression. Provide education on the importance of medication and on the equal importance of treating depression and other illnesses. Provide increased social support, including support groups co-led by residents who have dealt with depression successfully.
- Consider programs for residents who face transitions.
- Consider implementing Alcoholics Anonymous or Narcotics Anonymous groups.
- Promote the use of Feel Good Bingo and other similar activities. (Feel Good Bingo, distributed by Screening for Mental Health, Inc., has been used throughout North America as an entertaining way to screen for depression.)

Necessary Inputs

Participants identified factors required needed to promote wellness at senior living communities.

- Staff with expertise in wellness lifestyle models.
- Administrators who value and provide resources to wellness programs.

- Time- and cost-effective strategies to promote wellness. Facilities can engage and train volunteer residents to lead discussions and/or teach others about their avocational interests or skills—for mutual benefit.
- Awareness of activities in the broader community.
- Transportation to community programs.
- Support from primary care providers for wellness. Conflict typically exists between wellness-promotion activities and medical prescriptions for treatment. Increased education on moving from illness to wellness promotes mutual support by physicians and wellness staff.
- Stronger focus on research in wellness programs and specific interventions.
- Wellness providers who need to practice what they preach in pursuit of their own wellness.
- Promotion of a culture of caring among staff and residents.

Challenges in Promoting Wellness

- How to develop a change in mindset toward focusing on the interaction of mind and body that is necessary to develop successful wellness programs.
- How to achieve administrative buy-in to encourage participation and allocation of resources.
- How to connect wellness to suicide prevention (e.g., research on engaged people living longer).
- How to motivate residents (especially residents who are not doing well) to participate in wellness programs without the perception of nagging.
- How to translate research into practice, measure behavioral change, and teach the implementation steps for evidence-based practices.
- How to secure financial reimbursement for wellness activities.

Senior Leadership and Public Relations and Marketing Staff

Administrators and public relations and marketing professionals discussed worthwhile practices and activities to implement, enhance, and/or expand their efforts to promote mental health and prevent suicide.

Whole-Population Approaches

- Set an expectation for check-ins and encourage residents to buy into the transition.”

“When you buy a car, a salesman may invite you back to become familiar with your car. But after you start driving it, all you want to do is drive it. Nevertheless, you need a follow-up meeting to go over the details of how to care for your car. Marketing staff do this with new residents.”

- Implement gatekeeper programs for staff and residents. Educate on gatekeeper skills that elicit wide buy-in to a caring community that reaches out to know individual residents. Optimal gatekeeper education may involve scripting—phrases meant to be encouraging, pleasant, positive, and uplifting—to use in communications with residents on how they feel. Be aware of the need for consistent retraining. Consider a Community Watch model.
- Establish gatekeeper protocols for staff on how and what behaviors to observe, and how to share that information appropriately. Reward staff members who share their observations and identify residents at risk.

“We’ve done a focus group with men. One concern they’ve raised is getting away from the women, because the women watch too closely sometimes.”

- Educate residents at events such as community suppers by weaving in the topics of depression, symptoms of dementia, or stroke support groups with other subjects.
- Communicate on mental health and suicide with residents via the Internet and weekly newsletters, ensuring that they have the National Suicide Prevention Lifeline telephone number (800-273-TALK or 8255) at hand (along with other resources).
- Use initial screenings and assessments to inform care management. Assessments conducted when individuals consider residency may reveal baseline information about an individual’s wellness, including his or her social profile (e.g., loner or socially interactive) and level of involvement with family members. Later assessments may be useful in transitions or upon major losses.
- Develop a thorough understanding of HIPAA regulations to avoid unnecessarily bureaucratic barriers.
- Get to know staff as well as residents. Examine cultural and organizational barriers to implementation of suicide prevention efforts.
- Endeavor to link isolated individuals into the community.
- Articulate the fact that people are moving toward the end of their lives.

- Using the wellness model, offer opportunities for discussions of successful aging. Use “holiday blues” as a conversation starter on depression. Differentiate “down in the dumps” and a “bad day or week” from depression.
- Address anxiety about financial issues.
- Create a toolkit on addressing financial anxieties.
- Address the appropriateness of screening tools used by facilities with diverse populations.
- Students participate with senior living communities to fulfill community service requirements (e.g., Lifetime Legacy program that links students with older adults to make a record of an individual’s life. Evaluations have shown the program to be powerful.).

At-Risk Population Approaches

- Ensure approval by senior management of plans tailored by the care management team for individuals at risk. This practice fosters care managers’ efforts to do their best and may break down organizational, social, and cultural barriers to sharing.
- Help residents find meaning in life. Foster relationships among residents and between residents and staff.
- Arrange protocols to reach out to isolated residents (e.g., housekeepers pay particular attention, nurses make visits).
- Angry, isolated residents pose challenges. Staff members who get along with the resident may help with outreach.

Postvention Approaches

- Select and disseminate guidelines for management in dealing with the media and reaching out to survivors. See, for example, the guide posted by the Suicide Prevention Resource Center (www.sprc.org/library/media_guide.pdf).
- Post media messaging guidelines on the community’s Web site.
- Engage pastoral counselors and other trained staff members in postvention activities.
- Develop protocols for dealing with family, residents, paramedics, and others who come onto the scene of a crisis.

Public Health and Community Education Professionals, and Academic Gerontologist

Summit participants involved in the public health, community education, and gerontology fields discussed how to implement change, what is needed for change to happen, opportunities and obstacles, and current public health issues and solutions.

Whole-Population Approaches

- Engage the media. (The National Council on Aging [NCoA] plans to survey 60–100 reporters at an upcoming conference about stigma and suicide as a means to publicize the issue.)
- Build help-promoting environments. Develop print PSAs and post them in malls. Develop promotional items (e.g., stickers, magnets) to disseminate to assisted living facilities and nursing homes.
- Determine how to disseminate SAMHSA-developed or -funded information on best practices to enable knowledge utilization.
- Communicate with older adults using social networking vehicles (e.g., YouTube) and provide user training. This strategy can link homebound individuals into the community. Consider using intergenerational messages.
- Solicit TV stations or larger organizations to assume leadership roles in publicizing suicide prevention efforts.
- Improve networking opportunities by establishing partnerships with such organizations as the Institute for the Future of Aging. Share and develop information; host joint meetings.
- Shift from a treatment model to a prevention model, using messages of wellness to promote improved health.
- Promote networking among professional groups by convening a grant summit, perhaps sponsored by the Centers for Medicare and Medicaid Services. Recruit community-based organizations as well as large, influential, relatively resource-rich organizations.
- Engage the health care professional educators to incorporate information on aging in revised curricula. Address the need for incentives (e.g., fellowships) to generate interest in geriatric psychiatry. Schools of medicine, social work, psychology, and counseling that offer courses in geriatrics, for example, might work together with aging networks.

At-Risk Population Approaches

- Participate with NCoA/American Society on Aging and other organizations that work to enhance diffusion of evidence-based materials in depression care management. Time and funding are needed to facilitate the partnership and to move the suicide prevention efforts

for elders forward. The Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) program, for example, trains staff on suicide issues and resources to deal with suicide ideation. NCoA plans webinars on Healthy IDEAS and possibly PEARLS (Program to Encourage Active and Rewarding Lives for Seniors).

- To address older adults' financial issues, individuals can complete NCoA's anonymous online questionnaire to assess eligibility for Federal and State benefits (www.benefitcheckup.org).
- The public health sector should develop a plan to collect uniform population data and create a national database, identify organizations responsible for disseminating findings, and develop a plan for a data-driven program. Likely leadership candidates include the Centers for Disease Control and Prevention (CDC), American Federation of Assisted Living, and National Council of Assisted Living. Learn about how the Federal Maternal and Child Health Bureau collects data; States' quality improvement organizations can serve as resources.
- Invite the American Public Health Association and the National Association of State Mental Health Program Directors (NASMHPD) to join summit efforts.
- CDC's Behavioral Risk Factors Surveillance System recently published data on older adults.

Postvention Approaches

- State and local public health agencies should conduct training (on an ongoing basis) for broadcast and print media on guidelines to report suicides, including suicides among older adults.
- Engage State aging agencies in promoting mental health. (The Administration on Aging's network does not address suicide occurrences among older adults.)
- Suggested best practices for disseminating information to State offices:
 - Shift the focus of the Administration on Aging's network to healthy aging in conjunction with CDC, Appalachian Regional Commission, and National Institutes of Health.
 - Build a mental health component into a healthy aging approach.
 - Establish a caregiver initiative.
 - Connect with 211 telephone services (43 states have 211 links to an Information and Assistance Program on Aging and Disabilities).

- Attend conferences sponsored by, for example, the National Council on Older People, National Governors Association, State Medicaid Directors, National Conference of State Legislators, American Association for Homes and Services for Aging, and American Healthcare Association.
 - Host webinars, an inexpensive way to communicate to larger audiences on important topics.
 - Enlist State commissioners in efforts to promote suicide prevention among older adults.
- Address negative stereotypes in postvention. Inform the community about what to do in the aftermath of suicide.

Geropsychiatry, Geriatric Pharmacology, and Psychology Professionals

Professionals in geropsychiatry, geriatric pharmacology, and psychology discussed four major themes: models of mental health practice in senior living communities, workforce issues, professional training, and ethics.

Models of Mental Health Practice

- Few good models exist for geriatric professionals to engage actively in senior living communities.
- Survey best models and practices, both national and international, and disseminate findings.
- Recent mental health parity legislation may create opportunities for true collaboration between medical and mental health and substance abuse service providers.
- Best practices currently trend toward an interdisciplinary team model, in which both mental health and substance abuse specialty expertise is integrated into primary care in one-stop settings. This model contrasts with primary care practitioners taking on additional functions.
- Encourage senior living communities to offer periodic “mood and memory assessments”—a general term that implies many things without using language with negative connotations. The check-up would include attention to depression, cognitive functioning, sleep patterns, medications use, and polypharmacy and substance abuse issues.
- Expand the planning roles of geriatric professionals, particularly geropsychologists, at retirement communities.

- Develop models for bringing health care professionals into senior living communities; research internationally, as well as nationally, for guidelines.
- Promote team practice, rather than solitary practice, to coordinate care for older adults. Pharmacological problems are handled best in a collaborative care model that incorporates checks and balances. Improve monitoring of medications during check-ups rated against mood and memory check to eliminate unnecessary medications.
- Develop best practices and increase the evidence base specifically for older adults and suicide prevention.
- Incorporate substance use/abuse screening into check-ups; Alcoholics Anonymous and Narcotics Anonymous may increase detection of individuals experiencing problems.

Workforce Issues

- Lack of sufficient geriatric specialists in various professions and insufficient people entering the field pose major challenges.
- Provide incentives to recruit candidates for medical and other professional geriatric training, including tuition and loan forgiveness programs.
- Offer continuing education opportunities for practicing professionals.
- To compensate for the scarcity of consultation and staff support in rural and other underserved communities, use teleconferencing and other telehealth approaches.
- In addition to providing one-on-one services to older individuals, geriatric specialists serve in the areas of consultation and staff training. Explore reimbursement for engaging in those roles.
- Examine whether changes can be made to Medicare reimbursement/oversight policies as a mechanism to recruit individuals into specialty training to expand the geriatric workforce.
- Activities that promote well-being among older adults may be seen as not medically necessary—the “old car” analogy.

Professional Training Issues

- Training is needed on how to work on interdisciplinary teams. Systematic cross-training opportunities can include internships and lecture series.
- Training programs should stress exposure to well older adults, as well as to those with disabilities, to avoid students’ overly pathological view of working with seniors.

- Each discipline must be well informed about medication, polypharmacy, substance abuse, and mental health issues.
- Professionals must develop specific competencies in risk assessment for suicide and self-harm and in dealing with behavioral emergencies, and ways to test those competencies.
- Use Web-based resource centers in various fields to post information on best practices and models.
- Address gaps in professional training (e.g., incorporate topical curricula and competency assessments to ensure that providers can develop safety plans).
- Continuing education should include in-service and other mechanisms to maintain and update competencies.
- Determine the effect of the parity law for respective disciplines' future involvement and integration; it may create opportunities to increase the professions' scope and reach.
- Since most geriatric services are educational or consultative, it is difficult to secure Medicare and other reimbursement.
- High rates of staff turnover often lead to unnecessary repetition of medical procedures that are not reimbursed.
- Portray geriatrics as an attractive specialty relative to others by exposing candidates to healthy, vital older adults and decreasing the negative stereotypes of ageism.

Ethics

- Advocacy efforts must be directed to counteract general ageism, deal directly with death and mortality issues, and deal with infliction of self-harm.
- Advocacy should focus on reducing and eliminating negative stereotypes, improved reimbursement rates, and a Web portal for educational/advocacy materials/best practices.

13.

Postscript

In concluding the summit, Jerry Reed, Ph.D., M.S.W., director of the Suicide Prevention Resource Center, invoked the philosophy of the late Vice President Hubert H. Humphrey:

It was once said that the moral test of Government is how that Government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy, and the handicapped.

Reed called on participants to carry forward the summit's learnings and reminded them of the summit's theme, "It Takes a Community." He related the story line of *The Wizard of Oz* to the suicide prevention work that lies ahead:

Dorothy lands in Munchkin City and starts her journey on the yellow brick road. She first encounters a scarecrow who wishes he had a brain.

The summit offered knowledge about suicide prevention for whole populations, at-risk populations, and postvention.

Dorothy next comes across a tin man who wishes he had a heart.

The field of mental health requires heart—not just science, but people and emotions. Along with brains, let's use our hearts.

At the end of the journey, Dorothy encounters a lion who wishes he had courage.

It will take courage to pursue the work of suicide prevention with few new resources and much that needs to be accomplished.

We need to use our heads, follow our hearts, and use our courage to make a difference.

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