Suicide Assessment and Intervention Among Older Adults

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Disclosure Slide

- I have no actual or potential conflict of interest in relation to this program/presentation.

Outline:

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- Suggestions and Strategies
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- The Decision to Hospitalize
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Statistics

- The number of Americans aged 65 and older is projected to double from 46 million to more than 98 million by 2060.
- It will be the first time in history that the number of older adults outnumbers children under age 5.
- In addition, older adults will live longer than ever before: One out of every four 65-year-olds today
  - will live past age 90.
- The number of Americans over age 85 is increasing faster than for any other age group.
- The percentage of older persons who have completed high school has risen from 28 to 84 percent since 1970.
- The proportion of older adults living alone increases with advancing age. Among women aged 75 and over, almost half live alone.
- It is anticipated that the number of older adults with mental and behavioral health problems will almost quadruple, from 4 million in 1970 to 15 million in 2030.
- Mental health disorders, including anxiety and depression, adversely affect physical health and ability to function, especially in older adults.
- Some late-life problems that can result in depression and anxiety include coping with physical
  - health problems, caring for a spouse with dementia or a physical disability, grieving the death of loved ones and managing conflict with family members.

General Information

Many older adults may end their lives by refusing food and / or needed medications; however, these deaths are typically not officially deemed suicides.

Means of suicide differ by age, gender, and location.

Detection of suicide risk in older adults is crucial; interventions can then follow.

General Information

- Adult males aged 65 and older have the highest risk for suicide of any age group
- Older adults are more likely to use more lethal means (i.e. Firearms)
- Generally, **not** an impulsive act or decision, usually a deliberate act that does not allow for rescue
- Older adults are less likely than younger adults to use emergency interventions such as suicide hotlines

General Information

- Suicide in the older adult population is underreported
- Families advocate for cause of death to be listed as accidental
- Well-intentioned loved ones often minimize warning signs

General Information

"Older adult suicide is often triggered by elders' loss of control over health conditions or financial circumstances that results in feelings of hopelessness. (

Older men are at higher risk of committing suicide than older women. White males aged 85 and older are at the highest risk among all older adults.

According to Patrick Arbore, EdD, director of the Center for Elderly Suicide Prevention and Grief Related Services Institute on Aging in San Francisco. "An older person who is diagnosed with a complex illness such as cancer, Parkinson's, diabetes, dementia, etc. can trigger a depression," he says.

Losses that include the death of loved ones, pets, and even the potential loss of self can become extremely difficult to manage for elders, he says.

Fears surrounding the ability to maintain an independent living status "can arouse enormous anxiety, especially when the older person values autonomy above all else."

Source: http://www.todaysgeriatricmedicine.com/news/exclusive_03.shtml

Cultural factors that impact elderly suicide

Suicidal behaviors often result from experiencing humiliation and shame, lack of support from family members, failure to meet expectations or from environmental factors.

Although there are many services available—crisis hotlines, therapists, support groups— to those experiencing thoughts of suicide, the decision to seek help can be influenced by a person's cultural background.

"Just like there are cultural influences on one's view of physical health, there are cultural influences on how individuals might view their mental health distress," explains Senior Director of Education and Prevention of American Foundation for Suicide Prevention, Doreen S. Marshall, Ph.D."

Ethnic Groups and Suicide

In BIPOC populations, environmental factors often increase the likelihood of suicidal behavior.

Part of this shared cultural experience in African American families — like values, family connections, expression through spirituality or music, reliance on community networks and church — are enriching and can be great sources of strength and support.

However, another part of this shared experience is facing racism, discrimination and

inequity that can significantly affect a person's mental health.

Additionally, members of the BIPOC community face additional challenges accessing the care and treatment they need.

Risk and Protective Factors

Risk Factors

- Within the subgroup of older adults, risk for completion increases with age
- Caucasian and Male
- Previous suicide attempt(s)
- Diagnosis of a mood disorder
- Substance use disorder (prescription drug misuse and alcoholism)
- Loss of independent living
- Reduced Serotonin
- Poverty

Risk Factors

- Burdensomeness or fear of dependency
- Sudden onset of chronic illness
- Loneliness and Isolation
- Widowed
- Family history of suicide
- Hopelessness
- Relational, social, work, or financial loss
- Insufficient time to grieve losses: job, mobility, death of loves ones, health, income
- Loss of coping skills, problem-solving abilities

Protective Factors:

- Hope agency (goal-directed energy)
- Hope pathways (planning in order to accomplish goals)
- Optimism
- Religiosity
- Strong relationships with family members
- Social support
- Successful implementation of coping skills

Protective Factors:

- Interest in new activities
- Intact problem-solving ability
- Maintaining Independence

Assessment

Suicide Assessment & Prevention for Older Adults: **Warning Signs**

Remember "IS PATH WARM?"

- I Ideation
- S Substance Use
- P Purposelessness
- A Anxiety/Agitation
- T Trapped
- H Hopelessness/Helplessness
- W Withdrawal
- A Anger
- R Recklessness
- M Mood Changes

From the American Association of Suicidology (AAS) website (www.suicidology.org).

Assessment:

- Assessment is an ongoing process that relies on clinical judgment and should err on the side of caution
- Risk assessments are multimodal, typically involving several different sources of information
- Ask the tough questions

Suicide Assessment & Prevention for Older Adults: **Key Questions**

1. Ask about their feelings

- Do you feel tired of living?
- Have you been thinking about harming yourself and/or ending your life?
- Have you been thinking about suicide?

Suicide Assessment & Prevention for Older Adults: **Key Questions**

2. Ask about a suicide plan

- Have you thought of specific ways of hurting yourself or ending your life?
- Have you made any specific plans or preparations (giving away possessions, tying up 'loose ends')?
- Have you asked someone to help you end your life or join you in death?
- Do you have access to lethal means like a gun or other implements?
- Have you collected pills in order to take an overdose?
- Have you started to put a suicide plan into action?

Suicide Assessment & Prevention for Older Adults: **Key Questions**

3. Ask about their reasons to live

- What has kept you from harming yourself?
- Who or what makes life so worth living that you would not harm yourself?

What other questions could you ask?…

Assessment:

- Two major types of assessments: informal (unstructured) and formal (structured)
- Assessment Needs to Include:
  - Suicidal Intent- present/recent thoughts about killing oneself
  - Details of the suicide plan- the more specific, the more dangerous
  - Evaluate the access to means and the lethality of the means
  - History of suicidal attempts

Assessment Tools

- Biopsychosocial Assessment
- CANS
- ASI (Addiction Severity Index)
- Simple Screening Instrument for AOD Abuse Self Administered Form
- ASAM (American Society of Addiction Medicine)
- BDI (Beck Depression Inventory)
- CAGE Questionnaire
- Level of Care Utilization System (LOCUS)
- PRISM (Psychiatric Research Interview for Substance and Mental Disorders)
- Client's Assessment of Strengths, Interests, and Goals (CASIG)

Assessment

Look at case record at diagnosis and matching criteria for diagnosis in DSM

Mental status exam—pay specific attention to suicidal ideation at that time

Written history

History of substance use/Active Use

Family history of suicide

History of previous suicide attempts

- Single most reliable predictor of suicide attempt

Assessment:

- Stability of current mood
- Family history of suicide attempts
- Family history of mental disorders
- Client's mental state (via Mental Status Exam)
- Sleep problems
- Appetite problems
- Concentration Problems
- Substance Use
- Available support system
- Negative life events/stressors
- Willingness to comply with emergency plan

Formulating Risk

Intent	Plan & Lethality
Are suicidal thoughts/feelings present? • What are they? • Are they active/passive? • When did they begin? • How frequent are they? • How persistent are they? • Are they obsessive? • Can the client control them? • What motivates the client to die or to continue living?	**How far has the suicidal planning process proceeded?** • Specific method, place, time? • Available means • Planned sequence of events • Intended goal (death, Self-injury, other outcome) • Feasibility of the plan, access to means • Lethality of planned actions • Likelihood of rescue • What preparations have been made • Has the client rehearsed (i.e. rigging a noose, putting gun to the head) • HX of suicidal behavior

Suggestions and Strategies

Suicide Facts

People who are having thoughts of killing themselves are both relieved and grateful to have someone else bring it up

Many people *think* about killing themselves from time to time but most of them neither wish to die nor actually take their own lives

Clinician Responsibilities

- Know your legal obligations
  - Confidentiality rules
  - Who must you notify and when
  - What kind of notes should you keep about session
  - Follow up

Managing Safety and Treatment Planning

- High-risk suicidal clients can be safely and effectively treated on an outpatient basis if family
  - members or alternate caregivers are available to provide one-on-one support and supervision in the
  - home and if 24 hour acute care/community crisis stabilization/secure protected environment is available and accessible as required.
- When high risk does not dictate hospitalization, the intensity of outpatient treatment should vary in
  - accordance with risk indicators (e.g., more frequent appointments, telephone contacts, concurrent individual and group treatment).
- The availability of close supervision in the home setting must be assured in cases of high risk.
- Following a suicidal crisis, clients identified as high risk will benefit from intensive follow-up treatment.
- Note: Multiple attempts, psychiatric history, and current diagnostic comorbidity are some of the factors that indicate high risk.
- Video – "Suicide Risk Assessment"
- Video –"How to develop a Suicide Safety Plan"

- Source: https://www.health.gov.bc.ca/library/publications/year/2007/MHA_WorkingWithSuicidalClient.pdf

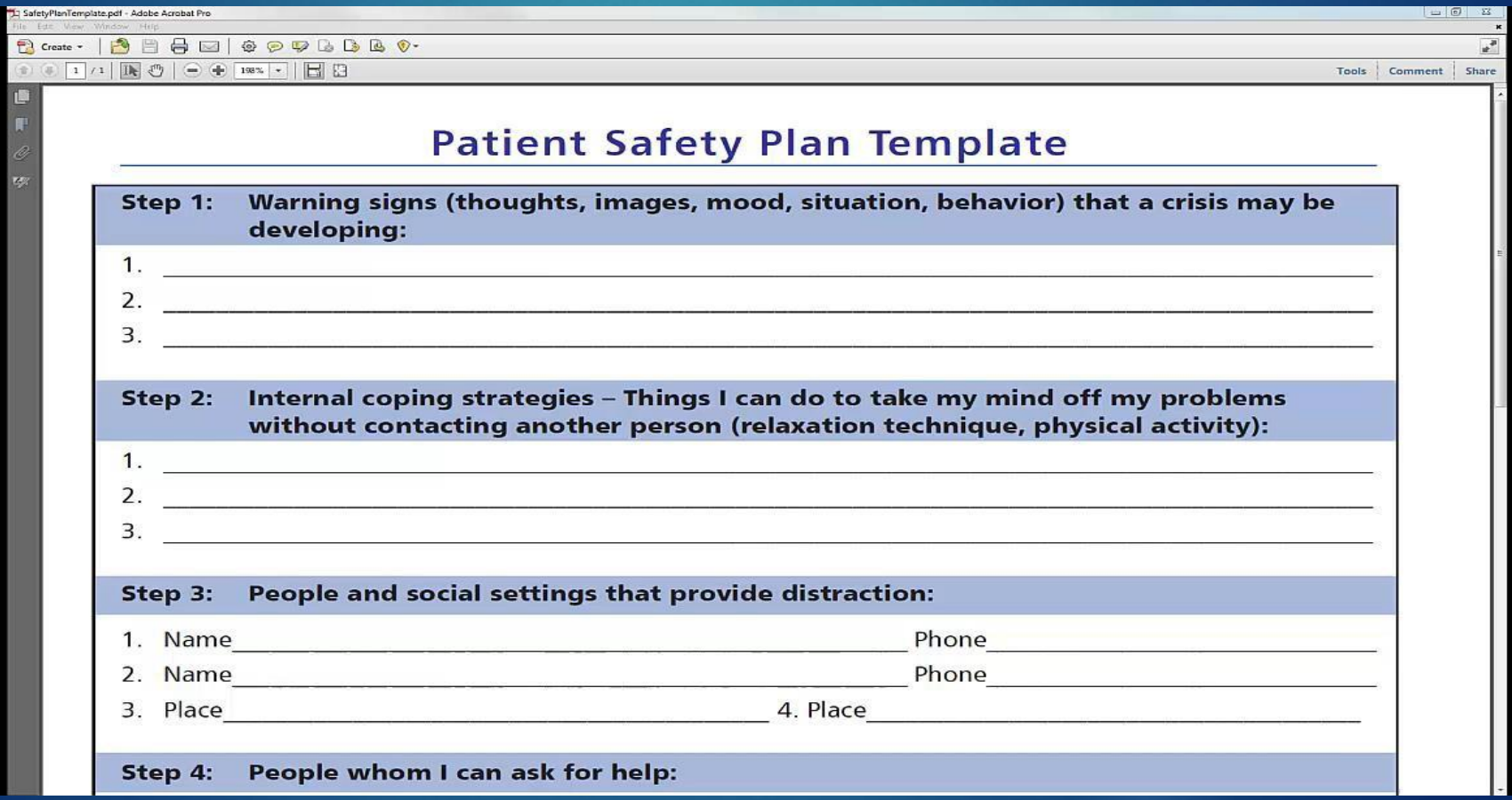
Short-term Intervention Strategies

- SEEK SUPERVISION/CASE CONSULTATION
- Assuring safety of client – Never leave Alone
- Crisis or emergency services necessary?
- Will Hospitalization Prevent Suicide?
- Is it the best option?
- Family or friends available to stay with client?
- Behavioral Contracts
- Providing a plan and resources for crisis (#'s, coping plans, action plans).

Safety Plan

- Warning signs, ask, "How will you know when this safety plan should be used?" and "what do you experience when you start to think about suicide?
- Coping strategies, ask, " What can you do if you become suicidal again?" Use collaboration, and problem solving to help them self define coping strategies.
- Social Contacts, Who May Distract From the Crisis, work with the client to help him/her understand that if step 2 doesn't work then try step 3, ask, "Who or what social setting help you take your mind off your problems? "Who helps you feel better when you are with them?", Help them identify potential safe places they can go to be around people,(peer support center, coffee shop) Ask the client to identify one or more additional safe places of people in case option one isn't available. The goal of this step is to distract the client from suicidal thoughts.
- Identify Family or Friends Who Would offer help, ask, "who among your family or friends do you think you could contact for help during a crisis, who do you feel you can talk to when under stress?" Ask for several people and their contact information, ask "May I call them now with you to be sure they feel they can do this?"
- Professionals and Agencies, ask, " who are the mental health professionals that we should identify to be on your safety plan?" List names contact information, in include crisis response and other supports such as the suicide lifeline.
- Making the Environment Safe, Ask about lethal means availability, assure there is a plan to restrict access, include family and significant others to assure removal of means.

How to develop a Suicide Safety Plan



SafetyPlanTemplate.pdf - Adobe Acrobat Pro

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

Outpatient Management

- Outpatients at mild suicide risk can usually be managed with recurrent evaluation and monitoring of suicidality
- Outpatients at moderate risk usually need intensified treatment such as increase in visits, frequent evaluation of risk
- Approach aimed at problem solving and adaptive coping (appropriate for mild-moderate risk)

Decision to Hospitalize

- Needed when establishment of treatment alliance and crisis intervention fails, and the client remains acutely suicidal
- The accepted protocol for clients at imminent risk is inpatient care.
- Voluntary or involuntary hospitalization is based on the clinicians estimate of risk-benefit ration
  - Hospitalization can be a traumatic experience

Inpatient Management

- Require a structured environment with clinically trained staff
- Assessment of imminent risk of self-harm should be conducted once admitted
- Psychopharmacology and psychotherapeutic interventions introduced as early as possible
- Psychopharmacology used to target high risk symptoms thus reducing potential for self-harm
- Continuity of care for inpatient to outpatient is necessary to mitigate against possible suicide during postdischarge period.

Therapeutic Interventions:

- Solution-focused Therapy
- Dialectical Behavioral Therapy
- Psychopharmacology
- Electroconvulsive Therapy
- Family Therapy
- CBT

Therapeutic Approaches:

- Family Therapy
  - Work to ameliorate family dysfunction
  - Improve communication and accountability among family members without generalizing or assigning blame
  - Establish new reality within the family

Family Involvement

- Involve Clients and Family in the Treatment
- Planning Process -Use individual and family approaches, including
- psychoeducation programs to treat the underlying factors
- or disorder (e.g., depression education, including self-management
- information).
- Teaching the family what might trigger an event or how to identify risk is empowering for family members and increases their understanding and support of the client's difficulties.
- Acknowledge their helpful contributions.

Therapeutic Interventions:

- Electroconvulsive Therapy
  - Used as a last resort
  - Highly controversial
  - Clients should be informed that this treatment may cause confusion or memory problems

Importance of Language:

- "Commit suicide"
  - Commit implies sin or crime
- Use "died by suicide" or "completed suicide"
- Language choice should be trauma informed but direct
  - "Do you have a plan to complete suicide?"
  - "Do you have the means to die by suicide?"
  - "Do you have a time frame?"

Prevention:

- Decrease access to lethal means
  - Restrict access to firearms
  - Restrict access to prescription drugs
- In community treatment or community living:
  - Implement efforts to reduce stigma and normalize help-seeking
  - Address barriers of seeking help

Prevention:

- Increase client knowledge of treatable risk factors and available services
- Promote social networks
  - Encourage attending enjoyable group activities
  - Encourage relationships with family
- Provide access to spiritual or faith services

Saint Louis Resources for Older Adults:

- St. Louis Area Agency on Aging
- Aging Ahead
- County Older Resident Program
- Department of Health and Senior Services
- VOYCE (formerly Long-Term Care Ombudsman Program)
- Mission St. Louis
- Provident Crisis Hotline: 314 647 4357
- Behavioral Health Response: 314 469 6644

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