Suicide in Older Adults: Assessing Risk

What Is Assessing Suicide Risk in Older Adults?
› Suicide by older adults is a serious global public-health problem: rates of completed suicide among older adults are higher than those of persons in any other age group. A social worker has at least a 1 in 5 chance of having a client commit suicide. It is crucial that social workers learn how to assess suicide risk accurately
• What: Suicide is a death that is self-inflicted with evidence that the individual intended to die. Intention is key: the actual suicide rate likely is higher than the reported rate because of the number of hidden suicides among older adults. These may take the form of intended overdose or noncompliance with medication or medical treatment
• How: There are risk assessments the social worker can conduct to evaluate the level of lethality of suicide ideation (i.e., the likelihood of the suicide attempt resulting in death) and the intensity of risk present. The social worker can then collaborate with the client on a plan to reduce that risk
  – There are several components that contribute to the level of lethality
    - Intent to die
    - A client with an intent to die might take provisions to avoid intervention
    - Availability of the method for suicide (e.g., gun in the home, access to lethal drugs)
    - Social acceptability of the method (e.g., women are less likely to use a firearm)
    - Medical lethality of the method
    - Studies have shown that using a firearm is the most deadly method of suicide, followed by hanging; using drugs to commit suicide has the lowest percentage of attempts resulting in death. Therefore, when a client is discussing suicide, the means he or she is planning to use contributes to the overall lethality of his or her ideation or intention (e.g., a male client discussing shooting himself would have a higher level of lethality than a male client discussing overdosing on sleep medication)
  – There is no one standard or scale to assess lethality that has been rigorously tested or verified. There are scales available but social workers should use their own interviewing skills to assess risk
• Where: Assessing suicide risk in older adults may be performed in any setting in which health care, mental health care, or other services are provided to older adults, including inpatient, outpatient, hospice, home care, and community mental health settings
• Who: Social workers, nurses, physicians, psychiatrists, psychologists, and/or other mental health clinicians are responsible for assessing suicide risk

What Is the Desired Outcome of Assessing Suicide Risk in Older Adults?
› The desired outcome of assessing suicide risk in older adults is identification of any present or future suicide risk, assessment of the lethality or likelihood of death from the potential suicide attempt and intensity of that risk if present, and collaboration with the client on an acceptable plan to reduce the risk

Why Is Assessing Suicide Risk in Older Adults Important?
› In the United States older adults have the highest rate of suicide, even higher than that of adolescents
They are at a high risk for depression, which increases the risk of suicide. Older adults are more likely to have physical health problems and loss of support (due to death and incapacitation of spouses and friends), which also are contributing risk factors. Older adults have frequent contact with the medical community, creating numerous opportunities for social workers and other staff/clinicians to assess for these risk factors and attempt to mitigate them.

**Facts and Figures**

- The World Health Organization (WHO) reported that in 2012 there were 800,000 suicides worldwide and that rates of suicide were highest among those 70 years old and older (World Health Organization, 2014).
- In the United States older adults are 3 times more likely to die by suicide than persons in any other age group (Aging Today, 2016). In South Korea the suicide rate for older adults is approximately 6 times higher than that in the United States (Park et al., 2016).
- In 2012 in the United States 16.3% of suicides were by persons age 65 and older, who made up 13.75% of the population; of those suicides, 83.6% were by men; and the overall suicide rate among those over 65 was 15.4 per 100,000, with older non-Hispanic White men having a rate of 32.24 per 100,000 (American Association of Suicidology, 2014).
- 1 in 4 suicide attempts in the United States among older adults is successful, compared to 1 in 100–200 attempts by persons of all other age groups; firearms are the most often used method of attempted suicide among older adults (72.1%), with men using them more often than women (American Association of Suicidology, 2014).
- The World Health Organization’s 2014 report on suicide noted that suicide rates by age vary from region to region, although some general patterns related to income levels are apparent: low- and medium-income countries have higher rates of suicide among young adults and older women than high-income countries, and high-income countries have higher rates of suicide among middle-aged to older men than low- and medium-income countries (World Health Organization, 2014).
- Between 28% and 33% of mental health social workers have had experience with fatal client suicide behavior and over 50% have had experience with nonfatal suicide behavior (Ting et al., 2008).

**What You Need to Know Before Assessing Suicide Risk in Older Adults**

- There are three elements that need to be present for a suicide to take place:
  - A specific plan
  - A plan with significant medical lethality (e.g., firearm versus pills versus cutting wrists)
  - Access to a deadly method (e.g., if the client talks about using a gun, does he or she own a gun?)
- Asking someone if he or she is having suicidal thoughts does not make him or her more likely to act upon those thoughts, and in fact has been shown to reduce risk.
- There is no one measure that is sensitive enough to consistently identify those who will commit suicide, or accurate enough to avoid false positives.
- Absolute prediction of suicide is not possible since it is a relatively uncommon behavior, there are many risk factors involved, and risk factors change with age and with circumstances (e.g., spousal loss, home loss).
- Actual rates for suicidal ideation may be higher than those indicated by research because of reporting bias (i.e., subjects denying ideation).
- There are risk factors for suicide that are specific to older adults:
  - Age (especially between 75 and 85)
  - Low socioeconomic status
  - Male gender
  - White
  - Living alone/isolation
  - Chronic illness
  - Chronic pain
  - Severe pain and pain that is not well controlled have been shown to increase risk of self-harm
  - Cognitive impairment
  - Feelings of hopelessness and despair
  - Recent personal losses (especially loss of one’s spouse)
  - Other losses
    - Economic
    - Social
• Substance abuse
• Intimate partner violence
• Family history of suicide
• Prior suicide attempts or ideation
• Dysfunctional coping skills
• Lack of a support system
• Feelings of worthlessness
• Fear of dependence or perceived burdensomeness, particularly among men, who tend to place a high value on autonomy
• Sleep problems

› A psychiatric diagnosis can be a risk factor, but individuals without psychiatric disorders commit suicide
› Close to 75% of individuals who commit suicide have made at least one prior attempt; a failed attempt does not mean an individual will not try again

› Mental health services may be underutilized by older adults because of
• Stigma of mental illness with this population
• Decreased ease of mobility (e.g., walking)
• Decreased ability to get to appointments (e.g., ability to drive)
• Lack of physician knowledge of geriatric-specific programs
• Lack of availability of geriatric-specific programs

› Depression in older adults frequently is misidentified, or not identified at all
• Signs of depression in older adults may be misinterpreted by physicians as symptoms of aging. Older adults also may have nondysphoric depression (i.e., depression without sadness), also called masked depression. Depression in older adults may be characterized by
  – Reporting of fewer mood-related symptoms
  – Fatigue
  – Trouble sleeping
  – Trouble concentrating
  – Memory issues
  – Lack of initiative
  – Weight loss
  – Irritability
  – Anxiety, worry, rumination
  – Denial of sadness or loss of interest/pleasure in activities

› If a depressed older adult shows an improvement in mood, this does not necessarily mean that his or her risk for suicide has decreased. Sometimes when an individual has made a decision to commit suicide his or her mood improves

› Older adults should be assessed for so-called passive suicide ideation (i.e., a desire to die or belief that life is not worth living versus an active plan to commit suicide), which was found by one study usually to indicate the presence of significant risk factors for suicide (Van Orden et al., 2014)

› Social workers may want to utilize the Beck Hopelessness Scale or Geriatric Suicide Ideation Scale in risk assessment

› In older adults, suicide attempts or completed suicides may not be obvious
• Passive suicide is when an older adult tries to hasten his or her death through behavior that is self-harming, including noncompliance with health care and indulging in destructive behaviors (e.g., drinking and then driving)

**Social Work Responsibilities in Regard to Assessing Suicide Risk in Older Adults**

› Explain clearly to client the limits of confidentiality when there are threats of self-harm. Ensure that the client understands that other members of the care team are there to help as well and that the social worker cannot keep a secret if it is related to the client hurting him- or herself

› If risk is present, determine if the risk is imminent, short-term, or long-term
  • Imminent risk is when it is determined that the client is likely to attempt suicide within the next 48 hours
  • Short-term risk is when the likelihood for attempting suicide is measured in days to weeks
  • Long-term risk is when risk factors indicate there is a sufficient risk for suicide in the future

› Conduct a risk assessment by asking key questions
  • What has been most difficult for you recently?
  • Have things become so bad you have thought about escaping? If yes, how?
• Are there times when death seems like an attractive option?
• Have you thought about hurting yourself?
• Have you thought about killing yourself?
• If you were going to hurt yourself, how would you do it?
• Do you have access to what you would need to carry out your plan?
• Have you thought about hurting yourself or have you hurt yourself in the past?
• What has kept you from hurting yourself so far?
• What might help you to not hurt yourself in the future?

› Determine if there is a need for hospitalization
› Treat or refer for treatment of any underlying mental health diagnoses, such as major depression
› Develop a collaborative, problem-solving approach to help the client to develop a suicide prevention plan rather than contracting for safety (which has been shown to be less effective)
› Plan should include alternatives to suicide, specific steps the client can take if he or she experiences suicidal thoughts, and alternative coping strategies (e.g., relaxation, distraction, music, exercise, contacting a friend)
› Provide or refer the older adult for individual and/or family therapy as appropriate
› Encourage family and friends to provide increased social support to the older adult who is at risk
› Social workers should practice with awareness of and adherence to the National Association of Social Workers (NASW) Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to suicide in older adults and practice accordingly

Other Interventions That May Be Necessary Before, During, or After Assessing Suicide Risk in Older Adults

› Remove access to lethal means
› Document carefully any conversations with a client regarding suicide and what steps were taken in response
› The social worker needs to be aware of potential barriers to access services. These may include:
  • Lack of immediate access to a service provider
  • Poor mobility
  • Transportation difficulties

What Social Work Models Are Used with Assessing Suicide Risk in Older Adults?

› Biologic/genetic theory aligns most closely with depression linked to suicide; it posits that low levels of serotonin and norepinephrine may contribute to a suicide decision. The genetic portion of the theory points to the tendency for suicide to run in families. This may indicate a genetic predisposition or it may occur because suicide was demonstrated as an acceptable coping mechanism, which is not biologic or genetic, but rather environmental. There may also be a genetic basis for depression
› Psychological theory examines the motivating forces behind suicide. Suicide may be considered an escape from psychological pain, including intense feelings of helplessness and hopelessness
› Sociological theory considers suicide as a reflection of the alienation the individual feels from others or society. Cultural factors may be involved, and may apply particularly when the client is an immigrant. An individual may feel that he or she is trapped or made powerless by factors such as being jobless, poor, or aged if the individual feels as if society has made him or her jobless, poor, or unsupported in older age
› Use a culturally competent model in which social workers are aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Furthermore, social workers must adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice

Red Flags

› Psychosis can produce symptoms of suicidal behavior as a result of command hallucinations
› Self-mutilation can be an indicator of suicide risk
› Surviving family and friends of a suicide victim are at risk for complicated grief and have a higher risk of committing suicide themselves
› The Geriatric Depression Scale may be less accurate if the older adult has dementia
References


