

OLDER AMERICANS BEHAVIORAL HEALTH

Issue Brief 4: Preventing Suicide in Older Adults



Suicide in Older Adults

An estimated 8,618 older Americans (ages 60+) died from suicide in 2010. Although the rate of suicide for women typically declines in older age, it increases with age among men. Older men die by suicide at a rate that is more than seven times higher than that of older women. The incidence of suicide is particularly high among older, white males (30.3 suicides per 100,000). Notably, the rate of suicide in the oldest group of white males (ages 85+) is over four times higher than the nation's overall rate of suicide.¹

There are several important risk factors for suicide in older adults. These include, among others:²

- Depression,
- Prior suicide attempts,
- Marked feelings of hopelessness,
- Co-morbid general medical conditions that significantly limit functioning or life expectancy,
- Pain and declining role function (e.g., loss of independence or sense of purpose),

Introduction and Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults. This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA and AoA are providing technical expertise and tools, particularly in the areas of anxiety, depression, and alcohol and prescription drug use and misuse among older adults, and are partnering to get these resources into the hands of aging and behavioral health professionals.

This Issue Brief is intended to help health care and social service organizations develop strategies to prevent suicide in older adults by providing:

- Information on the prevalence, risk factors, and lethality of suicide attempts in older adults;
- Recommendations on universal, selective, and indicated prevention strategies;
- Guidance for health and human service professionals on how to assess suicide risk and take appropriate actions to keep an older adult safe; and
- Suggestions and Resources to help aging services, behavioral health, and primary care providers develop and adopt effective suicide prevention programs.

- Social isolation,
- Family discord or losses (e.g., recent death of a loved one),
- Inflexible personality or marked difficulty adapting to change,
- Access to lethal means (e.g., firearms),
- Alcohol or medication misuse or abuse, and
- Impulsivity in the context of cognitive impairment.

Suicide attempts are often more lethal in older adults than in younger adults. Older people who attempt suicide are often more frail, more isolated, more likely to have a plan, and are more determined than younger adults. These factors suggest that older adults are less likely to be rescued, and are more likely to die from a suicide attempt than younger adults. Firearms are the most common means of suicide in older adults (67%), followed by poisoning (14%) and suffocation (12%).¹ Of note, older adults are nearly twice as likely to use firearms as a means of suicide than are people under age 60.¹ The lethality of older adult suicide attempts suggests that interventions must be aggressive and that multiple prevention methods should be used.

Prevention is the Key

Prevention of suicide in older adults requires many different strategies. Multi-layered prevention initiatives that combine universal, selective, and indicated prevention strategies may provide the greatest benefit in reducing suicide in older adults.²⁻⁴

Universal prevention focuses on the entire population. These strategies try to reduce risk factors for suicide and improve older adult health. They are usually done through providing information and improving the skills of older people and their caregivers. Selected recommendations²⁻⁴ include:

- Implement depression screenings.
- Provide education on factors associated with increased suicide risk and protective factors.
- Provide education on suicide prevention, “hot lines,” and local crisis team referral.
- Limit access to means of suicide, such as firearms.

Selective prevention targets people who are at increased-risk for suicide, but who may not display suicidal thoughts or behavior. Examples include older adults who experience life transitions (e.g., retirement, move from a home) or losses (e.g., death of a spouse/partner, painful chronic illness) that make them vulnerable to depression and suicide. Selective prevention efforts try to reduce risk factors for suicide or improve resilience. Some examples²⁻⁴ include:

- Focus services on reducing disability and enhancing independent functioning.
- Increase provider awareness of the losses that are important to older people, such as retirement, loss of drivers license, and loss of important body functions (e.g., vision, mobility).
- Increase provider awareness of substance abuse and mental health problems in older adults.

- Make systematic screening tools available to staff in medical and non-medical settings, and train staff to screen for suicide risk.
- Address social isolation and lack of access to social support for at-risk older adults.

Indicated prevention efforts aim to prevent suicide among older adults who have survived a suicide attempt or are at high-risk for suicide. Because of the close association between depression and suicide, the detection and effective treatment of depression are keys to reducing suicides. Routine screening for depression can be done with many instruments, such as the PHQ-9 (<http://www.phqscreeners.com>) and the Geriatric Depression Scale (GDS) (<http://www.stanford.edu/~yesavage/GDS.html>). A variety of psychotherapy and antidepressant medications are effective at treating symptoms of depression and can reduce suicidal ideation in some older adults (see Resources: *Treatment of Depression in Older Adults EBP KIT*). Selected recommendations²⁻⁴ include:

- Train professionals to detect, intervene, and manage depression and suicide risk.
- Implement practice guidelines for detection and management of suicide in later life.
- Reassure the depressed or hopeless older adult that his/her existence is meaningful and appreciated and that his/her well-being is important. Examples include home visits, regular postcards or phone calls, and connection to alarm central for immediate help when needed (e.g., TeleHelp-TeleCheck).
- Take action to ensure the safety and effective treatment of older adults who are at imminent risk for suicide (see below).

Assessing and Acting upon Suicide Risk

Aging service, behavioral health, and primary care providers can play an important role in preventing suicide by identifying at-risk older adults and taking appropriate follow-up actions. The goal of assessing suicide risk in an older person is to help determine the most appropriate actions to keep the older person safe.

Suicidal thoughts are often a symptom of depression and should always be taken seriously. *Passive* suicidal thoughts (also termed death ideation) include thoughts of being better off dead. They are not necessarily associated with increased risk for suicide but are a sign of significant distress and should be addressed clinically. The extent to which death ideation increases suicide risk is not known, and more research is needed. In contrast, *active* suicidal thoughts include thoughts of taking action toward hurting oneself. These thoughts are of immediate concern and require further assessment and intervention. The last question of the PHQ-9, a depression scale commonly used in many health care settings, asks: “In the last 2 weeks, have you had any thoughts of hurting or killing yourself?” If an older adult responds positively to a question about thoughts of self-harm, he or she is considered to have “active suicidal ideation” and should be asked additional follow-up questions, such as those in the P4 Screener⁵ (http://depression.acponline.org/content/all/tools/dcg_o08.pdf):

- **Past suicide attempt:** “Have you ever attempted to harm yourself in the past?”
- **Suicide plan:** “Have you had thoughts about how you might actually hurt yourself?” (*This could include thoughts of timing, location, lethality, availability of means, and preparatory acts.*)
- **Probability (perceived):** “How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?”
- **Preventive factors:** “Is there anything that would prevent or keep you from harming yourself?”

KEY ACTIONS

Lessons Learned from the Field

Positive answers to any of these questions should be discussed with a qualified mental health professional to determine the degree of urgency and steps for further assessment and intervention. Older adults who have thoughts about killing themselves with a plan and intent to act should not be left alone but should be supervised for their safety until emergency services are in place.

Timely and appropriate response to active suicidal thoughts can prevent suicide in older adults. Different levels of action should be taken for any endorsement of suicidal ideation.

- Using the algorithm of the “P4 Screener,”⁵ for an older adult showing **low risk** (i.e., suicidal thoughts without endorsement of “past suicide attempt” or “suicide plan”), suggested actions include: expressing concern, getting “buy in” to inform the older adult’s primary care provider, urging that the older adult remove means, consulting a supervisor within 24-48 hours, and identifying possible coping strategies.
- For an older adult with **moderate risk** of suicide (i.e., active suicidal thoughts with either a “suicide plan” or a “past suicide attempt”), the previously mentioned actions should be taken, consultation/supervision should be sought, and interventions such as phone check-ins and repeat assessments should be considered.
- For an older adult at **high risk** of suicide (i.e., active suicidal thoughts with a “past suicide attempt” or “suicide plan” as well as endorsement of “probability of acting or intent and/or lack of “preventive factors”), a supervisor/consultant should be called immediately without leaving the older adult alone, and emergency services should be considered (e.g., emergency room, mobile crisis, or 911).



Aging service, behavioral health, and primary health care providers and administrators can take important steps to prevent suicide in older adults.

Key Actions for Aging Services Providers

By delivering in-home and community-based services to older adults, aging service providers are in a unique position to identify older adults at-risk for depression or suicide. Suggested actions include:²⁻⁴

- Train aging service providers (and laypersons) to identify warning signs and refer to services those older adults who are at-risk for depression or suicide (e.g., “gatekeeper” training).
- Introduce depression and suicide screening in the course of non-clinical activity (e.g., senior day care, senior transportation, senior companions).
- Provide systematic outreach to assess and support high-risk older adults (e.g., recently widowed, socially-isolated older men) in improving life conditions and addressing issues and needs that can reduce stress.

Key Actions for Behavioral Healthcare Providers

Thoughts of death and suicidal ideation are common among older persons who are receiving mental health or substance abuse treatment. Behavioral health providers can take a variety of actions to reduce risk for suicide:²⁻⁴

- Screen for suicidal ideation among older adults receiving mental health or substance abuse treatment.
- Increase the effectiveness of behavioral health services by implementing evidence-based practices for depression, tracking outcomes systematically, and taking steps to improve treatment compliance (see Resources: *Treatment of Depression in Older Adults EBP KIT*).
- Offer assertive help after a suicide attempt and help the older adult explore realistic future perspectives.

Key Actions for Primary Healthcare Providers

Among older adults who die by suicide, approximately 77% see a primary care provider within their last year of life and 58% do so within their last month of life.⁶ Key actions for primary care providers include:²⁻⁴

- Implement routine standard screening for depression and suicidal ideation.
- Optimize diagnosis and treatment of late-life depression by using collaborative depression care management interventions (e.g., IMPACT: Improving Mood, Promoting Access to Collaborative Treatment—<http://impact-uw.org>; PROSPECT: Prevention of Suicide in Primary Care Elderly—<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=257>).
- Optimize treatment of pain, sleep problems, or other physical symptoms that can decrease an older adult’s quality of life and increase suicidal thoughts.
- Communicate with older suicidal patients before treatment, and include relatives and/or friends or caregivers in treatment talks.
- Develop and use registries to identify and monitor persons after a suicide attempt.

Actions for Coordination, Integration, and Financing of Services

Partnerships, coordination of care, and integration across service settings can help meet the needs of older adults who are at-risk for suicide. Financing outreach, case identification, and appropriate treatment can be a challenge. Consider the following options:

- Many treatments for depression are reimbursed through Medicare, Medicaid, and private insurance.
- Some services may be funded by private foundation support.
- Outreach, case identification, and telephone check-in programs can be performed by well-trained volunteers.
- Braided funding options incorporate funding from multiple funding streams.

Resources



Selected SAMHSA Suicide Prevention Resources:

<http://www.samhsa.gov/prevention/suicide.aspx>

- National Suicide Prevention Lifeline; 1-800-273-TALK: <http://www.suicidepreventionlifeline.org>
- Suicide Prevention Resource Center: <http://www.sprc.org>
- National Action Alliance for Suicide Prevention: <http://www.actionallianceforsuicideprevention.org>
- National Strategy for Suicide Prevention: <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html>

Selected SAMHSA Reports and Toolkits

- Center for Mental Health Services. *Promoting emotional health and preventing suicide: A toolkit for senior living communities*. HHS Publication No. SMA 4515, CMHS-NSPL-0197. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011. <http://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515>

- Center for Mental Health Services. *Treatment of depression in older adults evidence-based practices (EBP) KIT*. HHS Publication No. SMA-11-4631. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011. <http://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD>
- Center for Substance Abuse Treatment. *Addressing suicidal thoughts and behaviors in substance abuse treatment. Treatment Improvement Protocol (TIP) Series 50*. HHS Publication No. (SMA) 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/SMA09-4381>
- Haney EM, O'Neil ME, Carson S, Low A, Peterson K, Denneson LM, et al. *Suicide risk factors and risk assessment tools: A systematic review*. VA-ESP Project #05-225, 2012. <http://www.hsrp.research.va.gov/publications/esp/suicide-risk.cfm>

Works Cited

- ¹ Injury Prevention & Control: Data & Statistics (WISQARSTM). *Fatal Injury Reports*. [Accessed October 25, 2012]. <http://www.cdc.gov/injury/wisqars/fatal.html>
- ² Conwell Y, Van Orden K, Caine ED. (2011). Suicide in older adults. *The Psychiatric Clinics of North America*, 34(2): 451–468.
- ³ Erlangsen A, Nordentoft M, et al. (2011). Key considerations for preventing suicide in older adults: Consensus opinions of an expert panel. *Crisis*, 32(2): 106–109.
- ⁴ Lapierre S, Erlangsen A, et al. (2011). A systematic review of elderly suicide prevention programs. *Crisis*, 32(2): 88–98.

- ⁵ Dube P, Kurt K, B et. al. (2010). The p4 screener: evaluation of a brief measure for assessing potential suicide risk in 2 randomized effectiveness trials of primary care and oncology patients. *Primary Care Companion to the Journal of Clinical Psychiatry*, 12(6).
- ⁶ Luoma JB, Martin CE, Pearson JL. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, 159(6): 909–916.



OLDER AMERICANS
Behavioral Health
Technical Assistance Center

2012



Substance Abuse and Mental Health Services Administration

SAMHSA

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)