

## Suicide risk in the elderly

This guide for emergency department (ED) staff is based on the document *Working with the suicidal person: clinical guidelines for emergency departments and mental health services*. All ED clinicians should review the *Clinical guidelines* carefully to become familiar with the assessment and management of persons with suicidal behaviours, and then use the *Quick Reference Guides* to help remember major decision points.

Attempted suicide in the elderly is a very serious matter. ED staff are advised to remain vigilant to the presence of suicide risk factors in older people who present to EDs, as older people are more likely to have few social supports and are frailer in general, so self-injurious acts are more likely to have lethal consequences. Older adults have a tendency to minimise or underreport depressive or suicidal symptoms. Instead, they are more likely to complain of somatic symptoms of depression, such as insomnia, weight loss, guilt feelings and pain. The presence of physical illness should not detract from a close examination of an older person's mental state. Likewise, psychiatric presentations in the elderly may mask deterioration in physical health, so it is necessary to rule out organic causes in seemingly mental health presentations.

### 1. General guidelines

- Refer all older adults presenting with self-harm or attempted suicide for a specialist psychogeriatric assessment by a suitably trained medical practitioner.
- Consider all such aged people for admission to an aged-psychiatry inpatient unit.
- Conduct a thorough and systematic assessment of suicide risk factors for each older adult. In particular, screen for depression with or without concurrent anxiety, lack of social supports, and previous suicide attempts.
- Strengthen the assessment with good history-taking from the person and also from as many collateral sources as possible, particularly when cognitive impairment is suspected.
- Enhance health status and function by initiating treatment or improving management of underlying conditions, such as chronic pain or depression.
- Contemplate discharge only if a comprehensive psychosocial assessment and aftercare plan can be arranged before discharge.
- Regularly follow-up with active clinical contact, particularly in the immediate post-discharge period (the first month).
- Reassess older people at risk of suicide after the appropriate length of time indicated by the level of assessed risk.

## 2. Assessment

- Use multidisciplinary teams to provide rapid assessment of older people in EDs, but augment this with a specialist assessment at the registrar level or above.
- Enquire about medication history. Seemingly low quantities of ingested medications can have adverse effects in the elderly.
- Both depression and lack of social supports, which are significant risk factors for suicide among the elderly, can be readily screened for at presentation and are amenable to intervention. Helpful questions that focus on social supports include:
  - In the past two weeks, has someone provided you with help, either by giving you a ride somewhere or helping you around the house?
  - In the past two weeks, have others let you know they care about you?
  - Do you have someone special you could call if you need help? Who?
  - In general, how many people do you have that you feel close to and have contact with at least once a month?
- Assessing depth of hopelessness is as equally relevant in older adults as it is in younger individuals.
- Consider the possibility of more than one diagnosis to explain the presentation, since multiple pathologies are common. Liaise with aged-psychiatry services.
- Assess possible sensory impairment and communication problems. Is there a hearing problem? Is there a language difficulty? Does the person understand the clinician's questions? Is the person oriented? Is any confusion longstanding or has it arisen only as a sequel to an act of self-harm?
- Assess reasons for living (for example having a hobby, religious practice, integration in social networks and clubs, perceiving that life is meaningful and worth living).
- Assess the older person's functional status, for example activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

## 3. Management

- Where a clinical decision results in the person going home, follow-up assessment through specialised aged psychiatry services is highly recommended.
- Make a detailed record of contact and pass a copy onto the person's GP within 48 hours by fax.
- Schedule follow-up appointments and pursue missed appointments.
- Assign a case manager to encourage collaboration among care providers, for example social workers, GP, meals-on-wheels, home help, informal caregivers, family members.
- Make every effort to ensure that the person does not return to the same state of social isolation from which they came.

### Further information

You can download an electronic copy of this quick reference guide, the full *Clinical guidelines*, or the *Summary document* on the Department of Health website ([www.health.vic.gov/mentalhealth](http://www.health.vic.gov/mentalhealth)). The full guidelines contain all the recommendations, details of how they were developed and discussion of the evidence they were based on.

If you would like to receive this publication in an accessible format, please email: [tracy.beaton@health.vic.gov.au](mailto:tracy.beaton@health.vic.gov.au)

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