

Older Adult Suicide in Oregon

Recognition, Assessment & Prevention

Introduction

- Why integrate with primary care?
 - 93% of all Oregon elder suicides had an ongoing medical illness
 - 25% of all Oregon elder suicides had seen their primary provider within the month preceding their suicide

Quality of Life Issues Documented, Oregon Suicides Aged 65+, 2004

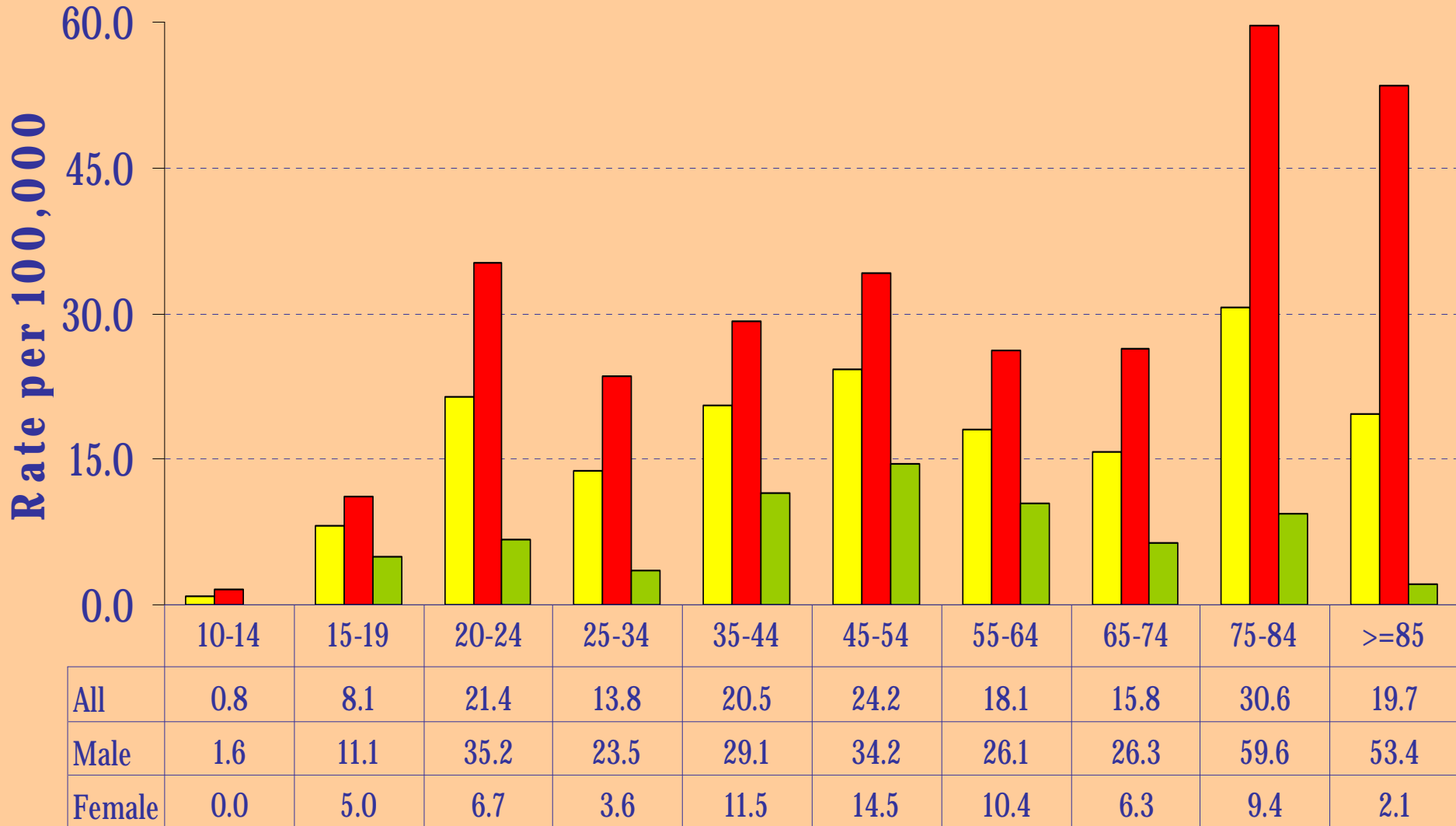
- 93% had at least one medical condition
- 68% had declining health
- 45% had a loss of autonomy or independence
- 45% were isolated or lived alone
- 25% had visited a physician in last 30 days
- 21% suffered from chronic pain

Demographics

- Suicide rate in the older adult is 54% greater than other age groups
- Older adult, white males are at especially greater risk (hence the population being targeted for prevention)

Age-specific rate of suicide, OR, 2006

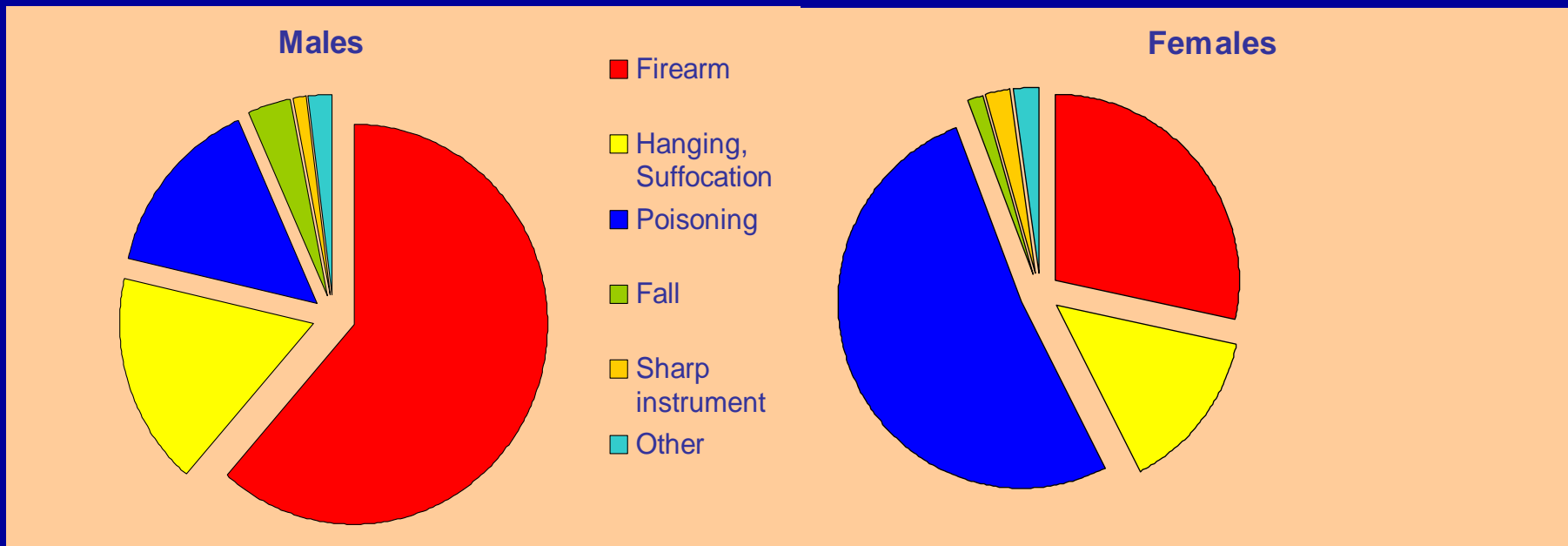
All Male Female



Source: OR Violent Death Reporting System

Age

Suicide methods by sex, OR, 2006



Depression in the Older Adult

- Consider DSM-IV diagnostic criteria
 - Depressed mood, anhedonia, guilt, etc
- Also look for:
 - Increased somatization
 - Increased irritability
 - Increased confusion
 - Delusions of illness, poverty

Myths of Geriatric Suicide

- Depression is a normal part of aging
 - “You’d be depressed to if...”
- Suicide is a rationale choice
 - “I’ve lived long enough”
- “There aren’t any other options”
- “My patient isn’t depressed so he’s probably not suicidal”

Risk Factors in Elder Suicide

- Male
 - Consistently demonstrated as one of the most important factors
- Depression¹
- Serious medical illness¹
- Family conflict¹
- Personality traits – rigid and lack of openness to new experiences (Duberstein, et al, 1994)

¹Waern M, et al; Gerontology, 2003; 49:328-334

Warning Signs (not inclusive)

- Loss of interest
- Cutting back on social interactions
- Overtly expressing suicidal thoughts or gestures, especially with developing plan
- Significant loss (death of spouse, etc)
- Breaking medical regimens
- Putting affairs in order

Warning Signs (cont)

- Stock-piling medications or other lethal means
- Insomnia (90%), weight loss (75%), hypochondriasis (50%), guilty feelings (50%) (Barraclough, 1971)

Protective Factors in Suicide

- Effective clinical care for underlying illnesses
- Access to interventions and support for seeking help
- Family or “community” support
- Medical or mental health care provider support
- Skills in problem-solving
- Cultural and religious beliefs

Protective Factors (cont)

- Future orientation/forward thinking
 - Hirsch, JK et al Am J Ger Psych 2006; 14:752-757
- Advancing dementia may be protective, but early dementia has received little attention (fears of dependency, impulse control dysregulation, etc)
 - Harris EC, et al Br J Psych 1997; 170:205-228

Meaning of Suicide in the Older Adult

- Bruno Bettelheim, MD – noted psychoanalyst committed suicide at 86y/o
 - Escaped the horrors of the Holocaust
 - Stressors late in life included:
 - Death of wife
 - Limiting stroke
 - Move from one coast to another
 - Move into retirement home
 - ??possible estrangement from a child

Meaning of Suicide (cont)

- Loss of identity
 - What is ones purpose in life
- Loss of independence
 - Failing health
 - Physical limitations
- Loss of support structures
 - Spouses and friends
 - Home
 - Hobbies and interests

Assessment of Suicidality

- Interview techniques
 - Mind ones own countertransference
 - How we feel towards the person or situation
 - Control the “crisis mode” – slow the pace!
 - Show empathic, nonjudgmental interactions
 - Ask for clarification, use open-ended questions
 - Use eye contact, do not bury oneself in notes
 - Allow time

Assessment (cont)

- Ask
 - Do not be afraid to ask the question; equally, do not be afraid of hearing the answer/response
 - Examples:
 - “Do you have thoughts of ending your life or killing yourself?”
 - “Do you have thoughts that others would be better off if you were not around?”
 - Avoid:
 - “You aren’t thinking of killing yourself are you?”
 - “You don’t want to do something like that do you?”

Assessment (cont)

- Inquire further
 - When did the thoughts start?
 - Thoughts of planning their suicide?
 - How far have they gone with their plan?
 - Who else knows about the thoughts/plan?
 - Will they allow you to talk with family/caregivers about their suicidal thinking?
 - What has kept them from acting on the thoughts thus far?

Assessment (cont)

- Inquire further (cont)
 - Availability of means (firearms, medications, etc)
 - Planning for after their death?
 - Updating their Will
 - Giving away or labeling possessions
 - Getting affairs in order
 - Prior suicide attempt?
 - Under current psychiatric care?
- Assess current risk factors
 - Presence or absence of risk factors in context of the overall clinical presentation

Assessment (cont)

- Under development
 - Geriatric Suicide Ideation Scale (GSIS)
 - Scale to assess suicidal thinking in the older adult
 - Not yet clinically available
 - Heisel J, et al Am J Ger Psych 2006; 14:742-751

Crisis Intervention

- Access emergency services for imminently high risk
- County mental health crisis telephone number
- Community mental health center (if they have a crisis walk-in center)
- Develop a relationship with mental health provider ahead of time and make use of that relationship (not unlike relationships we have already with cardiologists, rheumatologists, etc)

Crisis Intervention (cont)

- Remove availability of lethal means
- Initiate treatment for underlying psychiatric illness (depression, anxiety, etc)
- Close follow-up
 - Ensure treatment compliance
 - Provide some forward-thinking for the patient
 - Provides ongoing opportunity to assess improvement or worsening in suicidal ideation

Crisis Intervention (cont)

- Telephone contact between visits
 - Bruce M, et al; Am Fam Phys, 2004 (PROSPECT)
 - de Leo D, et al; Br J Psych; 2002; 181:226-229

Treatment Options

- No specific psychopharmacologic treatment for acute suicidality
 - Electroconvulsive therapy may be effective
- Consider starting antidepressant based on symptom presentation, prior treatment history and current medical comorbidities
 - SSRI's and SNRI's generally first line

Treatment Options (cont)

- Consideration that antidepressants may increase the risk of suicidal ideation across most age groups (may be spurious in that antidepressant treatments early on partially treat the depression and the patient is still at risk for ongoing development of depression symptoms, like suicidal ideation)

Treatment Options (cont)

- Involve family and friends

“Pearls” in Older Adult Suicide

- Assessing depression symptoms should be a part of patient contact, especially in the high risk population (male, medically complex, complicated psychosocial situation)
- Directly ask about suicidal thinking – probe their answers to understand their thinking
- Initiate follow-up, treatment and referral promptly

Questions/Answers