American Foundation *for* Suicide Prevention

Suicide Prevention

Saving Lives
One Community at a Time

America Foundation for Suicide Prevention
Dr. Paula J. Clayton, AFSP Medical Director
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www.afsp.org

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Facing the Facts

An Overview of Suicide

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Facing the Facts

- In 2007, 34,598 people in the United States died by suicide. About every 15.2 minutes someone in this country intentionally ends his/her life.
- Although the suicide rate fell from 1992 (12 per 100,000) to 2000 (10.4 per 100,000), it has been fluctuating slightly since 2000 – despite all of our new treatments.

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Facing the Facts

- Suicide is considered to be the second leading cause of death among college students.
- Suicide is the second leading cause of death for people aged 24-34.
- Suicide is the third leading cause of death for people aged 10-24.
- Suicide is the fourth leading cause of death for adults between the ages of 18 and 65.
- Suicide is highest in white males over 85.
  (45.4/100,000, 2007)

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Facing the Facts

- The suicide rate was 11.5/100,000 in 2007.
- It greatly exceeds the rate of homicide. (6.1/100,000)
- From 1979-2007, 881,443 people died by suicide, whereas 550,304 died from AIDS and HIV-related diseases.

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Facing the Facts

Death by Suicide and Psychiatric Diagnosis

- Psychological autopsy studies done in various countries over almost 50 years report the same outcomes:
  - 90% of people who die by suicide are suffering from one or more psychiatric disorders:
    - Major Depressive Disorder
    - Bipolar Disorder, Depressive phase
    - Alcohol or Substance Abuse*
    - Schizophrenia
    - Personality Disorders such as Borderline PD

*Primary diagnoses in youth suicides.

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Facing the Facts

Suicide Is Not Predictable in Individuals

- In a study of 4,800 hospitalized vets, it was not possible to identify who would die by suicide — too many false-negatives, false-positives.
- Individuals of all races, creeds, incomes and educational levels die by suicide. There is no typical suicide victim.

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Facing the Facts

Suicide Communications Are Often Not Made to Professionals

- In one psychological autopsy study, only 18% told professionals of intentions*
- In a study of suicidal deaths in hospitals:
  - 77% denied intent on last communication
  - 28% had "no suicide" contracts with their caregivers" **
- Research does not support the use of no-harm contracts (NHC) as a method of preventing suicide, nor from protecting clinicians from malpractice litigation in the event of a client suicide***

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Facing the Facts

Suicide Communications ARE Made to Others

- In adolescents, 50% communicated their intent to family members*
- In elderly, 58% communicated their intent to the primary care doctor**

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Facing the Facts

Research shows that during our lifetime:

- 20% of us will have a suicide within our immediate family.
- 60% of us will personally know someone who dies by suicide.

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Facing the Facts

Prevention may be a matter of a caring person with the right knowledge being available in the right place at the right time.

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Myths Versus Facts About Suicide

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Myths versus Facts

- **MYTH:**
  People who talk about suicide don't complete suicide.

- **FACT:**
  Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously.

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Myths versus Facts

- **MYTH:**
  Suicide happens without warning.

- **FACT**:
  Most suicidal people give clues and signs regarding their suicidal intentions.

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Myths versus Facts

- **MYTH:**
  Suicidal people are fully intent on dying.

- **FACT**:
  Most suicidal people are undecided about living or dying, which is called "suicidal ambivalence." A part of them wants to live; however, death seems like the only way out of their pain and suffering. They may allow themselves to "gamble with death," leaving it up to others to save them.

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Myths versus Facts

- **MYTH:**
  Men are more likely to be suicidal.

- **FACT:**
  Men are four times more likely to kill themselves than women.
  Women attempt suicide three times more often than men do.

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Myths versus Facts

- **MYTH:**
  Asking a depressed person about suicide will push him/her to complete suicide.

- **FACT:**
  Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.

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Myths versus Facts

- **MYTH:**

  Improvement following a suicide attempt or crisis means that the risk is over.

- **FACT**:

  Most suicides occur within days or weeks of "improvement," when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts. The highest suicide rates are immediately after a hospitalization for a suicide attempt.

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Myths versus Facts

- **MYTH:**

  Once a person attempts suicide, the pain and shame they experience afterward will keep them from trying again.

- **FACT**:

  The most common psychiatric illness that ends in suicide is Major Depression, a recurring illness. Every time a patient gets depressed, the risk of suicide returns.

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Myths versus Facts

- **MYTH:**
  Sometimes a bad event can push a person to complete suicide.

- **FACT:**
  Suicide results from having a serious psychiatric disorder. A single event may just be "the last straw."

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Myths versus Facts

- **MYTH:**

  Suicide occurs in great numbers around holidays in November and December.

- **FACT:**

  Highest rates of suicide are in May or June, while the lowest rates are in December.

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Risk Factors For Suicide

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Risk Factors

- Psychiatric disorders
- Past suicide attempts
- Symptom risk factors
- Sociodemographic risk factors
- Environmental risk factors

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Risk Factors

Psychiatric Disorders

- **Most common psychiatric risk factors resulting in suicide:**
  - Depression*
    - Major Depression
    - Bipolar Depression
  - Alcohol abuse and dependence
  - Drug abuse and dependence
  - Schizophrenia

*Especially when combined with alcohol and drug abuse

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Risk Factors

- **Other psychiatric risk factors with potential to result in suicide *(account for significantly fewer suicides than Depression):***
  - Post Traumatic Stress Disorder (PTSD)
  - Eating disorders
  - Borderline personality disorder
  - Antisocial personality disorder

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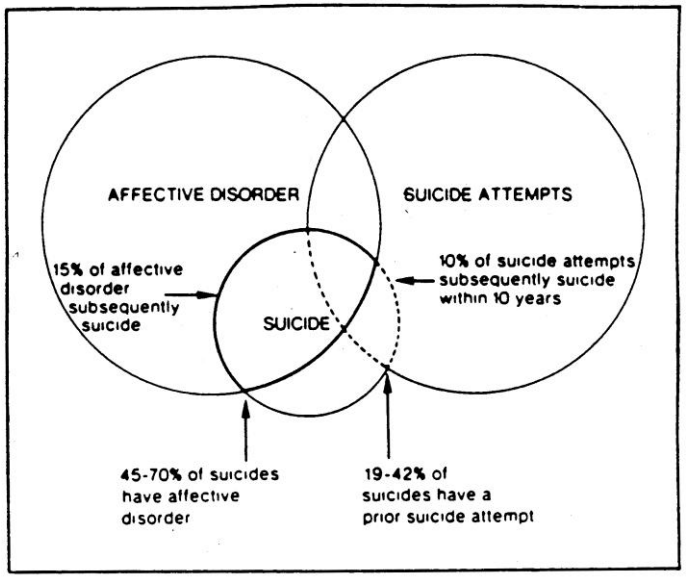
Risk Factors

Past suicide attempt

(See diagram on right)

- After a suicide attempt that is seen in the ER about 1% per year take their own life, up to approximately 10% within 10 years.
- More recent research followed attempters for 22 years and saw 7% die by suicide.



Venn diagram summarizing data concerning suicide and its relationship to affective disorder and suicide attempts.

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Risk Factors

Symptom Risk Factors During Depressive Episode:

- Desperation
- Hopelessness
- Anxiety/psychic anxiety/panic attacks
- Aggressive or impulsive personality
- Has made preparations for a potentially serious suicide attempt* or has rehearsed a plan during a previous episode
- Recent hospitalization for depression
- Psychotic symptoms (especially in hospitalized depression)

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Risk Factors

- Major physical illness, especially recent
- Chronic physical pain
- History of childhood trauma or abuse, or of being bullied
- Family history of death by suicide
- Drinking/Drug use
- Being a smoker

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Risk Factors

Sociodemographic Risk Factors

- Male
- Over age 65
- White
- Separated, widowed or divorced
- Living alone
- Being unemployed or retired
- Occupation: health-related occupations higher (dentists, doctors, nurses, social workers)
  - especially high in women physicians

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Risk Factors

Environmental Risk Factors

- Easy access to lethal means
- Local clusters of suicide that have a "contagious influence"

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Preventing Suicide
One Community at a Time

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Preventing Suicide

Prevention within our community

- Education
- Screening
- Treatment
- Means Restriction
- Media Guidelines

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Preventing Suicide

Education

- Individual and Public Awareness
- Professional Awareness
- Educational Tools

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Preventing Suicide

Individual and Public Awareness

- Primary risk factor for suicide is psychiatric illness
- Depression is treatable
- Destigmatize the illness
- Destigmatize treatment
- Encourage help-seeking behaviors and continuation of treatment

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Professional Awareness

- Healthcare Professionals
  - Physicians, pediatricians, nurse practitioners, physician assistants
- Mental Health Professionals
  - Psychologists, Social Workers
- Primary and Secondary School Staff
  - Principals, Teachers, Counselors, Nurses
- College and University Resource Staff
  - Counselors, Student Health Services, Student Residence Services, Resident Hall Directors and Advisors
- Gatekeepers
  - Religious Leaders, Police, Fire Departments, Armed Services

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Educational Tools

- Depression and suicide among college students:
  - *The Truth About Suicide: Real Stories of Depression in College* (2004)
    - Comes with accompanying facilitator's guide
- Depression and suicide among physicians and medical students:
  - *Struggling in Silence: Physician Depression and Suicide* (54 minutes)*
  - *Struggling in Silence: Community Resource Version* (16 minutes)
  - *Out of the Silence: Medical Student Depression and Suicide* (15 minutes)
    - Both shorter films are packaged together and include PPT presentations on the DVD's
- Depression and suicide among teenagers:
  - *More Than Sad: Teen Depression* (2009)**
    - Comes with facilitator's guide and additional resources
  - Suicide Prevention Education for Teachers and Other School Personnel (2010)
    - Includes new film, *More Than Sad: Preventing Teen Suicide, More Than Sad: Teen Depression*, facilitator's guide, a curriculum manual and additional resources

*received 2008 International Health & Medical Media Award (FREDDIE) in Psychiatry category
**received 2010 Eli Lilly Welcome Back Award in Destigmatization category

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Screening

- **Identify At Risk Individuals:**
  - Columbia Teen Screen and others
  - AFSP Interactive Screening Program (ISP):

    The ISP is an anonymous, web-based, interactive screen for individuals (students, faculty, employees) with depression and other mental disorders that put them at risk for suicide. ISP connects at-risk individuals to a counselor who provides personalized online support to get them engaged to come in for an evaluation. Based on evaluation findings, ISP was included in the Suicide Prevention Resource Center's Best Practice Registry in 2009. It is currently in place in 16 colleges, including four medical schools.

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Treatment

- Antidepressants
- Psychotherapy

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Preventing Suicide

Antidepressants

- **Adequate prescription treatment and monitoring**
  - Only 20% of medicated depressed patients are adequately treated with antidepressants – possibly due to:
  - Side effects
  - Lack of improvement
  - High anxiety not treated
  - Fear of drug dependency
  - Concomitant substance use
  - Didn't combine with psychotherapy
  - Dose not high enough
  - Didn't add adjunct therapy such as lithium or other medication(s)
  - Didn't explore all options including: ECT or other somatic treatment

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Psychotherapy

- **Research shows that when it comes to treating depression, all therapy is NOT created equal.**
    - Study shows applying correct techniques reduce suicide attempts by 50% over 18 month period
- **To be effective, psychotherapy must be:**
    - Specifically designed to treat depression
    - Relatively short-term (10-16 weeks)
    - Structured (therapist should be able to give step-by-step treatment instructions that any other therapist can easily follow)
- **Examples: C**ognitive **B**ehavior **T**herapy (CBT), **I**nter**p**ersonal **T**herapy (IPT), **D**ialectical **B**ehavior **T**herapy (DBT)
- **Implement teaching of these techniques**

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Means Restrictions

- Firearm safety
- Construction of barriers at jumping sites
- Detoxification of domestic gas
- Improvements in the use of catalytic converters in motor vehicles
- Restrictions on pesticides
- Reduce lethality or toxicity of prescriptions
  - Use of lower toxicity antidepressants
  - Change packaging of medications to blister packs
  - Restrict sales of lethal hypnotics (i.e. Barbiturates)

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Preventing Suicide

Media

- **Guidelines**
- **Considerations**

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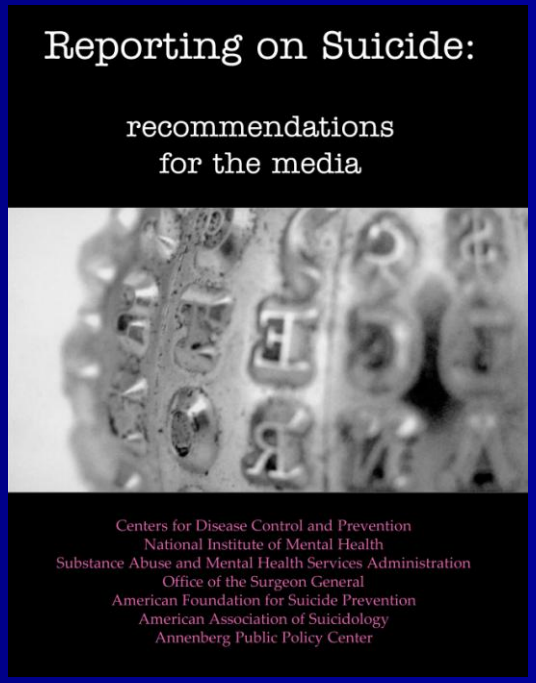
Preventing Suicide

Media Guidelines

- Encourage implementation of responsible media guidelines for reporting on suicide, such as those developed by AFSP in partnership with government agencies and private organizations.

Reporting on Suicide:
recommendations for the media

Can be found on AFSP website:
www.afsp.org/media



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Media Considerations

- **Consider how suicide is portrayed in the media**
  - TV
  - Movies
  - Advertisements
- **The Internet danger**
  - Suicide chat rooms
  - Instructions on methods
  - Solicitations for suicide pacts.

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You Can Help!

Adapted with permission
from the Washington Youth Suicide Prevention Program

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You Can Help

- **Know warning signs**
- **Intervention**

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You Can Help

- Most suicidal people don't really want to die – they just want their pain to end
- About 80% of the time people who kill themselves have given definite signals or talked about suicide

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You Can Help

Warning Signs

- **Observable signs of serious depression**
  - Unrelenting low mood
  - Pessimism
  - Hopelessness
  - Desperation
  - Anxiety, psychic pain, inner tension
  - Withdrawal
  - Sleep problems
- **Increased alcohol and/or other drug use**
- **Recent impulsiveness and taking unnecessary risks**
- **Threatening suicide or expressing strong wish to die**
- **Making a plan**
  - Giving away prized possessions
  - Purchasing a firearm
  - Obtaining other means of killing oneself
- **Unexpected rage or anger**

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Proposed DSM-V Suicide Assessment Dimension

Level of concern about potential suicidal behavior: (sum of items coded as present) 1. 0: Lowest concern 2. 1-2: Some concern 3. 3-4: Increased concern 4. 5-7: High concern		Suicide risk factor groups: 1. Any history of a suicide attempt 2. Long-standing tendency to lose temper or become aggressive with little provocation 3. Living alone, chronic severe pain, or recent (within 3 months) significant loss 4. Recent psychiatric admission/discharge or first diagnosis of MDD, bipolar disorder or schizophrenia 5. Recent increase in alcohol abuse or worsening of depressive symptoms 6. Current (within last week) preoccupation with, or plans for, suicide 7. Current psychomotor agitation, marked anxiety or prominent feelings of hopelessness

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Intervention

Three Basic Steps:

1. **Show you care**
2. **Ask about suicide**
3. **Get help**

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You Can Help

Intervention: Step One

- **Show You Care**
- **Be Genuine**

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You Can Help

- **Show you care**
  - **Take ALL talk of suicide seriously**
    - If you are concerned that someone may take their life, trust your judgment!
  - **Listen Carefully**
  - **Reflect what you hear**
  - **Use language appropriate for age of person involved**
    - Do not worry about doing or saying exactly the "right" thing. Your genuine interest is what is most important.

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- **Be Genuine**
  - **Let the person know you really care. Talk about your feelings and ask about his or hers.**
    - "I'm concerned about you… how do you feel?"
    - "Tell me about your pain."
    - "You mean a lot to me and I want to help."
    - "I care about you, about how you're holding up."
    - "I'm on your side…we'll get through this."

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Intervention: Step Two

- **Ask About Suicide**
- **Be direct but non-confrontational**

- **Talking with people about suicide won't put the idea in their heads.** Chances are, if you've observed any of the warning signs, they're already thinking about it. Be direct in a caring, non-confrontational way. Get the conversation started.

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You Can Help

- You do not need to solve all of the person's problems – *just engage them.* Questions to ask:
  - Are you thinking about suicide?
  - What thoughts or plans do you have?
  - Are you thinking about harming yourself, ending your life?
  - How long have you been thinking about suicide?
  - Have you thought about how you would do it?
  - Do you have __? (Insert the lethal means they have mentioned)
  - Do you really want to die? Or do you want the pain to go away?

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- Ask about treatment:
  - Do you have a therapist/doctor?
  - Are you seeing him/her?
  - Are you taking your medications?

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Intervention: Step Three

- **Get help, *but do NOT leave the person alone***
  - Know referral resources
  - Reassure the person
  - Encourage the person to participate in helping process
  - Outline safety plan

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You Can Help

Know Referral Resources

- **Resource sheet**
- **Hotlines**

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You Can Help

Resource Sheet

- **Create referral resource sheet from your local community**
  - Psychiatrists
  - Psychologists
  - Other Therapists
  - Family doctor/pediatrician
  - Local medical centers/medical universities
  - Local mental health services
  - Local hospital emergency room
  - Local walk-in clinics
  - Local psychiatric hospitals

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Hotlines

- **National Suicide Prevention Lifeline**
  - **1-800-273-TALK**
  - **www.suicidepreventionlifeline.org**
- **911**
  - **In an acute crisis, call 911**

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You Can Help

- **Reassure the person that help is available and that you will help them get help:**
  - "Together I know we can figure something out to make you feel better."
  - "I know where we can get some help."
  - "I can go with you to where we can get help."
  - "Let's talk to someone who can help . . . Let's call the crisis line now."
- **Encourage the suicidal person to identify other people in their life who can also help:**
  - Parent/Family Members
  - Favorite Teacher
  - School Counselor
  - School Nurse
  - Religious Leader
  - Family doctor

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You Can Help

- **Outline a safety plan**
  - Make arrangements for the helper(s) to come to you OR take the person directly to the source of help - do NOT leave them alone!
  - Once therapy (or hospitalization) is initiated, be sure that the suicidal person is following through with appointments and medications.

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Suicide and the Elderly

Paula Clayton, M.D.
Medical Director
American Foundation for Suicide Prevention

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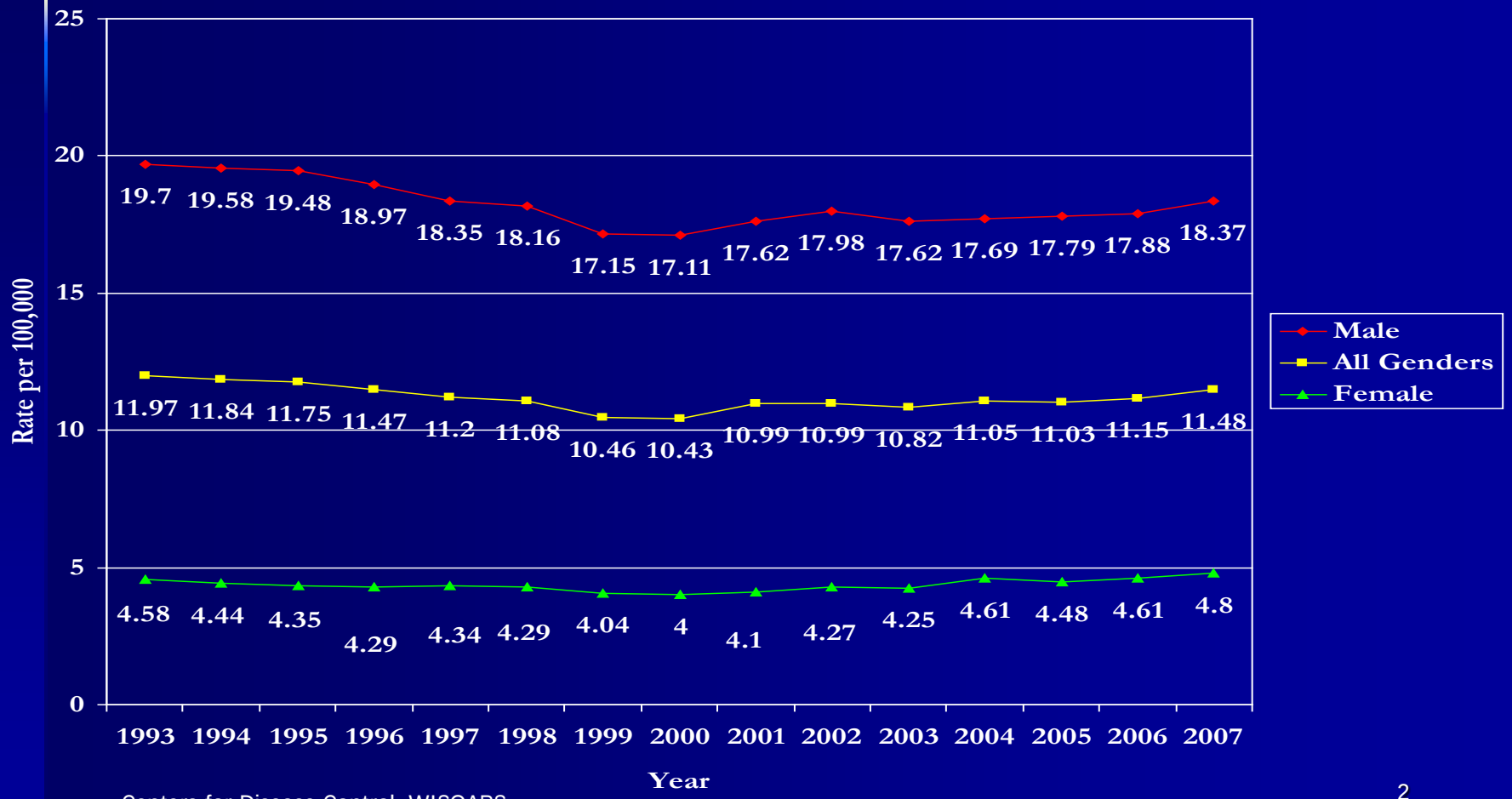
U.S. Suicide Rates by Gender and Year - All Ages



Centers for Disease Control, WISQARS.
http://www.cdc.gov/injury/wisqars/index.html

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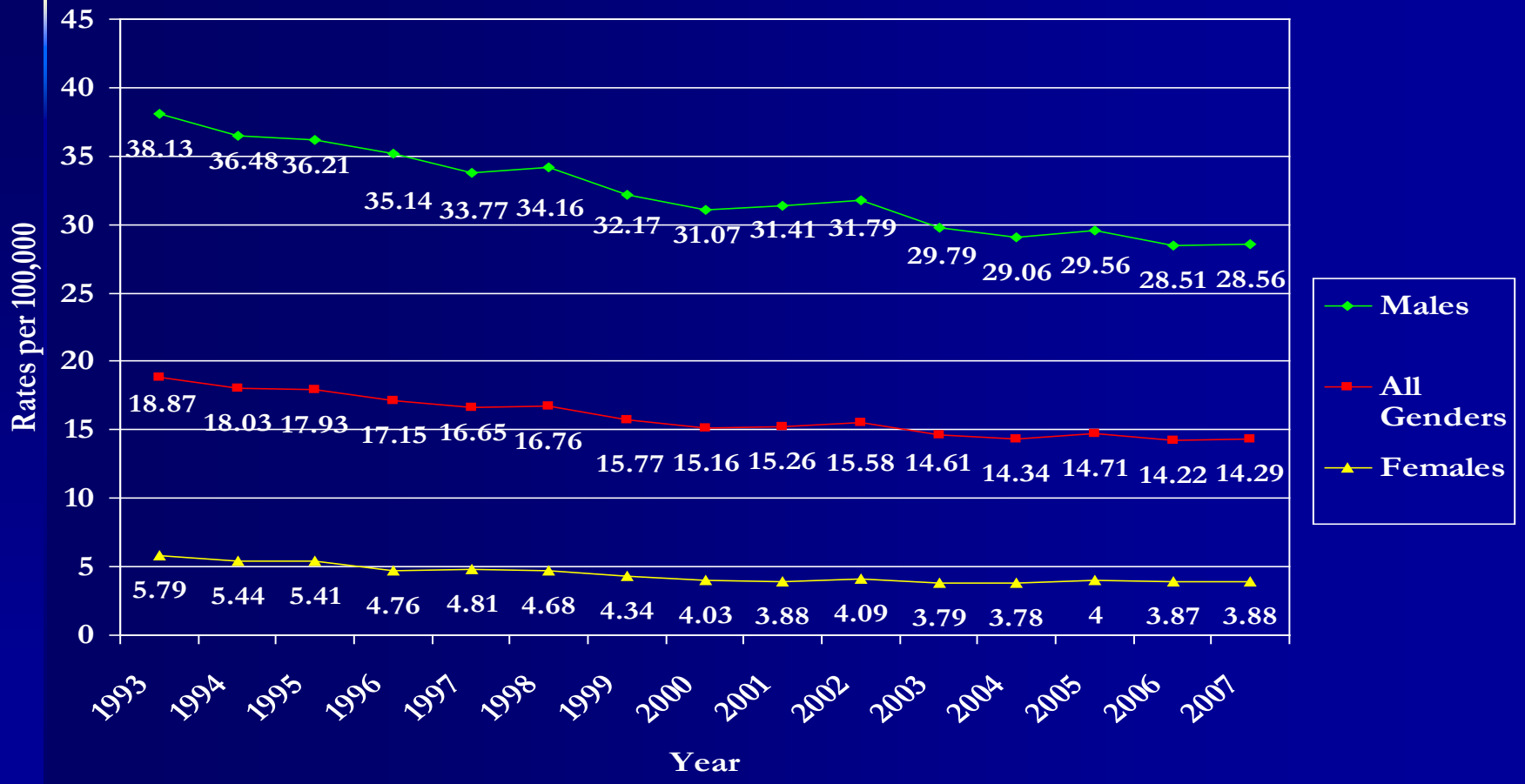
U.S. Suicide Rates by Gender, Age 65+



Centers for Disease Control, WISQARS.
http://www.cdc.gov/injury/wisqars/index.html

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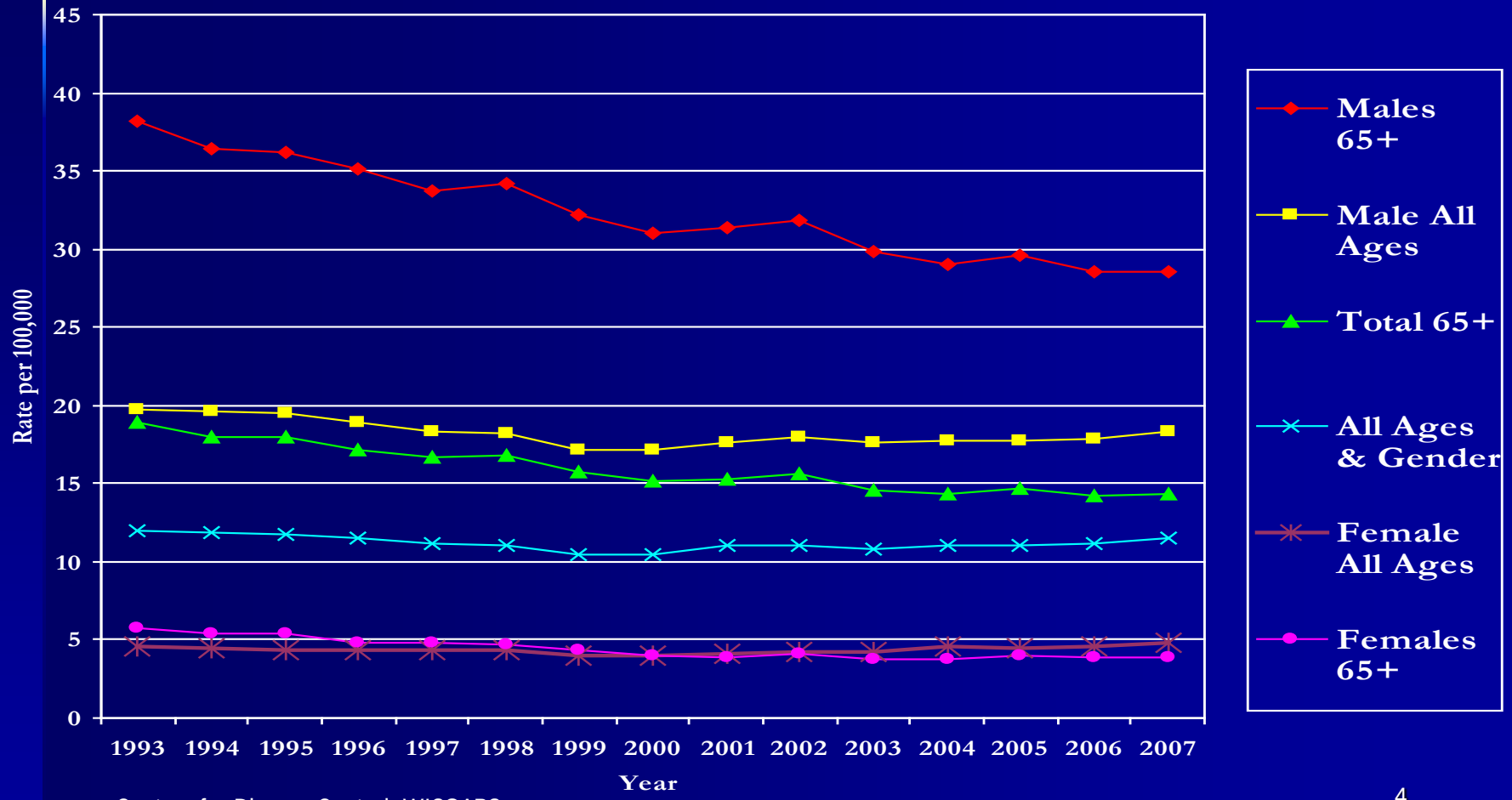
U.S. Suicide Rates of All Ages and Those 65+, by Gender



Centers for Disease Control, WISQARS.
http://www.cdc.gov/injury/wisqars/index.html

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Attitudes Towards Elderly Suicide

- Society is more accepting of death and dying with the elderly compared to adolescents: years of potential life lost much greater
- Less media attention towards elderly suicides
- Less attention in research and literature compared to adolescents and young adults

PubMed search of almost 10,000 articles from 1966-1999
21.4% included Ages 65+ (of these, 3.1% were 80+)

Conwell, Y., & Duberstein, P. (2001). Suicide in Elders, *Annals NY Academy of Science, 932*: 132-47.

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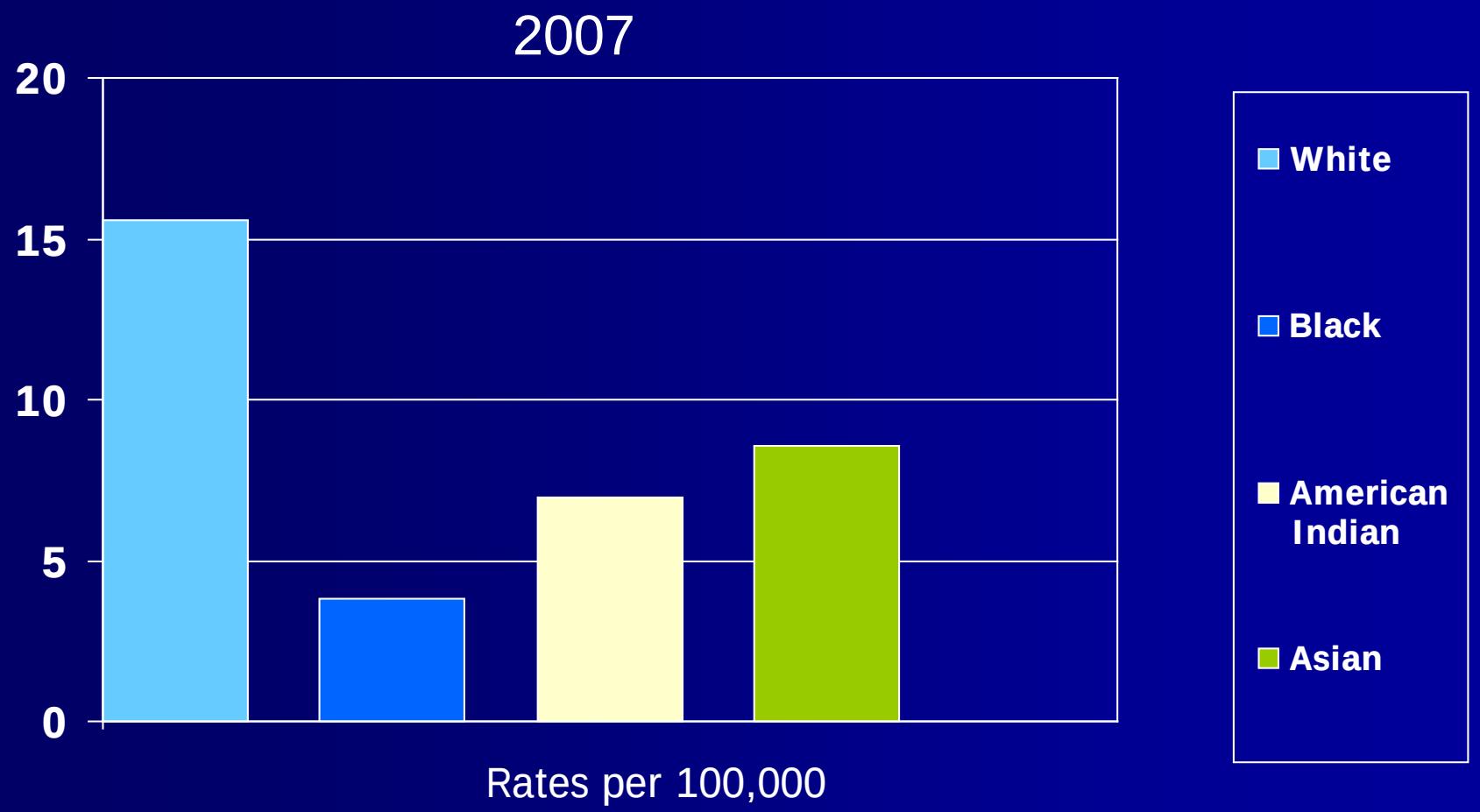
U.S. Suicide Rates - Ages 65+, By Race



Centers for Disease Control, WISQARS.
http://www.cdc.gov/injury/wisqars/index.html

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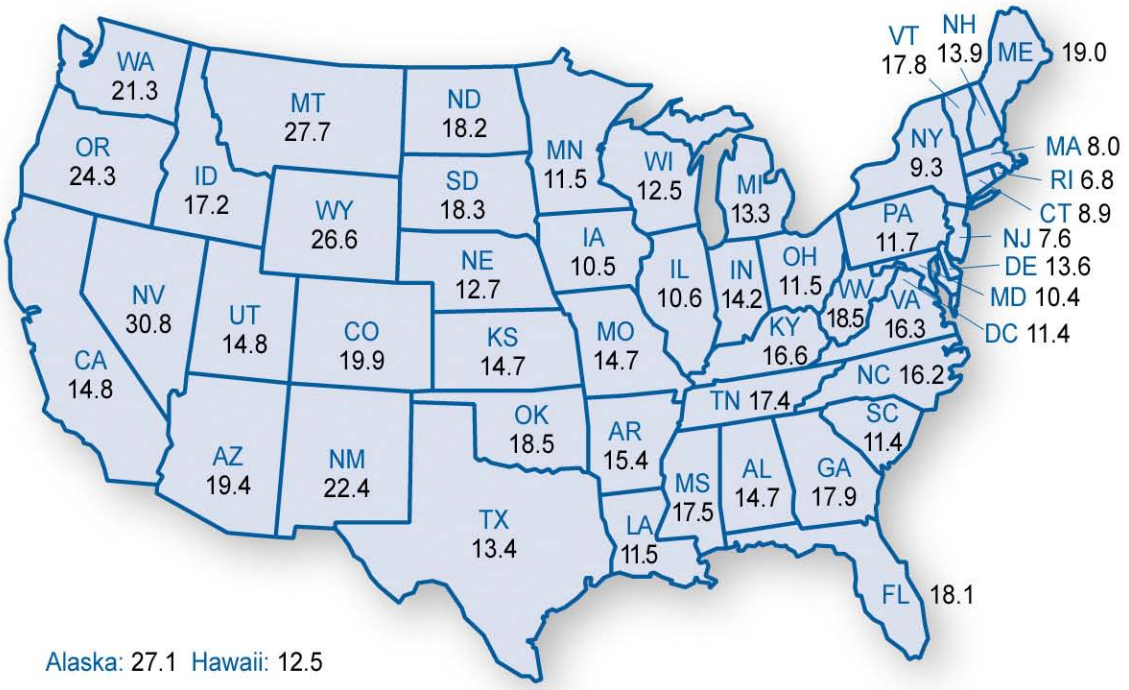
2007 State Suicide Rates Ages 65+
(per 100,000 population)



Centers for Disease Control. WISQARS. http://www.cdc.gov/injury/wisqars/index.html

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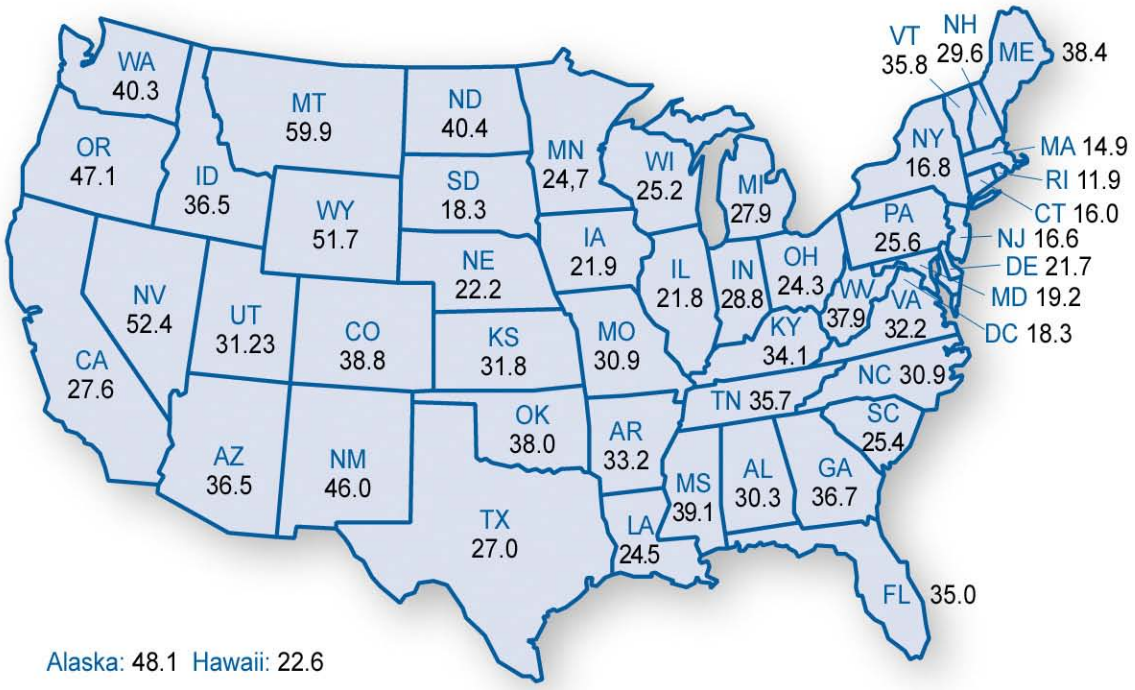
2007 State Suicide Rates for Males 65+
(per 100,000 population)



Centers for Disease Control. WISQARS. http://www.cdc.gov/injury/wisqars/index.html

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End of Life Care: Oregon's Death with Dignity Act (DWDA)

- Oregon Department of Human Services has (beginning fall of 2006) changed the term "physician-assisted suicide" to "physician-assisted death"
- Legalized physician-assisted suicide (PAS) in the state of Oregon since 1997

  2009: 59 Oregonians died by PAS

  Numbers have remained in the same +/- 5 range from 2002-2009, except in 2006 (46, eight more deaths) and 2008 (60, 11 more deaths)

  PAS deaths account for 19.3 in every 10,000 deaths

  2007 (Latest available data): 594 total suicides in Oregon

  211 suicides for those age 55+

  PAS statistics don't include people who use PAS outside of the DWDA

- As in prior years, most participants were between 55 and 84 years of age (78.0%), white (98.3%), well-educated (48.3% had at least a baccalaureate degree), and had cancer (79.7%). Patients who died in 2009 were slightly older (median age 76 years) than in previous years (median age 70 years).
- PAS users more likely to die at a younger age than general population 69 versus 76 years

Ertel, S. (2006, October 17). Oregon under fire for changing "assisted suicide" wording in reports. *LifeNews,* retrieved 10/18/2006 www.lifenews.com/bio1802.html

12th Annual Report on Oregon's Death with Dignity Act, March 2010

Centers for Disease Control, WISQARS. http://www.cdc.gov/injury/wisqars/index.html/

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End of Life Care: Oregon's Death with Dignity Act (DWDA) (cont.)

- Criteria:
  - 18 years of age or older
  - Capable of making and communicating health care decisions
  - Terminally ill with a life expectancy of < 6 months
  - Request to doctor for PAS made in writing and verbally
  - Prescribing doctor and consulting physician must agree
  - Medication must be administered orally

http://www.oregon.gov/DHS/ph/pas/docs/Requirements.pdf

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End of Life Care: Oregon's Death with Dignity Act (DWDA) (cont.)

- Males (53%) more likely than females (47%) to choose PAS
- Divorced and never-married more likely
- Under 85 years of age more likely
- Higher numbers of patients with Amyotrophic Lateral Sclerosis (ALS)
- Motivating factors:
  - Loss of autonomy
  - Loss of dignity
  - Decreased ability to participate in activities that make life enjoyable

12th Annual Report on Oregon's Death with Dignity Act, March 2010

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End of Life Care: Oregon's Death with Dignity Act (DWDA) (cont.)

- Upheld by United States Supreme Court decision in January 2006

  Gonzales v. Oregon (04-623)

- High level of palliative care system in Oregon thought to contribute to low numbers of assisted suicides in the state

8th Annual Report on Oregon's Death with Dignity Act, March 9, 2006

Okie, S. (2005). Physician-assisted suicide – Oregon and beyond. *New England Journal of Medicine 352* (16): 1627-30.

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Elderly Suicide in the U.S.: Statistics

- Completed suicides for ages 65 and over comprise nearly 16% of all suicides

  This age group is 12.6% of total U.S. population

- Method is overwhelmingly by use of firearms (not the case for Europe and elsewhere)

  71.9%: firearms

  11.1%: poisoning

  10.8%: suffocation (hanging)

  1.7%: falling

  1.1%: drowning

  0.5%: fire

Note: 50% of all suicides in the United States in the year 2007 used a firearm

Centers for Disease Control. WISQARS. http://www.cdc.gov/injury/wisqars/index.html/

United States Census Bureau, www.census.gov

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Characteristics of Elderly Suicide

- Fewer warnings of intent
- Attempts are more planned, determined
  2/3 have high suicide intent scores
- Less likely to survive a suicide attempt due to use of more violent and immediate methods

Conwell Y, Duberstein PR, Cox C, Herrmann J, Forbes N, & Caine ED. Age differences in behaviors leading to completed suicide. *American Journal of Geriatric Psychiatry,* 1998 6(2), 122-6.

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Characteristics of Elderly Suicide (cont.)

- More likely to have suffered from a depressive diagnosis prior to their suicide compared to younger counterparts
- Suicidal ideation less common in elderly (studies range from 1 to 36%)
- Ratio of attempts to completed suicide range from 4:1*

*Note: Ratio for younger female population is 200:1

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Risk Factors

- Suicide attempt
  - Regard all suicide attempts in the elderly as “failed suicide”
- Psychiatric disorders (77% of suicides, 63% of those were depressed)
- Physical illness, pain, and functional impairment
- Social isolation and decreased social support
- Marital status
  - Single, divorced, widowed

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Risk Factors - references

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Risk Factors (cont.)

- Recent bereavement

  Controversial- some case control studies show that it is not a factor*, other studies show it is in early bereavement** and other after more than one year ***

  Oldest old men (age 80+) experience highest increase in suicide risk immediately after the loss**

- Access to means (especially firearms)****
- Financial burdens may or may not be a risk factor for the elderly

* Rubenoqitz, E., Waern, M., Wilhelmson, K., & Allebeck, P. (2001) Life Events and psychosocial factors in elderly suicides: A case-control study. *Psychological Medicine 31* (7), 1193-1202.

** Erlangsen, A., Jeune, B., Bille-Brahe, U., & Vaupel, J. W. (2004). Loss of partner and suicide risks among oldest old: A population-based register study. *Age and Ageing, 33* (4), 378-83

*** Harwood, D. M. J., Hawton, K., Hope, T., Harriss, L., & Jacoby, R. (2006). Life problems and physical illness as risk factors for suicide in older people: A descriptive and case-control study. *Psychological Medicine 36* (9), 1265-1274.

**** Conwell, Y., Duberstein, P. R., Connor, K., Eberly, S., Cox, C., Caine, E. D., (2002). Access to firearms and risk for suicide in middle-aged and older adults. *American Journal of Geriatric Psychiatry10*(4), 407-16.

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Psychiatric Disorders and Medical Illness

- Study using coroner reports and medical records of all Ontario residents age 66 or older who died by suicide from 1992-2000 (n=1354) Control Group: 4 patients for each experiment subject

- Research points to major depression as the highest risk factor for suicide in the elderly

  Bipolar depression also a high risk factor

- Other illnesses associated with an increased risk were:

  severe pain
  congestive heart failure
  chronic lung disease
  seizures

  <u>but not:</u>

  diabetes
  breast cancer
  prostate cancer

- A patient with three or more illnesses had a three-fold increase in risk for suicide

Juurlink, D. N., Herrmann, N., Szalai, J. P., Kopp, A., & Redelmeier D. A. (2004). Medical illness and the risk of suicide in the elderly. *Archives of Internal Medicine 164*, 1179-1184.

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Physical Illness, Life Factors and Suicide

- Psychological autopsy study of 100 suicides in 5 English counties, ages 60+
- 82% suffered from physical health problems which were a contributing factor in 62% of suicides
- 55% presented interpersonal problems, which were a contributing factor in 31% of cases
- 47% had “bereavement related problems”. Bereavement was a contributing factor in 25% of cases
- 15% had financial problems; they were a contributing factor in 10%

Harwood, D. M. J., Hawton, K., Hope, T., Harriss, L., & Jacoby, R. (2006). Life problems and physical illness as risk factors for suicide in older people: A descriptive and case-control study. *Psychological Medicine 36* (9), 1265-1274.

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Elderly Suicide Without Psychiatric Illness

- Psychological autopsy study of 23 completed suicides, from 4 counties in England*
- 57% had some kind of physical illness investigators felt was a main contributing factor in 39% of the sample
- 48% had a “bereavement problem” (type not specified) in the year before their death
- 44% with personality trait accentuation (display of strong traits of personality types, but not severe enough to meet criteria for personality disorder)
- 25% had life-threatening illness
- 13% with no major disorders had significant depressive symptoms

* The subjects came from a 2001 study by the authors in the International Journal of Geriatric Psychiatry, Issue 16, pp155-165

Harwood, D. M. J., Hawton, K., Hope, T., & Jacoby, R. (2006). Suicide in older people without psychiatric disorder. *International Journal of Geriatric Psychiatry, 21*, 363-367.

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Alcohol and Suicide

- Estonian study, psychological autopsy on 427 cases from 1999 (*all ages*)
- Living control group of 427 from 2002-2003, selected from GPs

Alcohol abuse was found in 10% of suicide cases

Alcohol Dependence was found in 51% of suicide cases

In men, alcohol abuse and dependence (AAD) was a significant predictor of completed suicides

In women, abstinence was a significant predictor of completed suicides

Doctor recognized symptoms of alcoholism in only 25% of cases in both groups

Compared to previous study, proportion of women suicide cases with AAD rose alarmingly (from 5% to 29%)

Kõlves, K., Varnik, A., Tooding, L-M., & Wasserman, D. (2006). The role of alcohol in suicide: A case-control psychological autopsy. *Psychological Medicine 36*(7), 923-30.

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Suicide in Nursing Homes

- Psychological autopsy study in Finland of all suicides by patients aged 60+ in nursing homes (N=12) between April 1987 and March 1988

  Group comprised 0.9% of the total number of suicides in Finland during the 12-month period (N=1397)

- 75% of these patients were male, although 75% of nursing home residents in Finland are female
- Most common method: hanging (67%)
- 33% had previously attempted suicide in the nursing home prior to their death
- One or more Axis I diagnoses for all study patients

  Depressive syndrome was diagnosed in 75% of patients, although only 33% had been identified prior to their death

Suominen, K., Henrikson, M., Isometä, E., Conwell, Y., Heilä, H., & Lönnqvist, J. (2003). Nursing home suicides: A psychological autopsy study. *International Journal of Geriatric Psychiatry, 18* 1095-1101

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Treatment with SSRIs and the Elderly

- Most studies on risk of suicide with SSRI use focus on youth or middle aged participants

- Study of Ontario residents who completed suicide, age 66 or older, from 1992-2000, and with matched living controls

  - 1,329 cases (4,552 comparison subjects)
  - *68% received no antidepressant therapy within 6 months prior to suicide*
  - 32% were on antidepressant therapy within 6 months prior to suicide

Juurlink, D. N., Mamdani, M. M., Kopp, A., & Redelmeier, D. A. (2006). The risk of suicide with selective serotonin reuptake inhibitors in the elderly. *American Journal of Psychiatry 163*(5), 813-821.

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Treatment with SSRIs and the Elderly (cont.)

- 5 fold risk of completed suicide in first month of SSRI treatment, but not in subsequent months (in suicide cases initiating therapy, SSRI N=62 and non-SSRI N=17)
- Associated with more violent methods
- Absolute risk of suicide was low in first month for people taking an SSRI as well as for those on other antidepressants
- Risk of suicide in first month may increase due to improvement in symptoms, which "energize patient to suicide"
- Conclusion: There is a low risk of suicide for elderly patients who are taking an SSRI, and the benefits outweigh the risks (future research is necessary)

Juurlink, D. N., Mamdani, M. M., Kopp, A., & Redelmeier, D. A. (2006). The risk of suicide with selective serotonin reuptake inhibitors in the elderly. *American Journal of Psychiatry 163*(5), 813-821.

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Contact with Medical Professionals

- Meta analysis of 40 reports: completed suicide and contact with primary care physicians (PCP) or mental health services (MHS), ages 55+

- Results

  With PCP:

  58%- prior to one month

  77%- prior to one year

  With MHS:

  11%- prior to one month

  8.5%- prior to one year

  Contact with MHS significantly less for elderly

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry 159* (6), 909-16.

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Depression in the Primary Care Setting

- Estimated 6-9% of elderly patients in primary care are suffering from major depression
- 17-37% suffering from mild depressive symptoms
- 7% reporting some suicidal ideation (above 30% for patients with major depression)

Bruce, M. L., Have, T. R. T., Reynolds, C. F., Katz, I. I., Schulberg, H. C., Mulsant, B. H., Brown, G. K., McAvay, G. J., Pearson, J. L., & Alexopoulos, G. S. (2004). Reducing suicidal ideation and depressive symptoms in depressed older primary care patients. *Journal of the American Medical Association 291*(9), 1081-1091.

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Intervention: Reducing Suicidal Ideation and Depressive Symptoms in Depressed Older Primary Care Patients (PROSPECT)

- PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial)

  Stage One: Age stratified (60-74; ≥75) depression screening (CES-D: Centers for Epidemiologic Studies Depression scale) with 20 primary care practices that had upcoming appointments:

  9,072 patients screened for depression

  1061 (11.7%) had CES-D's >20 which was the cut off to become eligible for treatment
  All got additional interview with SCID, HAMD- 24 and SSI

  598 patients in total participated in baseline.

  In 10 practices, patients got intervention, in 10 other practices patients received "usual care"

  Intervention: choice: Citalopram (N=139) or psychotherapy (N=62)

  Stage Two: Follow-up telephone assessments at 4 & 8 months, in-person interview at 12 months

Bruce, M. L., Have, T. R. T., Reynolds, C. F., Katz, I. I., Schulberg, H. C., Mulsant, B. H., Brown, G. K., McAvay, G. J., Pearson, J. L., Alexopoulos, G. S. (2004). Reducing suicidal ideation and depressive symptoms in depressed older primary care patients. *Journal of the American Medical Association 291*(9), 1081-1091.

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Intervention: Reducing Suicidal Ideation and Depressive Symptoms in Depressed Older Primary Care Patients (PROSPECT)

- Results:

  Rates of suicidal ideation declined faster (p =.01) in intervention patients compared with usual care patients

  At 4 months, raw rates of suicidal ideation declined 12.9% in the intervention group compared to 3.0% in the usual care group

  Larger portion of intervention patients responded to intervention at 4 months compared to usual care

  4-month remission rates for major depression were significantly higher in intervention group compared to usual care

  Resolution of suicidal ideation declined faster in intervention group than usual care: differences peaked at 8 months

  After 12 months, over 2/3 of both groups no longer reported suicidal ideation

Bruce, M. L., Have, T. R. T., Reynolds, C. F., Katz, I. I., Schulberg, H. C., Mulsant, B. H., Brown, G. K., McAvay, G. J., Pearson, J. L., & Alexopoulos, G. S. (2004). Reducing suicidal ideation and depressive symptoms in depressed older primary care patients. *Journal of the American Medical Association 291*(9), 1081-1091.

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Intervention: Reducing Suicidal Ideation and Depressive Symptoms in Depressed Older Primary Care Patients (IMPACT)

Study:

1800 adults 60 or older with Major Depression or Dysthymia (Dx by SCID)

Randomized Intervention: Collaborative Care (RN's & MA or PhD/PsyD psychologists along with patients' Primary Care Physician) or Care as Usual

Collaborative care used the IMPACT intervention (Improving Mood: Promoting Access to Collaborative Treatment) for Late Life Depression in Primary Care program

12 month intervention and 12 month follow-up

Unutzer, J., Tang, L., Oishi, S., Katon, W., Williams, Jr. J. W., Hunkeler, E., Hendrie, H., Lin, E. H. B., Levine, S., Grypma, L., Steffens, D. C. Fields, J., & Langston, C. (2006). *Journal of the American Geriatric Society, 54,* 1550-1556

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Intervention: Reducing Suicidal Ideation and Depressive Symptoms in Depressed Older Primary Care Patients (IMPACT)

Results:

Comparison Group: 119 (13.3%) had suicidal thoughts at baseline

Intervention Group: 139 (15.3%) had suicidal thoughts at baseline

Thoughts of suicide and thoughts of death or dying reduced significantly from baseline at 6, 12, 18, and 24 months in intervention group

IMPACT program provides close follow-up and monitoring of patients

Of participants who died, none were known to have died via suicide..

No available data on suicide attempts

Unutzer, J., Tang, L., Oishi, S., Katon, W., Williams, Jr. J. W., Hunkeler, E., Hendrie, H., Lin, E. H. B., Levine, S., Grypma, L., Steffens, D. C. Fields, J., & Langston, C. (2006). *Journal of the American Geriatric Society, 54,* 1550-1556

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Community-Based Suicide Prevention Programs

- Japan: Minami district (pop. 1685) of Nagawa town
- Higher elderly suicide rate in agricultural, rural areas
- SUPPRESS: Intervention Program

  (*SU*icide *P*revention *PR*ogram of *E*ducation and *S*ocial *S*upport)

  1) Two-step depression screening
  2) Mental health workshop (psychoeducation)
  3) Group activity program

Oyama, H., Ono, Y., Watanabe, N., Tanaka, E., Kudoh, S., Sakashita, T., Sakamoto, S., Neichi, K., Satoh, K., Nakamura, K., Yoshimura, K. (2006). Local community intervention through depression screening and group activity for elderly suicide prevention. *Psychiatry and Clinical Neurosciences 60*, 110-114.

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Community-Based Programs (cont.)

- Intervention cohort from Minami district of Nagawa town
- Program implementation: 1999-2004 (baseline 1993-1998)
- 1/3 of females & 1/10 of males partook in social & educational activities (third component)
- Assessed by public health nurses
- Suicide risk for females reduced by 74% during six-year implementation
- Suicide risk for males unchanged

Oyama, H., Ono, Y., Watanabe, N., Tanaka, E., Kudoh, S., Sakashita, T., Sakamoto, S., Neichi, K., Satoh, K., Nakamura, K., Yoshimura, K. (2006). Local community intervention through depression screening and group activity for elderly suicide prevention. *Psychiatry and Clinical Neurosciences 60*, 110-114.

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Telephone Support Intervention

STUDY

- Study of the TeleHelp-TeleCheck system in Veneto region of Northern Italy over an 11 year period from Jan. 1988 to December 1998 (N=18,641; 65+) 84% female (67.4% of all 65+ residents of region are women)
- Participants had an emergency-help device they can activate anytime (TeleHelp)
- Participants interviewed twice a week on the phone by trained and paid staff to monitor welfare and offer emotional support (TeleCheck)
- Mean age of the users was 79.97 years
- Many of the users had higher proportions of problems than in the general population
  - 22% clinical depression (1.98% in the general population)
  - 64% reported at least a partial loss of autonomy

DeLeo, D., Buono, M. D., & Dwyer, J. (2002). Suicide among the elderly: The long-term impact of a telephone support and assessment intervention in northern Italy. *British Journal of Psychiatry 181,* 226-229

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Telephone Support Intervention (cont.)

RESULTS:

- Reduction in suicide rate among those 65+ (even though the program was not designed for suicide prevention)
- The number of observed suicides was significantly less than expected (6 vs. 20)
- Significant difference in females between observed and expected suicides (2 vs. 12)
- Observed suicide rate was 6 times lower than expected
- Targets known risk factors, such as isolation
- Small male population sample, noticeable lack of benefits for them

DeLeo, D., Buono, M. D., & Dwyer, J. (2002). Suicide among the elderly: The long-term impact of a telephone support and assessment intervention in northern Italy. *British Journal of Psychiatry 181,* 226-229

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Recommended Interventions

- Recognizing and treating depression
  - Education to PCP and nurse assistants
- Elderly attempters
- Means restriction (Ex: reduce accessibility to firearms via gun locks)

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Challenges for Interventions

- How to get more males to participate in community-based programs and increase their outcomes
- How to change attitudes
- Increase screening for alcoholism
- Need for more funding for programs and research

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Current AFSP Research

- Yeates Conwell, M.D., University of Rochester

  Adaptation of a Depression Care Management Intervention for Elder Suicide Prevention in the Aging Services Network

- Development and testing of a innovative depression treatment program for older adults in an aging services network.

- Based on depression care management protocol developed by the MacArthur Initiative on Depression in Primary Care, designed to enhance the ability of primary care physicians to recognize, manage depression. Will be modified for use by aging services care managers.

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Current AFSP Research

- Matthew Miller, M.D. , Harvard University

  Physical Illness and Suicide in Elderly Americans

- Determine whether elderly individuals who die by suicide differ from others with similar medical conditions in their patterns of prescription drug use, especially analgesics and other pain medications (physical illness)

- Database of New Jersey Medicare recipients, age 65+, receiving pharmaceutical assistance from 1994-2004

- Individuals identified via state mortality records, compared to age, gender and race-matched control patients who died from other causes on the basis of physical diagnoses

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