Suicide in Old Age

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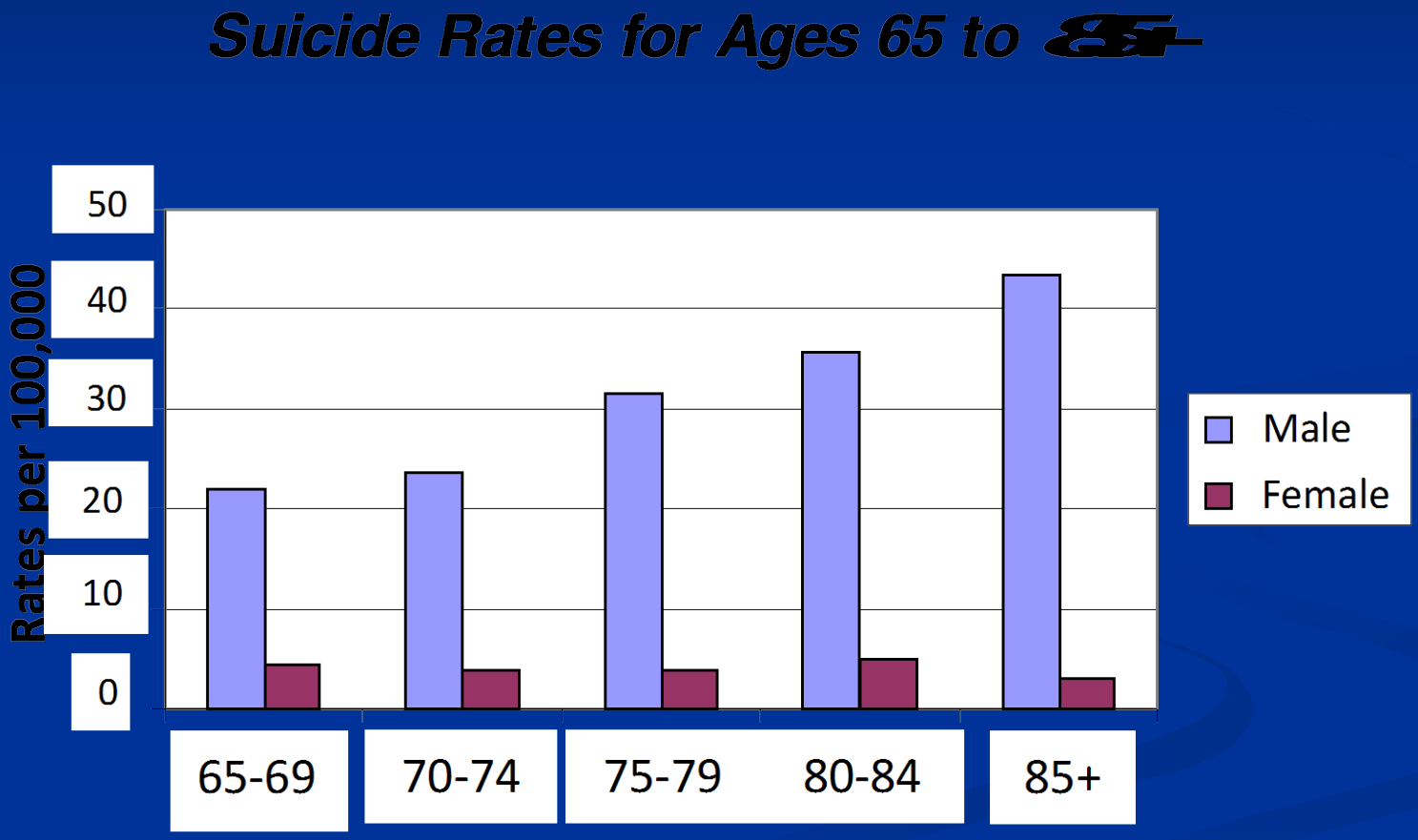
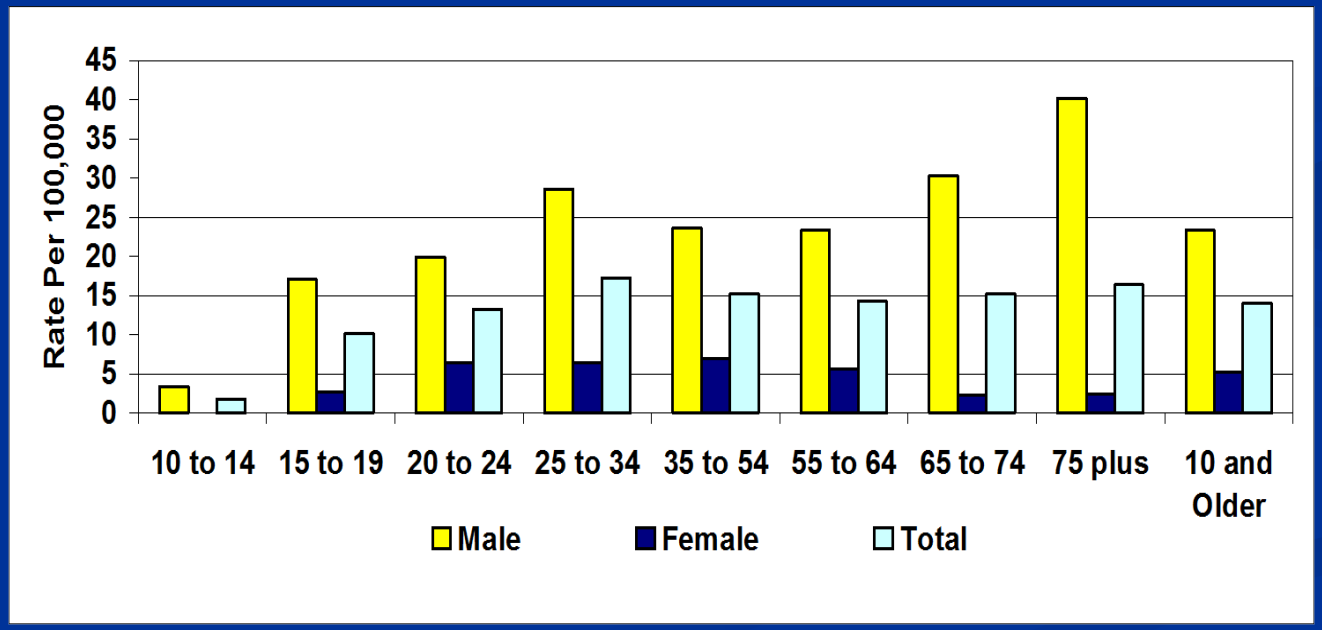
Data from NCIPC (CRC)



Maine Suicide Rates 1999-2003

Figure 2.c. illustrates suicide rates by age and gender in Maine between 1999 and 2003. In all age groups, males have higher suicide rates than females. Those 75 years and older has the highest suicide rate for males, at 40.2 per 100,000 population. Among females, the age group with the highest suicide rate is women aged 35 to 54, with a rate of 7.0 per 100,000 population.

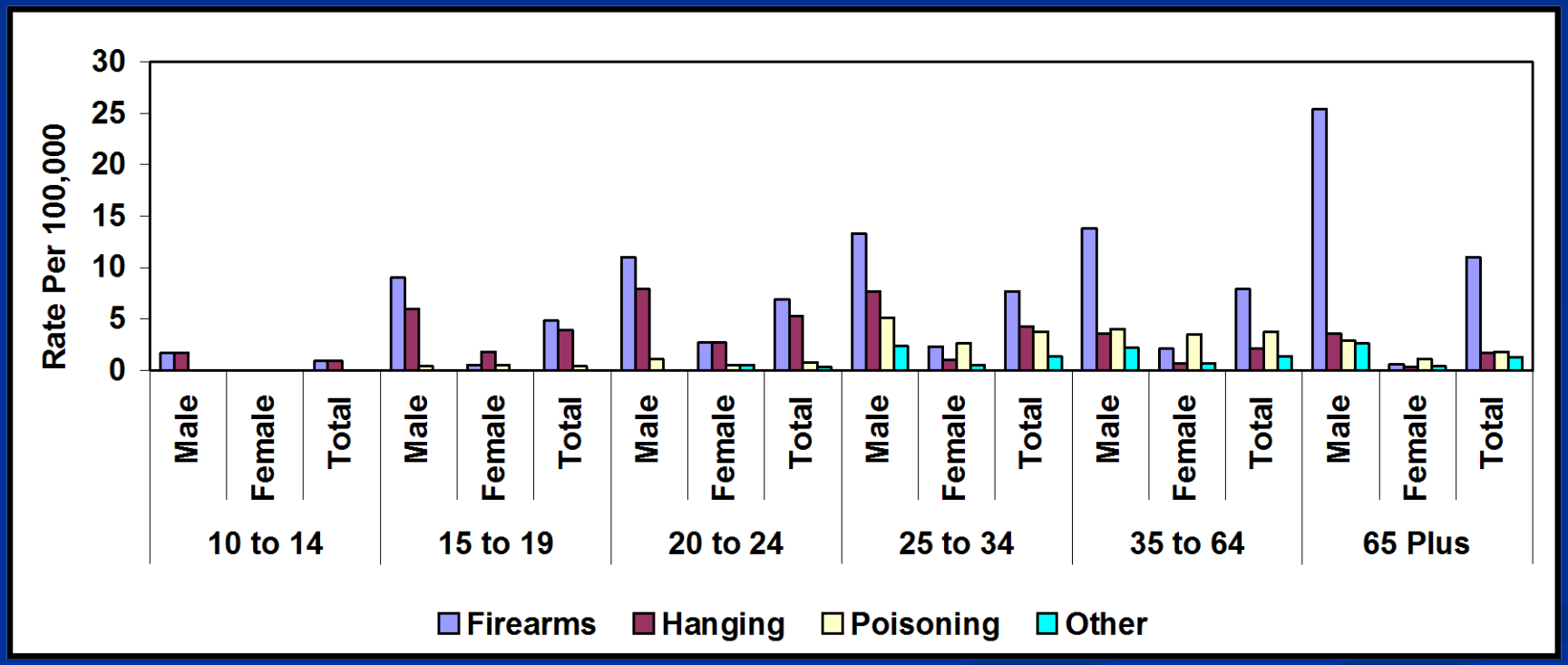
Figure 2.c. Age and Gender-specific Suicide Rates (per 100,000), Maine, 1999-2003.



*Data Source: NCHS Database

Maine Suicide Methods

Figure 2.e. Causes of Suicide by Gender and Age in Maine, 1999-2003.



*Data Source: NCHS Database

Suicide Methods, Oregon 65+

Years 1999-2002

Method	Frequency (%)
Firearm	341 (78.6%)
Poisoning (OD)	40 (9.2%)
Suffocation	35 (8.1%)
Cut/pierce	6 (1.4%)
Fall	5 (1.2%)
Drowning	1 (0.2%)
Other	6 (1.4%)
Total	434 (100%)

Suicide Methods by Gender

Oregonians Age 65+ 1999-2002

Method	Females	Males
Firearms	44%	84%
Poisoning (OD)	28%	6%
Suffocation	20%	6%

Mental Health in Old Age CDC Data 2006

Age	50-64 Maine	50-64 US	65+ Maine	65+ US
Perceived inadequate social support (% ± CI)	7.1 (5.7-8.9)	8.1 (7.7-8.5)	10.9 (8.8-13.4)	12.2 (11.8-12.7)
Poor life satisfaction	4.6 (3.5-5.9)	5.8 (5.5-6.1)	4.2 (2.8-6.2)	3.5 (3.3-3.8)
Frequent mental distress	9.1 (7.5-10.9)	11.1 (11.1-11.6)	4.5 (3.2-6.3)	6.5 (6.5-6.9)
Currently depressed	5.4 (4.3-6.9)	9.4 (8.9-9.9)	3.7 (2.4-5.6)	5.0 (4.6-5.4)

Associated Factors

Oregonians Age 65+, 2003

	Females	Males
Reported to be depressed	61%	50%
Reported to be receiving treatment	54%	20%
Physical health problems	72%	76%
Disclosed suicidal intent	39%	27%

Risk Factors

- Age > 85
- Male
- White race
- Independent personality traits
- Mental illness
  - Depression (74%)
  - Alcohol
  - Psychotic disorder
- Social Factors
  - Recent stress
  - Recent bereavement
  - Widowed or divorced
  - Social isolation
  - Access to means
  - Family history
- Neurobiological
  - 5HT dysfunction
  - Executive dysfunction

* Conwell et al. Bio Psychiatr 2002, 1:52:3:193-204

Sense of Burden and Meaning

Van Orden KA et al. Aging and Mental Health 2012; 1-6

- Measured sense of burden and meaning of life longitudinally in older adults
- Sense of burden known to be a risk factor for suicidal ideation ("interpersonal theory of suicidal ideation")
- Found of depression associated with burden and higher rates loss of meaning in life
  - Clinical population was studied: depression cause or effect?

Is Health Status a Risk Factor?

- Physical illness affecting functional status is a risk factor for depression
- Depression is a risk factor for suicide
- But health status has not be shown to be independently associated with increased risk of suicide *in the absence of depression*

The Role of Primary Care

- Two-thirds of people who commit suicide have seen a physician within a month of death
- Primary care providers are the de facto mental health system of the elderly
- Responsibilities:
  - Diagnose and treat depression
  - Detect and respond to suicidal ideation

Screening for Depression

- Assess symptoms relevant to diagnosis
- Screening instruments double detection rates:
  - Geriatric Depression Scale
  - CES-D
  - Beck Depression Inventory
  - Cornell Scale for Depression in Dementia

Missing the Diagnosis

- Oldest old w/>1 co-morbidity: 4.1%
- Only 16.7% recognition on inpatient medicine service
  - Pouget et al. *Aging-Clin Exp Res* 2000; 12:4:301-7
- Of residents with dementia and depression in nursing homes only 14% with MDS diagnosis of depression
- NH staff recognize 37-45% of patients with depression (aides have highest rates of recognition)
  - Teresi et al. Soc Psych & Psych Epid 2001; 36:613-620

Screening for Suicidal Ideation

- Direct questions to assess intensity of ideation:
  - Do you wish you were dead?
  - Do you think about suicide?
- Direct questions about intention and plans:
  - Are you thinking of attempting suicide?
  - If yes: when and how?
  - If no: what keeps you from doing it?

Treating Depression with SI

- Hospitalize if there is:
  - Intention, plan, means
- No harm contract
- Frequent, brief contact
- Antidepressant medication
- Mobilize community resources
- Refer for psychotherapy
- Family or social network enforcement of control over EtOH, weapons, pills, auto

Helpful Techniques

- Acknowledge difficult situation
- Listen without interrupting
  - Resist urge to reassure too quickly
- Gently challenge negativity
  - Hopelessness is a symptom of depression
  - Depression affects reasoning
- Remember that depression passes
- Avoid being “infected” by pessimism

Consider Prognosis

- **Good prognosis:**
  - First or second episode
  - Few co-morbidities
  - Good social support
- **Poor prognosis:**
  - CVD/WMD
  - Co-morbidities
  - Multiple episodes
  - Ongoing stress

Cautions

- Remember that treatment can increase risk of suicide in the early weeks of treatment
  - Treatment may increase motivation and energy *before* mood and outlook improve
- Be suspicious of "flight into health"
  - Sudden improvement in affect may reflect relief of having made a decision to kill oneself
  - Antidepressants may produce a rapid improvement that fades after a week or two

Rational and Passive Suicide

- Data from Oregon indicate that those choosing physician-assisted suicide are not depressed but do have a strong "internalized locus of control"
- Desire to die does not always indicate depression….but statements about wanting to die should lead to conversations about quality of life, prognosis and rational treatment refusal

Oregon's Death with Dignity Act

- 2011: 26 males, 45 females
- 1998-2010: 282 males, 243 females
- Must have terminal illness
- Depression must be ruled out
- Autonomy is major factor motivating people who chose to get prescription
- Since law was passed in 1997, 935 people have obtained prescription and 596 people used it to die.

2011 Data for Reasons to Choose Prescribed Suicide

	63 (88.7)
	64 (90.1)
	53 (74.6)
	24 (33.8)
	30 (42.3)
	23 (32.4)
	2 (2.8)

Death with Dignity Act
Age Distribution Data

Age	2011	1998-2010	Total
18-34 (%)	0 (0.0)	6 (1.1)	6 (1.0)
35-44 (%)	1 (1.4)	13 (2.5)	14 (2.3)
45-54 (%)	5 (7.0)	39 (7.4)	44 (7.4)
55-64 (%)	16 (22.5)	107 (20.4)	123 (20.6)
65-74 (%)	23 (32.4)	147 (28.0)	170 (28.5)
75-84 (%)	18 (25.4)	150 (28.6)	168 (28.2)
85+ (%)	8 (11.3)	63 (12.0)	71 (11.9)
Median years (range)	70 (41-96)	71 (25-96)	71 (25-96)

Summary

- Demoralization and loss of hope underlies the decision to kill oneself
- Wanting to take back control
- Older white males are at highest risk
- Prevention depends on:
  - recognition of depression with SI
  - interventions to control impulses
  - decrease access to means
  - restoration of hope and connection
  - strengthening sense of purpose