

Suicide and Older People

Some issues regarding suicide with
older people.

Today

We will review issues to do with Aged and suicide:

- Commonality
- Senate Inquiry
- Statistics
- Some Recent studies and evidence
- Questions about assessment
- Treatment – service system and keys issues
- A Vignette
- Treatment Issues
 - Connectedness: a closing comment

Suicide Commonality

- Completed suicide is a rare event
- However, every suicide is a waste – a failure to foster learning and human growth and a waste of a precious human resource.

Senate Inquiry 2010

The Hidden Toll: Suicide in Australia

- In Australia, suicide is a leading cause of death with over 2000 persons dying every year, three quarters of these deaths are men.
- Attempted suicide is also an important issue with estimates that in Australia over 60,000 people a year attempt to take their own lives, the majority being women.

Senate Inquiry 2010

The Hidden Toll: Suicide in Australia

- It is recognised that the number of suicides and attempted suicides is likely to be underreported for a number of reasons including the practical problems of determining a person's intentions, reporting problems and the stigma around suicide and self harm.

Research

- NHMRC mental health research funding had steadily increased from \$7.5 million in 2000-01 to \$28.9 million in 2006-07.
- In contrast, funding for suicide research was \$0.96 million in 2000-01 and had fallen to \$0.58 million by 2006-07.

RANZCP submission to Senate

Despite a reduction in overall suicide rates, the RANZCP expected the number of suicides among older men to rise given they constitute a fast growing segment of the population.

They stated:

- Suicide rates reach a second peak (after the 25-44 age group) in older men aged over 85 years. Men aged 75 years and over remain a high risk group.

RANZCP submission to Senate

- Contributing factors in old age suicide may include:
 - physical or economic dependency,
 - mental and/or physical health problems, chronic pain,
 - grief,
 - loneliness,
 - alcoholism or carer stress.

Neglect of suicide in old age

- At the Senate Inquiry:
- Professor Brian Draper considered suicide in old age remained a neglected topic.
- He commented that the circumstances leading up to a suicide attempt in old age frequently involve '...declining health including chronic pain, in combination with social isolation, lack of social support, and evolving depression & hopelessness'.
- Brian Draper is Conjoint Professor in the School of Psychiatry, UNSW and Assistant Director, Academic Department for Old Age Psychiatry, Prince of Wales Hospital Sydney.

Reporting and relationship to euthanasia

- Professor Draper noted:
 - Suicide is likely to be under-reported in the elderly with GPs and other doctors being more likely to record deaths in frail elderly as being due to natural causes to avoid stigma for families and possibly in some circumstances to cover up assisted suicides. There is an issue of overlap with euthanasia but this would affect less than 10% of late life suicides

National Survey of Mental Health and Wellbeing 2007

The results of the showed that:

- ...13.3% of Australians aged 16-85 years have, at some point in their lives, experienced some form of suicide ideation, 4.0% had made a suicide plan and 3.3% had attempted suicide.
- This is equivalent to over 2.1 million Australians having thought about taking their own life, over 600,000 making a suicide plan and over 500,000 making a suicide attempt during their lifetime...

Elderly Lesbian, gay, bisexual, transgender and intersex (LGBTI) people

Dr Jo Harrison highlighted for the Committee the lack of recognition of the needs of elderly LGBTI people in aged care and mental health support as well as suicide prevention activities. She commented:

Older GLBTI people are at an increased risk of social isolation and lack of support networks compared to non-GLBTI people. They are also less likely to approach services for support until the point of desperation, due to fear of homophobic retribution and abuse.

Elderly Lesbian, gay, bisexual, transgender and intersex (LGBTI) people

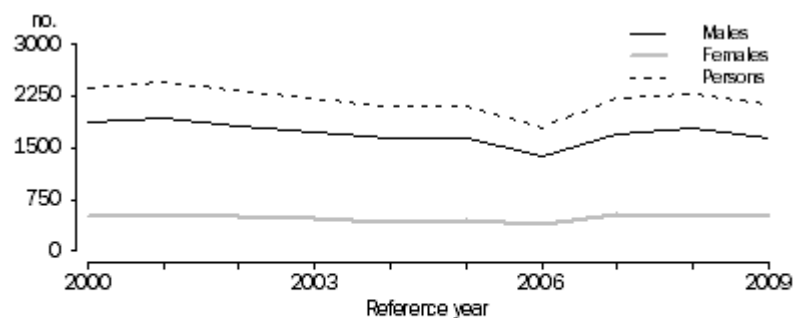
- The LGBTI Retirement Association (GRAI) emphasised the majority of older LGBTI people:
'...have grown up in an environment where they have had to hide their sexual orientation... [many] have been subjected to overt discrimination, prejudice and violence'. They noted the apprehensions of LGBTI people regarding entering aged care facilities.

Senate Findings for aged

- All we could find was
“... that this area of policy should be reviewed.”

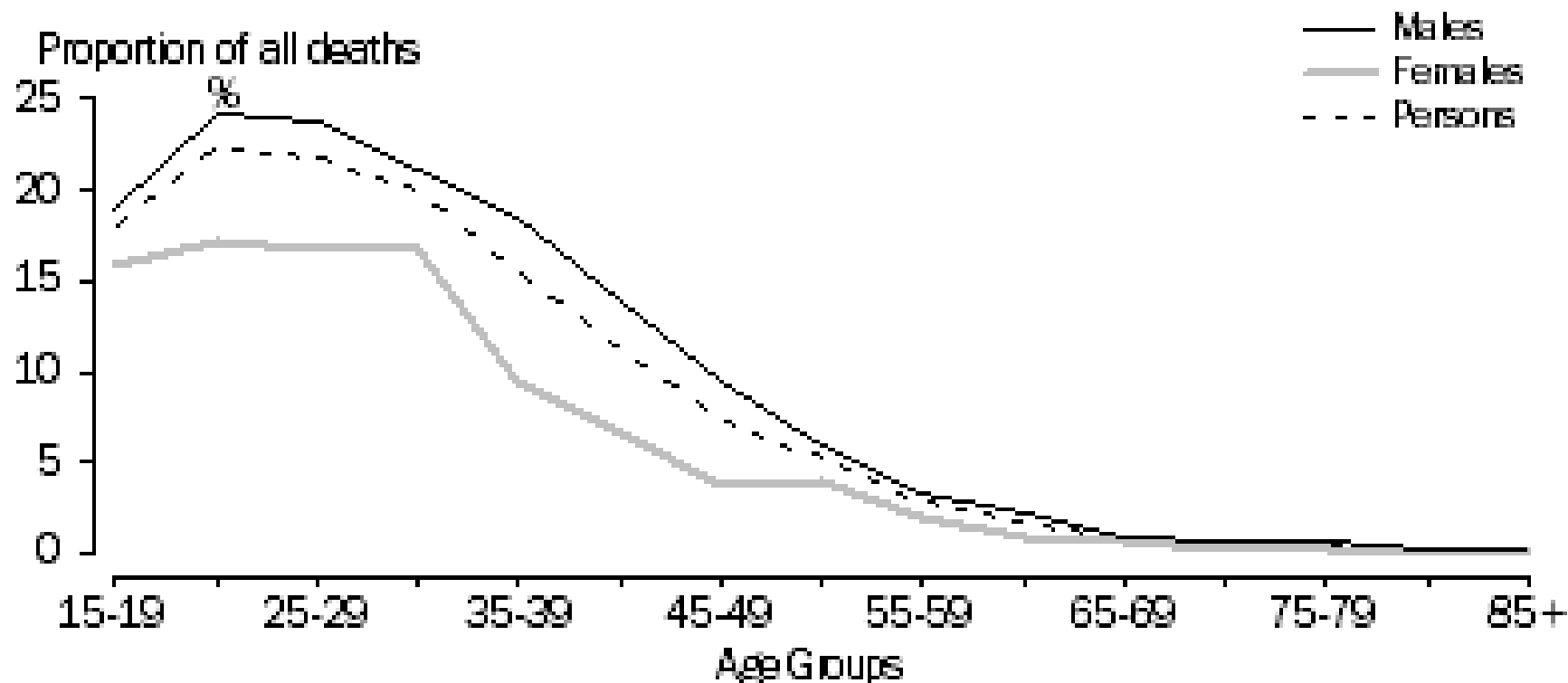
Statistics:

Number of deaths by suicide: 2000-2009



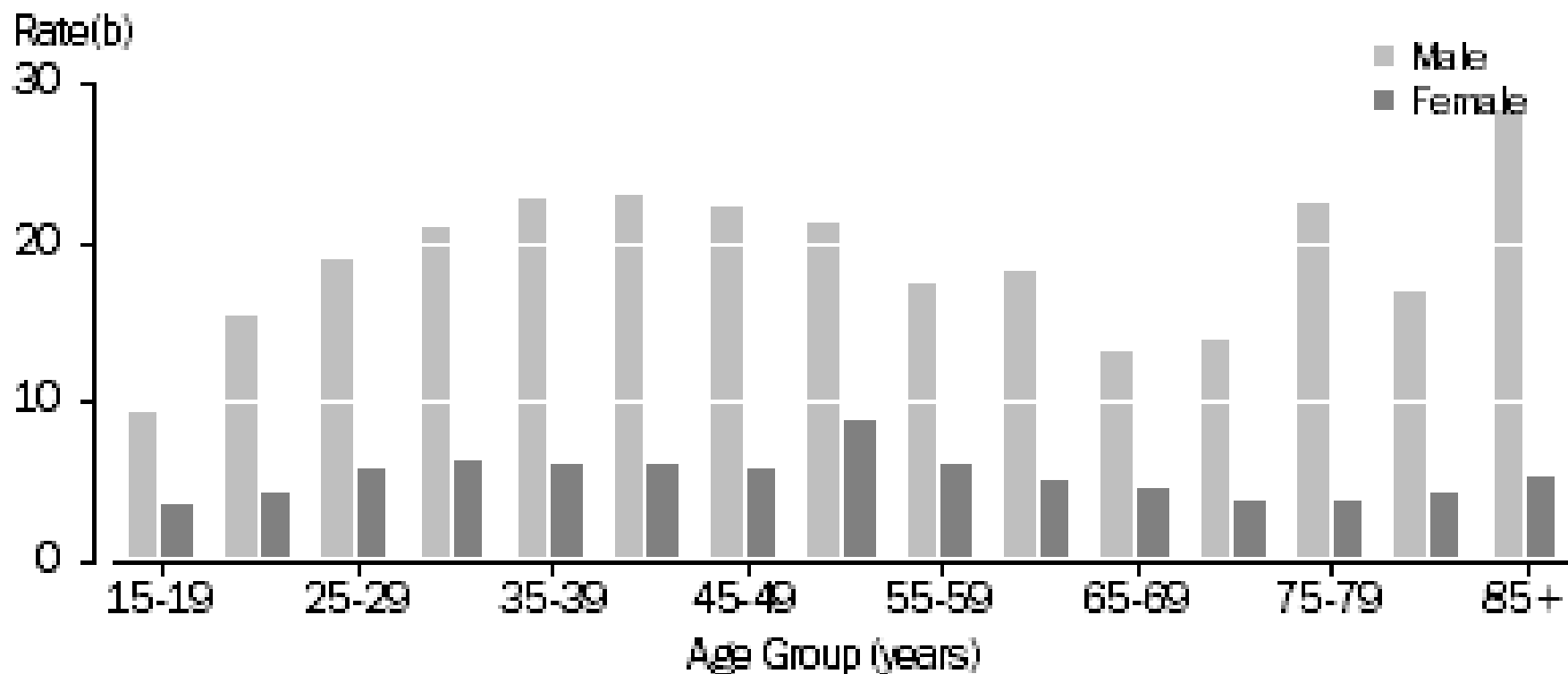
(a) Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 80-83.
(b) Causes of death data for 2009 are preliminary and subject to a revisions process. Causes of death data for 2008 have been revised and are subject to further revisions. Causes of death data for 2007 have undergone two years of revisions and are final. See Technical Note: Causes of Death Revisions and Explanatory Notes 28-32.

2009 – by selected age groups



(a) Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 80-83.
(b) Causes of death data for 2009 are preliminary and subject to a revisions process. See Technical Note: Causes of Death Revisions and Explanatory Notes 28-32.

Age specific rates 2009



(a) Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 80-83.

(b) Rate per 100,000 estimated resident population for each age group and sex.

(c) Causes of death data for 2009 are preliminary and subject to a revisions process. See Technical Note: Causes of Death Revisions and Explanatory Notes 28-32.

METHOD OF SUICIDE

In 2009, the most frequent method of suicide was by:

- Hanging, strangulation or suffocation (X70), a method used in just over half (51.3%) of all suicide deaths.
- Poisoning by drugs was used in 14.9% of suicide deaths, followed by poisoning by other methods including by alcohol and motor vehicle exhaust (11.7%).
- Methods using firearms accounted for 7.7% of suicide deaths.
- The remaining suicide deaths included deaths from drowning, jumping from a high place, and other methods.
- "Double suicides" involving spouses or partners occur most frequently among the aged.

RECENT RESEARCH

Suicidal ideation and its correlates among elderly in residential care homes

[\(Malfent, Wondrak, Kapusta, & Sonneck, 2010\)](#)

- **Abstract: Objective:** The highest suicide rates are found among the elderly, therefore suicidal ideation is prevalent in long-term care facilities. Despite these facts and multiplying losses, most residents show no signs of suicidal ideation. There is a lack of information on which factors protect against suicidal thoughts among the elderly. The aim of this pilot study was to assess the prevalence and correlates of suicidal ideation with risk and protective factors among older residential care home residents in Vienna.
- A cross-sectional study was conducted of 15 Viennese residential care homes with voluntary participation of 129 residents aged 60 years or more, active suicidal ideation during the last month was identified in 7%, with 11% reported active suicidal ideation during the past year.

Social inclusion affects elderly suicide mortality

(Yur'yev et al., 2010)

- Abstract: Background: National attitudes towards the elderly and their association with elderly suicide mortality in 26 European countries were assessed, and Eastern and Western European countries compared.
- Results:
 - Perception of the elderly as having higher status, recognition of their economic contribution and higher moral standards, and friendly feelings towards and admiration of them are inversely correlated with suicide mortality.
 - Suicide rates are lower in countries where the elderly live with their families more often.
 - Elderly suicide mortality and labor-market exit age are inversely correlated.
- Conclusions: Society's attitudes influence elderly suicide mortality; attitudes towards the elderly are more favorable among Western European citizens; and extended labor-market inclusion of the elderly is a suicide-protective factor.

Suicide in later life: public health and practitioner perspectives

[\(Manthorpe & Iliffe, 2010\)](#)

- Suicide in later life is a public health concern. Given the need for practical guidance and policy implementation, this paper aimed to provide a critical interpretive synthesis approach to prioritize the likely relevance of publications and the contribution that they make to understanding of the problem.
- Results: Whilst the majority of older people who commit suicide have major depression, suicide seems to be due to a combination of personality factors and co-morbidities, including chronic pain and disablement. Complex multi-component public health studies are underway and are likely to provide useful knowledge to guide practice more precisely, but there is remarkably little information about the involvement of older people in risk reduction or about harm minimization approaches at patient and public participation levels.
- Conclusions: For lack of sufficient evidence from intervention trials that are specific to older people, practitioners need to extrapolate from studies of younger adults and be aware of risk factors for suicide in later life. Greater collaboration needed

Diagnoses, psychosocial stressors and adaptive functioning in attempted suicide [\(Persson, 1999\)](#)

- A systematic sample of 78 suicide attempters (37 men and 41 women), of whom 83% were hospitalized, were interviewed according to SCID I and II and Axes III-V according to DSM-III-R. Mood disorders were most common (56%).
- Forty-four suicide attempters (56%) suffered from co-morbid diagnoses on Axis I-II. Borderline personality disorder was more common among women than men (56% vs. 24%, respectively, $p = 0.01$). Axis III disorders were confirmed for 45%. Sixty-two percent of the suicide attempters had severe psychosocial stressors (Axis IV).
- When comparing subjects with only Axis I disorders to those with Axis I and II disorders, no difference with respect to psychosocial stressor grade was observed. Moreover, those with only Axis I disorders were not impaired in their adaptive functioning (Axis V) even if severe psychosocial stressors were present. In contrast, an association ($p = 0.02$) was found between high stress and low functioning in patients with both Axis I and Axis II disorders. The data suggest that in clinical practice, beside evaluation of Axis I and Axis II disorders, also stressors and global functioning should be included in the assessment of suicide risk after attempted suicide.

The mediating effect of perceived burdensomeness on the relation between depressive symptoms and suicide ideation in a community sample of older adults

([Jahn, Cukrowicz, Linton, & Prabhu, 2011](#))

- Objectives: Suicide is a prevalent problem in older adults. One of the best predictors of suicide in older adults is suicide ideation; suicide ideation has been frequently associated with depression. However, suicide ideation is not always present when an older adult is depressed and is sometimes present when an older adult is not depressed. Perceived burdensomeness, a recently proposed risk factor [Joiner Jr, T.E. (2005)], has been linked to suicide ideation in depressed samples and in older adults. Thus, perceived burdensomeness may be the necessary risk factor for suicide ideation.
- Results: Perceived burdensomeness mediated the relation between depression and suicide ideation, accounting for 68.3% of the variance in suicide ideation.
- Conclusion: Clinicians seeing older adults should assess for depression and perceived burdensomeness when determining suicide risk. Future research directions include treatment studies for perceived burdensomeness as a way to reduce suicide ideation.

Suicidal ideation and its correlates among elderly in residential care homes —Cont'd

[\(Malfent, Wondrak, Kapusta, & Sonneck, 2010\)](#)

- Primarily found that protective factors like internal locus of control, self-efficacy, and satisfaction with life were important single predictors of active suicidal ideation during the past month. Depressive symptoms and current psychotherapeutic treatment were additionally important predictors.
- Conclusions: Suicidal ideation is prevalent in Viennese residential care homes; consequently it is necessary to recognize and treat suicidal ideation in an adequate way. Our findings suggest that research and prevention strategies could not merely target risk, but also include protective factors

Self-injurious behavior in the nursing home setting

([Mahgoub, Klimstra, Kotbi, & Docherty, 2011](#))

- Background: Self-injurious behavior (SIB) in older adults is defined as harm inflicted on oneself without conscious suicidal intent. SIB as a separate entity distinct from suicidal intent is poorly understood. However, it is of great concern to the patients' families and caregivers and it poses serious clinical challenges for clinicians.
- Methods: We searched the database of PubMed, Ovid Medline, and ScienceDirect for reports published between 1970 and 2009 using combination of the following keywords: "self-injurious behavior", "self-destructive behavior", "self-mutilating behavior", "older adults", "geriatric population", and "nursing homes".
- Results: Clinical studies of SIB in older adult nursing home residents are sparse. This limited literature suggests that SIB is a prevalent phenomenon and is reported to be as high as 14% in one study of nursing home subjects aged 65 and older. It is reported to be strongly associated with dementia and a risk of accidental death. It has been suggested that SIB among demented patients occurs in the context of poor impulse control and physical isolation.

The association between personality disorder and an act of deliberate self harm in the older person

([Ritchie et al., 2011](#))

Background: Suicide rates are higher in the over 65s than in younger adults and there is a strong link between deliberate self harm (DSH) and suicide in older people. The association between personality disorder (PD) and DSH in older adults remains uncertain. Our objective was to describe this association.

Methods: A case control study was conducted in which participants were: (i) those who had undertaken an act of DSH and (ii) a hospital-based control group drawn from a geographical contiguous population. PD was assessed using the Standardised Assessment of Personality (SAP)

- **Results:** Seventy-seven cases of DSH were identified; 61 (79.2%) of these participants were interviewed. There were 171 potential controls identified of whom 140 (81.9%) were included. An SAP was completed in 45/61 (73.8%) of cases and 100/140 (71.4%) of controls. The mean age was 79.8 years (SD = 9, range 65–103).
- There was no association between PD and DSH after age 80. The adjusted odds ratio for PD in the group <80 years was 20.5 [(95% CI 3, 141) $p = 0.002$]. Borderline and impulsive PD traits tended to be associated with an episode of DSH more than other personality types.
- **Conclusions:** PD appears to be a strong and independent risk for an act of DSH in people aged between 65 and 80 years and should be looked for as part of any risk assessment in this population. Access to specialist services may be required to optimally manage this problem and reduce the subsequent risk of suicide.

Suicidal behaviour in the Elderly (Szanto, [2003](#))

- In summarizing the literature, Dr. Szanto is assistant professor of psychiatry at the University of Pittsburgh Medical Center, noted in 2003”

“Suicide-specific treatments that target not only depression, but also hopelessness, anxiety and substance use are needed. Treatment should involve a significant other whenever possible to help motivate the patient to remain in treatment, comply with pharmacotherapy and psychotherapy, and abstain from alcohol. When working with suicide attempters, clinicians should inquire whether there was suicidal communication before the suicide attempt. In a non-blaming manner, clinicians should explore how the significant other felt about this and how they reacted to this communication. It is frequent for significant others to deliberately ignore suicidal communication and this may be a significant factor that further increases a sense of isolation and despair in a suicidal elderly person.”

Commentary / informal critical analysis

Looking at the research we would note:

- (i) there is a scarcity of research that takes a system-wide approach to suicide prevention in later life;
- (ii) there is simply a scarcity of research;
- (iii) little evidence or guidelines about the contributions of different professional groups;
- (iv) a noticeable absence of reference to nursing, psychology, OT and social work professions in Hearing and investigations.

This would tend to support a hypothesis that professionals in the aged field may not be successfully advocating about these issues in their professions

Some Training Observations

- In training people about suicide some of my observations have been:
 - Assumption by some staff that if the mental illness is treated the issue of suicidality has been dealt with.
 - Over-reliance on the plan-availability-lethality triangle questions (also known as the ASIST questions) with little else available.
 - A dearth of knowledge about the other issues and factors surrounding suicidality, including basic CBT.

Some aspects of suicide prevention and treatment

- There are several aspects of training and the treatment regarding suicide in Victoria that need to be noted and possibly questioned:
 - The most common form of training available which is used for mental health staff: ASIST
 - The range of services need to assist people with suicidality; and
 - Assessment commonly in use.



ASIST

Applied Suicide Intervention Skills Training

Training: ASIST

- ASIST is the most commonly taught suicide training package in Australia.
- It is a well developed and well structured training package.
- It has been a major innovation in community education

Training: ASIST Background

- ASIST is a 2-day interactive workshop in suicide first aid.
- Participants learn to recognise when someone may be at risk of suicide and respond in ways that help increase their immediate safety and link them to further help.
- ASIST aims to enhance a caregiver's abilities to help a person at risk avoid suicide.
- The workshop helps people apply suicide first aid in many settings - with family, friends, co-workers and team mates and more formal helping roles.

Training: ASIST Goals

- Reflect on how their attitudes and beliefs about suicide affect their intervention role;
- discuss suicide with a person at risk in a direct manner;
- build a collaborative approach to intervention focused on safe outcomes;
- review immediate suicide risk and develop appropriate safe plans;
- demonstrate skills required to intervene with a person at risk of suicide;
- identify resources available to a person at risk of suicide;
- make a commitment to improving community resources; and
- recognise that suicide prevention is broader than suicide first aid and includes life-promotion and self-care for caregivers.

Training: ASIST Assessment questions

- These question fit the basic plan-availability-lethality triangle and are generally presented as:
 - Assess if they intend to act - ask!
 - Assess if they can act
 - Assess if they have the means
 - Assess if they have made a time or have a time line.

Training: Suicide Assessment

- Are they suitable for a mental health service?
- The answer is usually: “Yes, but only as a basic set of questions with in the framework on an MSE.”
- But often I have found little else that staff have been trained in.

Warning Signs

- Loss of interest in things or activities that are usually found enjoyable
- Cutting back social interaction, self-care, and grooming.
- Breaking medical regimens (e.g., going off diets, prescriptions)
- Experiencing or expecting a significant personal loss (e.g., spouse)
- Feeling hopeless and/or worthless ("Who needs me?").
- Putting affairs in order, giving things away, or making changes in wills.
- Stock-piling medication or obtaining other lethal means.

Assessment

- To what level does our current assessments explore the three “I”’s and the suicide as a social learning situation and / or problem solving situation?
- How do our current assessment help us to help the person with the story in their head?

Assessment: Thorough MSE

- Only a thorough MSE that includes these issues as major exploration points is the appropriate answer.
- Within this, however, we need a model of suicidal behaviour that considers these issues.

Assessment: Thorough MSE

- Systemic interview is most important: use of the MSE is critical as your basic building block
- There are many forms of suicidal behaviour and they vary in frequency, intensity and duration.
- A willingness to disclose suicidality does not place the person at less risk.
 - Suicidal ideation is not primarily an emotional feeling – it is about how to solve a problem.
 - Be sure to collect the information to support your specific clinical purpose.

Clinical Purpose and Assessment

(Chiles, 2005)

- With each assessment we have a clinical purpose.
- When suicide is an issue, we need to consider whether we wish to continue with assessment using a:
 - assessment/risk-oriented approach**
 - or a**
 - versus assessment/treatment-oriented approach.**
- Let's consider the difference:

Assessment models: Clinical Issues to each

Clinical issue	Assessment/risk oriented	Assessment/treatment oriented
1. Focus of session	Assess and manage suicide risk	Reframe suicidality as problem solving
2. Importance of knowing suicide risk factors	Very important, central part of interaction	Less important, collected in problem-solving context
3. Importance of assigning "reliable risk"	Central to type and frequency of treatment	Less important, suicide potential is not predictable
4. Risk management concerns	Very high, focus on risk factors, be prepared to take strong steps to protect patient	Low, suicidal behavior per se cannot be prevented; focus on patient's underlying problems

Assessment models: Clinical Issues to each

Clinical issue	Assessment/risk oriented	Assessment/treatment oriented
5. Stance regarding ongoing suicidal behavior	Prohibitive, requires ongoing detection and prevention	Anticipated, forms a basis for collecting data about problem solving
6. Legitimacy of suicidal behavior	It is the problem; the goal is to get rid of it	It is a legitimate but costly form of problem solving
7. Time allotment for discussing suicidality	Much more session time	Much less session time
8. Prevention orientation	Most strategies built around preventing suicidal behavior	Fewer prevention strategies

Treatment

(Key Reference Used [Chiles, 2005](#))

- As we know, some experts in the aged field note that for older people there is no such thing as a suicide attempt, there is only a “missed” suicide. For older people, the second “attempt” is more likely to be fatal than any other age group.

Suicide as Problem Solving

- For many people suicide is an attempt to resolve a problem – often on where the person is in emotional pain (from and of loss, loneliness, poverty, etc)
- In general they have become hopeless as there no longer appear other answers to their problem.
- For people who are suicidal, treatment of their mental illness symptoms is critical, but we also need to address the way are trying to solve their life problems.

Essence of a Suicidal Crisis

- The essence of a suicidal crisis involves the three “I”’s and these are needed to be understood if we are to assist the person with their logic. These are also needed to be known for successful assessment, case management and treatment to work.
- The three I’s summarize how the person sees their emotional pain which they are trying to escape from:
 - Intolerable
 - Inescapable
 - Interminable

Psychotherapy

([Heisel, 2004](#))

- In summarizing the literature of treatments in 2004, Heisel noted:
 - Findings from the treatment literature on late-life depression show individual and interpersonal cognitive interventions (including life review, problem-solving therapy, cognitive behavioral therapy and interpersonal psychotherapy) to be efficacious in reducing depression (Are'n and Cook, 2002; Blazer, 2003; Karel and Hinrichsen, 2000), with some evidence for their efficacy in potentially ameliorating late-life suicide ideation (Szanto et al., 2003).

Psychotherapy (Cont'd)

(Heisel, 2004)

- By better assessing and addressing cognitive and social-cognitive vulnerability factors for suicidal features in older adults, and by focusing on sources of meaning in the lives of older adults, we may not only prevent suicide but also promote more meaningful living in later life.

Services required

- To successfully assist people who are suicidal, (and outside of attitudes, risk, negligence and ethics) there are three crucial service issues that need to be addressed and in place for a person who is suicidal:
 - **Assessment and Crisis Stabilization,**
 - **Case Management, and**
 - **Treatment (Psychotherapy).**
- Within this model treatment of the underlying mental illness is part of Crisis Stabilization.

Services: “Are these in place?”

- Do all services have a basic array of services concretely in place for each of:
 - Assessment and Crisis Stabilization,
 - Case Management, and
 - Treatment?
- Are these within each service and are they thoroughly defined and all staff aware of the importance of each?
- To date about half the services I have talked to appear to have the latter (treatment / psychotherapy) in place or as part of a solid referral network that is followed up.

Vignette

- Vignette

A story



So ...

- For higher mammals, the issue's of co-operation, compassion combined with empathy and connectedness, are critical.
- We all know that social isolation is a risk factor for suicide, social connectedness is a protective factor.
- Very simply, like the whale, you do not die if you are not alone. People do not normally suicide in the presence of others (except in China).

References

- Chiles, J., Strosahl, K. (2005). *Clinical Manual for Assessment and Treatment of Suicidal Patients* Arlington VA: American Psychiatric Publishing Inc.
- Heisel, M. J. (2004). Suicide Ideation in the Elderly *Psychiatric Times.*, 21(3).
- Jahn, D. R., Cukrowicz, K. C., Linton, K., & Prabhu, F. (2011). The mediating effect of perceived burdensomeness on the relation between depressive symptoms and suicide ideation in a community sample of older adults. [Article]. *Aging & Mental Health*, 15(2), 214-220. doi: 10.1080/13607863.2010.501064
- Mahgoub, N., Klimstra, S., Kotbi, N., & Docherty, J. P. (2011). Self-injurious behavior in the nursing home setting. [Review]. *International Journal of Geriatric Psychiatry*, 26(1), 27-30. doi: 10.1002/gps.2486
- Malfent, D., Wondrak, T., Kapusta, N. D., & Sonneck, G. (2010). Suicidal ideation and its correlates among elderly in residential care homes. [Article]. *International Journal of Geriatric Psychiatry*, 25(8), 843-849. doi: 10.1002/gps.2426
- Manthorpe, J., & Iliffe, S. (2010). Suicide in later life: public health and practitioner perspectives. [Review]. *International Journal of Geriatric Psychiatry*, 25(12), 1230-1238. doi: 10.1002/gps.2473
- Persson, M., Runeson, B, Wasserman, D. (1999). Diagnoses, Psychosocial Stressors and Adaptive Functioning in Attempted Suicide *Annals of Clinical Psychiatry*, 11(3), 119-128.
- Ritchie, C. W., King, M. B., Nolan, F., O'Connor, S., Evans, M., Toms, N., . . . Blanchard, M. (2011). The association between personality disorder and an act of deliberate self harm in the older person. [Article]. *International Psychogeriatrics*, 23(2), 299-307. doi: 10.1017/s1041610210001742
- Szanto, K. (2003). Suicidal Behavior in the Elderly *Psychiatric Times*, 20 (No. 13).
- Yur'yev, A., Leppik, L., Tooding, L. M., Sisask, M., Varnik, P., Wu, J., & Varnik, A. (2010). Social inclusion affects elderly suicide mortality. [Article]. *International Psychogeriatrics*, 22(8), 1337-1343. doi: 10.1017/s1041610210001614