DISCLOSURES

None
OBJECTIVES

Participants will have a greater understanding of epidemiology of suicide in older adults

Participants will express greater confidence in identifying those at risk of suicide

Participants will have enhanced comfort in suicide screening

Participants will have new strategies for management of suicidal ideation
SUICIDAL BEHAVIOR

67 year old male with ALS in LTC
Debilitating loss of function, wanted to die
Depression and psychosis (someone trying to harm him)
Poor communication, cognitive impairment, not capable to make decision re MAID
Attempted suicide by hanging on curtains
COMPLETED SUICIDE

72 yo retired physician with cancer
Unbearable pain
Consult in hospital re mood
6 months later jumps off bridge to death
## Suicide Prevalence in General (All Ages)

<table>
<thead>
<tr>
<th></th>
<th>WHO</th>
<th>USA</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEATHS/YEAR</td>
<td>800,000</td>
<td>43,000</td>
<td>4,254 (2012)</td>
</tr>
<tr>
<td>DEATH/TIME (all ages)</td>
<td>1/40 sec</td>
<td>1/11.9 min</td>
<td>1/120 min</td>
</tr>
<tr>
<td>RANK as CAUSE OF DEATH</td>
<td>17th</td>
<td>10th</td>
<td>9th</td>
</tr>
<tr>
<td>M:F</td>
<td>3:1</td>
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<td>3.5:1</td>
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</table>
COMPLETED SUICIDE - EPIDEMIOLOGY

Rate US 12/100,000 (M:18, F:5.4)

Rate Canada 12.3 (M:20, F5)
- Heart disease 289.5
- MVA 18.8
- Homicide 10.0
SUICIDE — EPIDEMIOLOGY ALL AGES

Females attempt 3X more than males

Males have higher rate of completed suicide
  - This is decreasing in last decade but still higher than females

Mental illness increases the risk by 5-15fold

Increased risk 0-12 months after discharge from psychiatric hospitalization
USA CAUSES OF DEATH 2015

- Firearms: 53%
- Suffocation/Hanging: 28%
- Poison: 16%
- Cutting/Piercing: 2%
- Drowning: 1%
OLDER ADULT CANADIAN STATS

~6,195,500 older adults
  ▪ 20% increase since 2011

639 suicides in 2014 (15% of all suicides)
<4:1 attempts to death ratio
Age-standardized suicide rates, by marital status and sex, 2007

Suicides per 100,000

Marital status

Single
Married
Divorced
Widowed

Males
Females

Sources: Statistics Canada, Canadian Vital Statistics Death Database; Statistics Canada, CANSIM, table 051-0010—Estimates of population, by marital status, age group and sex for July 1, Canada, provinces and territories, annual (persons).
SUICIDE HAPPENS BUT IS NOT COMMON

Seniors Mental Health

• 8 physicians, 4 RNs
• 162 years experience

• Suicides seen:
  • 80 yo professional with cancer, jumps off bridge
  • 60 yo female, multiple losses, hangs herself
  • 70 yo overdose, call 911, survives
LONG TERM CARE POPULATION IN NOVA SCOTIA

Residents in LTC each year 7850
/
Average Length of stay 3.1 years
= 2532 Residents /year
Years to have 100,000 residents = 39 years to see 12 suicides
Visiting primary care within 1 month of suicide
- 70+% for older adults vs ~45% of adults (Luoma 2002)

Within 1 year of suicide
- ~40% of older adults express SI or thoughts of dying to health professional
- 75% tell family/acquaintance
- 8% deny SI (Waern 1999)
SURVIVOR STATS

- Devastating effects = 11 (9.4%)
- Major life disruption + = 25 (21.3%)
- Life disrupted for a short time + = 53 (45.1%)
- Little effect + = 115 (100%)
WARNING SIGNS - IS PATH WARM

- Ideation
  - Direct statements = I want to die
  - Indirect statements = I am a burden

- Substance abuse

- Purposeless
- Anxiety
- Trapped
- Hopeless

Withdrawal
Anger
Recklessness
Mood changes

(American Association of Suicidology)
RISK ASSESSMENT

SAD PERSONS

- Sex
- Age
- Depression
- Previous attempt
- Ethanol abuse
- Rational thought loss
- Social supports lacking
- Organized plan
- No spouse
- Sickness
RISK FACTORS IN LATE LIFE

Personal loss
Medical history
Lack of resiliency
RESILIENCY FACTORS

Resilience

- Personal interests
- Healthy lifestyle
- Socialization
- Adaptive coping
- Hope / Optimism
- Meaning / Purpose (Religion)
- Help-seeking behaviors
RESILIENCY FACTORS

**Resilience**
- Personal interests
- Healthy lifestyle
- Socialization
- Adaptive coping
- Hope / Optimism
- Meaning / Purpose (Religion)
- Help-seeking behaviors

**Fountain of Health**
- Learning new things (Brain challenge)
- Physical activity
- Social Activity
- Good Mental Health
- Positive thinking
RISK ASSESSMENT

Geriatric Suicide Ideation Scale
- 31-item Likert scored; evaluates suicidal ideation, death ideation, loss of worth and perceived meaning of life

Harmful Behaviors Scale
- For nursing home residents; observer completed

Reasons for Living - Older Adults
- 69-item Likert scored, lengthy

Suicidal Older Adult Protocol
- 18-items, clinical interview
LONG TERM CARE

Suicidal thoughts common

19% of LTC facilities have suicidal behaviour (Osgood 1990)

1-3% completed suicide (Osgood 1989, Suominen 2003, Magagna 2013)

Highest risk in first 7 months

1 yr prevalence = 14%

Lifetime prevalence = 34%
Number of Canadian Seniors is expected to increase dramatically. By 2021 18% of Canadians will be over 65. 20% of those over 65 have mental illness. 80%+ residents of long term care have some form of mental illness (including dementia). **Older adults (men 40-60 yrs in Canada) had the highest rates of suicide behaviour worldwide** (McIntosh et al 1994)
DEFINITIONS

Suicide is an intentional self inflicted act that results in death.

Self harm is an intentional and often repetitive behavior that involves the infliction of harm to one’s body for purposes not socially condoned without suicidal intent. (The majority of individuals who engage in self harm do not wish to die)

The difficulty in distinguishing suicidal behaviours from purposeful self harm is determining the person’s INTENT.

Active suicidal ideation involves an existing wish to die accompanied by a plan for how to carry out the death.

Passive suicidal ideation involves a desire to die, but without a specific plan for carrying out the death.
WHY ARE THE ELDERLY SUSCEPTIBLE?

Our elderly in LTC face unique stressors:

Illness
Death of loved ones
New living arrangements
Suicide can result from hopelessness, extreme despair, intense emotional pain, shame associated with feelings of sadness, hopelessness, despair
Difficult life events/social factors
MEDICAL ILLNESS = INCREASED RISK

Visual impairment
Seizure d/o
Neurologic d/o
COPD
Cancer

Arthritis
Fracture
Moderate to severe pain
Perception of physical problems can increase risk
<table>
<thead>
<tr>
<th>OBSERVATIONS FOR RISK ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agitation/easily upset</td>
</tr>
<tr>
<td>Angry outbursts</td>
</tr>
<tr>
<td>Extreme frustration or irritability</td>
</tr>
<tr>
<td>Thoughts of hurting self or others</td>
</tr>
<tr>
<td>Anxious, fearful, stressed</td>
</tr>
<tr>
<td>Being withdrawn, sullen, moody</td>
</tr>
<tr>
<td>Mood swings</td>
</tr>
<tr>
<td>Feeling/acting guilty</td>
</tr>
<tr>
<td>Being emotionally flat/blunted</td>
</tr>
<tr>
<td>Acting strangely (paranoid, dissociating)</td>
</tr>
</tbody>
</table>
INTERPERSONAL: RISK FACTORS

- Lacking a confidant or feeling lonely
- Being unmarried
- Living alone
- Little social interaction
- Lack of religious beliefs
ASSESSMENT

Best practice indicates that suicide risk assessment MUST be done in the context of a THERAPEUTIC RELATIONSHIP and THERAPEUTIC INTERVIEW, not via a checklist.
LONG TERM CARE

Methods:
- Cutting, firearms, asphyxiation/hanging, drowning, jumping, overdose, food/medication refusal

Risk factors
- Staff turnover, facility size, facility type, serious/life threatening illness, deterioration, previous attempt/MH illness, intact cognition, LOS, white, male

No difference to risk if MH professional present

“I WANT TO DIE” = SUICIDAL?

Not necessarily

Determine

- Active
- Passive
- Motivation
**DURING SCREENING/ TESTING**

Listen

Life review decreases depressive symptoms but has no impact on levels of hopelessness or suicidal ideation

Avoid urge to problem solve or give advice

Try not to judge/argue

Try not to push too hard

Offer gentle support + concern

Express empathy “I realize that things have been difficult lately”
BUILDING RAPPORT/VALIDATION

Let them know you are glad they opened up
Acknowledge pain
Talk about hope
Don’t be discouraged if they don’t want to talk
DO NOT promise to keep secret
Limit/remove access to lethal means
ASSESSMENT DIFFICULTIES

Provoke strong feelings

- Anxiety because error could lead to suicide
- Anger at certain patients (multiple attempters) may lead to punitive behavior
“Suicide cannot be predicted and in some cases cannot be prevented, but an individual’s suicide risk can be assessed and a treatment plan can be designed with the goal of reducing that risk”

-APA Practice Guideline, 2004
What are we assessing?

Suicide

At risk for suicide*

Everyone else
Suicide

At risk for suicide*

Everyone else

What are the modifiable risk factors?
SUICIDE IS PREVENTABLE

Risk factors alone or in combination do not have adequate specificity or sensitivity

Ability to elicit patient thoughts and feelings more important

Assessment cannot be reduced to a checklist
“THE ASSESSMENT” — ENVIRONMENT

Safe environment
  - minimize elopement risk
  - certify to evaluate if necessary

Make the patient comfortable (food)

Empathy

Calm and uncritical

Establish some degree of rapport if possible
“THE ASSESSMENT” — THE SITUATION/STRESSES

Ask about recent stresses “the context”
- Losses, illness, pain etc

Proceed from general to specific questions:
- “You have a lot going on. With all that, do you ever feel hopeless or like giving up?”
- Do you feel so bad you wish you were dead?
- Would you ever do anything to hurt yourself?
“THE ASSESSMENT” – SUICIDAL THOUGHT

Suicide - thoughts and plans
- Tell me what you have been thinking about?

Active or passive?
- Do the thoughts come to you but you don’t want them?
- Have you been making actual plans to harm yourself?

Passive examples
- I never want to wake up
- I wish someone would take me away/kill me
- I have thoughts of taking my pills but I don’t want to

Active examples
- I will take all my pills
- I plan to hang myself
- I will go in the garage and turn the car on
“The assessment”— actual plan

Plans
  ▪ Detailed, access to gun or pills (search bags, home for guns)
  ▪ Are the means lethal
  ▪ Provision to be saved?

Future orientation (affairs in order)
“THE ASSESSMENT” — PAST ATTEMPTS

Methods
Hospitalizations/Treatment
“THE ASSESSMENT” — PROTECTIVE

What is stopping you?

- Religion
- Family
- Fear of death

All can be powerful deterents
“THE ASSESSMENT” — MENTAL STATUS

- Depression, anxiety, psychosis
- Psychomotor slowness or *agitation
- Fear
- Hopeless
- Sense of failure
- Intoxication
DISPOSITION

Are they safe to go home/stay LTC?

Indicators they may be safe:
- Suicide is reaction to precipitating event and their view has changed
- Family or other support are willing to have them home (comfort level)
- Outpatient follow-up (crisis plan)
- *may be best management for chronic suicidal ideation without serious attempts
DISPOSITION-ADMISSION OPTIONS

1. Admission general medical unit (e.g. overdose) with psychiatric consult

2. Voluntary admission to psychiatry
   - Prevent suicide, more aggressive treatment of illness

3. Certified admission
DISPOSITION

Documentation important

Remove firearms, lethal medications, etc.

Intoxication - reevaluate when sober
RISK MANAGEMENT

Don’t leave individual alone until you have arranged for the involvement of another appropriate care provider/source of protection.

Establish immediate safety plan (if required) that includes:

- Family support
- Homecare support
- MHMCT or police if necessary
RISK MANAGEMENT

Consider care needs:

Emergency services
Telephone/in person supports
MH services/SMH
Medical services
Social service providers

Ensure follow up is arranged
ongoing risk management

Address underlying issues:
- Medical illness
- Mental health issues
- Social problems, concerns
- Environmental factors

Continually re-assess risk, resiliency, warning signs

Continue to build and sustain therapeutic relationships
ONGOING RISK MANAGEMENT

Look for ways to foster hope and enhance sense of meaning in life.

Develop safety plan that includes after hours supports
• Although CLOSE OBSERVATION and psychiatric hospitalizations are absolutely appropriate interventions when individuals express the **intent** to immediately end their lives.

• Both of these approaches are **ineffective** or **inappropriate** in situations when individuals exhibit some suicidal behaviors (such as suicidal ideation) but are at low or minimal risk of death by suicide
SAFE PRESCRIBING IN PATIENTS AT RISK FOR SUICIDE

Avoid TCAs

Benzodiazepines are dangerous only in combination with other centrally acting agents

Give small quantities that are non-lethal in those at risk

Clozapine and lithium decrease suicide attempts; ECT decrease suicidal thoughts
SSRIS AND SUICIDE

Evidence from limited data that SSRIs may precipitate suicidal behavior, especially in children.

Antidepressant use doubled in Britain in past 15 years, suicide rates have fallen.

No strong evidence that antidepressants account for decreased suicide rates in adults.

More data needed in children/adolescents.
MAID
MEDICAL ASSISTANCE IN DYING
Assisted death is available to:

a **competent** adult person who

1. clearly consents to the termination of life; and
2. has a **grievous and irremediable medical condition** (including an illness, disease or disability) that **causes enduring suffering** that is **intolerable to the individual** in the circumstances of his or her condition.”

**EXCLUDES:**

Dementia

Depression or other psychiatric condition
SUICIDE - SUMMARY

Prediction in general population difficult
Assess patients at risk
Looks for modifiable factors—depression, pain, isolation ...
Ask the tough questions - if you feel comfortable they will too
Make safe and appropriate disposition
(don’t always need admission)
Document !!!!
MAID
GREEN CARD

To order: psychiatry@dal.ca
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Thank you