Late Life Suicide Prevention and Intervention

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Beyond the Basics
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Goals

• Increase awareness

• Provide tools

• Build skills

• Increase comfort
Objectives

• Name known risk factors
• Intervene with confidence and sensitivity
• Recognize impact of ageism
• Take action for prevention

Suicidality

• Threats
• Acts of self-harm
• Completed acts of suicide

Examining our attitudes

LEARNING CIRCLE #1
Attitudes Towards Elderly Suicide

- Society more accepting of death and dying with elderly
- Less media attention towards elderly suicides
- Less attention in research and literature

PubMed search of almost 10,000 articles, 3.1% were 80+

Senior suicides

Suicide Rates of Specific Age Cohorts per 100,000 of population in the year 2000

Suicide Rates by Age, United States, 2000-2013

One person every 80 minutes
Every 97 minutes a person age 65 and over dies from suicide.

Tend to be violent deaths.

Senior suicide rates are most effective; 1 in every 4 attempts as compared to youth rate of 1 in every 150-200 attempts.

Alcohol plays a diminished role in later life suicide.

Nursing Homes Suicides
A growing concern

Elderly Man Commits Murder-Suicide

Resident takes 6-story death

Fear is a terrible adviser

“The fear of nursing homes among elderly Germans is far greater than the fear of terrorism or the fear of losing your job.”
**Risk factors**

**In Community**
- Oldest old
- Men
- Chronic medical illness
- Depression
- Functional impairment

**In Nursing Homes**
- 60 - 69 year olds
- Men
- Depression
- Cognitive impairment
- Physical disability
- Recently admitted

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**Warning Signs**

- Elaborate good byes
- Disengagement
  - Social, personal care
- Worsening symptoms
- Worsening health
  - Stopping treatment

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**Warning Signs**

- Giving away possessions
- Putting affairs in order
- Lifting of mood
- Direct or indirect threat
LEARNING CIRCLE #2

John

- Gender
- Age
  - high risk group for community dwellers
- Chronic medical condition
  - high blood pressure
- Functional impairment
  - instrumental activities of daily living
  - decreased mobility
- Depression (?)

Framework

- Clinical depression is
  - NOT a normal part of aging
  - medical disorder
  - chronic condition
  - public health issue
  - worldwide disability
  - preventable
  - treatable
  - common
Clinical depression

- ↑ use of medical services
- ↑ morbidity from medical illness
  - Longer hospitalizations
  - Slower recovery
  - Poor control diabetes
- ↑ pain

Clinical Depression

- Interferes with problem-solving
- Colors life darkly
- Robs life of pleasure
- Prevents an attitude of hope

What you’ll hear...

“I cry all the time. For no reason”

“I just can’t stop feeling sad”

“I don’t enjoy things like I used to. Not even my grandchildren”
Talking with someone who is depressed

- Convey hope
  "I know you feel this way now, but you will not always"

- Avoid false cheer

Thoughts of suicide

- "I wish I were dead"

- "I pray every night for God to take me"

- "I'd be better off dead"

- Every statement worthy of follow-up

Everyone’s role

When to take a threat seriously?

ALWAYS
Assessment

• ASK!
  – You cannot prevent a suicide if you don’t ask

Follow-up questions

• Is the person thinking of taking his or her life?

• How likely is he or she to act on those thoughts?

Common barriers

• The person might get angry

• I don’t know what to say

• I don’t know what to do
Threat of self-harm

- Assess the risk
- Communicate risk
- Assist person in accessing supports
- Discuss with supervisor
- If risk imminent, notify appropriate parties

Key concepts

- People who threaten to kill themselves DO
- Asking about suicide does not put the idea in someone’s head
- Thoughts of suicide are a SYMPTOM as well as an expression of CHOICE

The decision to kill one's self is too important to make when one is depressed
PAIRED CONVERSATION

Prevention

- **Whole Population Approach (Universal):**
  - Activities and programs that benefit emotional well-being
- **At-Risk Approach (Selective):**
  - Strategies ensuring staff properly identify and effectively treat
- **Individual Approach (Indicated):**
  - Procedures for appropriate responses to suicide deaths and attempts

Know resources
Universal Strategies

- Primary care health professional training
- Gatekeeper training
- Psychiatric consultation for primary care MD's
- Means restriction/education
- Guideline based depression care

What You Can DO

For your constituents

- Sponsor a suicide prevention awareness training
- Educate yourself – websites, statewide conference
- Promote depression screening
- Know community referral sources

What you can DO

- Enhance protective factors
- Check out volunteering (Interfaith Volunteers)
- Check out Meals on Wheels
- Ask them about faith practices
- Access wellness planning
Selective strategies

• Advocacy
  – Depression screening policy
  – Mental health access
  – Suicide risk protocols

For at risk individuals

• Ask the Question
• Listen actively
• Persuade them to seek help
• Involve others
• Accompany them to help
• Make a Referral

Have hope

• “Hope is a condition of the spirit; it’s a condition of the mind. It is not the belief that things will turn out well, but that they will make sense regardless of how they turn out.”

  Disturbing the Peace
  Vaclav Havel
Summary

- Elderly suicide is not part of the natural course of aging
- Elderly suicide is very often the result of untreated depression
- Elderly depression needs to be recognized and treated
- All patients expressing a wish to die should be carefully screened for depression and cognitive impairment
  - Elderly Suicide is Preventable

Thanks for coming

Please stay in touch

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