Suicide in Older Patients

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Suicide in Older Patients

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Suicide in Older Patients

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Disclosures

- The individuals presenting today have no conflicts of interest to disclose
Objectives

- Learn about the unique clinical problems that are often associated with suicidal ideation among patients 65 and older.

- Learn how to collaborate as physicians and behavioral health scientists in a primary care clinic to optimally screen and assess patients who might have suicidal ideation.

- Increase understanding about the treatment options, both outpatient and inpatient, for elderly patients with suicidal thoughts and/or suicidal plans.
Total US Population – Steady Incline
US Population Trending Older


PEW RESEARCH CENTER
Suicide in the US

- Suicide is the 10th leading cause of death
- Suicide rates increased 24% from 1999-2014, sharply after 2006
- 44,000 per year
- 121 per day
- Half the suicides are by firearms
- Men at 3.5 times the rate of women

*CDC National Center for Health Statistics*
Suicide Rates per 100,000 (CDC)
US Female Suicide Rates 1999-2014 (CDC)
US Male Suicide Rates 1999-2014 (CDC)
Methods of Suicide 1999-2014 (CDC)
Summary

- Suicide rates increasing against a backdrop of declining mortality
- Suicide rates jumped after 2006
- Slight narrowing of suicide rates between females and males
- Suffocation methods increased
- Rates among American Indian/Alaska Natives are very high, although underreported (2.9% of deaths)
- Latino rates of suicide are slightly higher than whites (1.9% vs 1.6% of total deaths in 2014)

CDC National Center for Health Statistics
Nature of Suicide

- Teenagers and young adults
- Emotional and social stressors
- Fantasizing and planning suicide
- Inciting event
- Access to lethal modes of harm
- Impulsive actions
Nature of Suicide

- **Older adults**
  - Compounding risk factors
- Passive death wishes
- Active thoughts of suicide
- Detailed plans
- Access to lethal modes of harm
Older Adults and Suicide

- Primary care physicians are most likely to see older adults with mental health problems

- Suicidal ideations are high among the elderly, especially those with depressive disorders (as high as 50%)

- Contemplation to completion


- Approximately 45% of elderly suicide completers see their primary care physician in the month prior

Risk Factors

- Late life depression/mood disorders
- Social disconnectedness
- Physical illness
- Functional impairment
- Cultural factors
Late Life Depression

- Often undetected

- As high as 10% of older adults seen in primary care office have clinically significant depression

- Highest in women, chronic medical issues, persistent insomnia, stressful life events, substance abuse, social isolation, cognitive impairment

- Associated with poor quality of life and increased mortality

Late Life Depression

- Ongoing debate as to who we should screen for depression and how often in older adults
- US Preventative Task Force- must have adequate systems in place
- American Academy of Family Physicians- same requirement
- **AAFP** Grade B recommendation- high certainty of net benefit
  - **AAFP January 27, 2016**
Screening

- Patient Health Questionnaire 2 (PHQ2)
- Depressed mood and anhedonia in the previous 2 weeks
- Risk for Depression: Sensitivity of 100%
- Risk for Depression: Specificity of 77%

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.
0 Not at all
1 Several days
2 More than half the days
3 Nearly every day

Feeling down, depressed or hopeless.
0 Not at all
1 Several days
2 More than half the days
3 Nearly every day

Total point score:

Score interpretation:

<table>
<thead>
<tr>
<th>Score</th>
<th>Prob of Major Depression %</th>
<th>Prob of any depressive disorder %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15.4</td>
<td>36.9</td>
</tr>
<tr>
<td>2</td>
<td>21.1</td>
<td>48.3</td>
</tr>
<tr>
<td>3</td>
<td>38.4</td>
<td>75.0</td>
</tr>
<tr>
<td>4</td>
<td>45.5</td>
<td>81.2</td>
</tr>
<tr>
<td>5</td>
<td>56.4</td>
<td>84.6</td>
</tr>
<tr>
<td>6</td>
<td>78.6</td>
<td>92.9</td>
</tr>
</tbody>
</table>
# Assessment Instruments

<table>
<thead>
<tr>
<th>TOOL</th>
<th>ITEMS</th>
<th>TIME</th>
<th>RESPONSE</th>
<th>SPEC_SENS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Depression Depression Scale</td>
<td>30</td>
<td>15 minutes</td>
<td>Yes-No</td>
<td>92%  95%</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>21</td>
<td>10 minutes</td>
<td>0-3</td>
<td>100%  96%</td>
</tr>
<tr>
<td>Patient Health Questionnaire 9</td>
<td>9</td>
<td>5 minutes</td>
<td>0-3</td>
<td>88%  88%</td>
</tr>
</tbody>
</table>
Evaluation

- History of bipolar disorder (MDQ)
- Presence of mania symptoms
- Mood disorder history- especially depression and suicide attempt
- Ongoing medical issues
- Functional impairment
- Current medications
- Substance abuse history

Risk Factor: Social Disconnectedness

- Social loneliness - lack of contact with others
- Emotional loneliness - lack of companionship and support

Sometimes this can be perceived by the patient and others will not know

Family members may say “He had so much support.”
Loneliness

“So Lonely I Could Die” Julianne Holt-Lunstad, Ph.D.
APA Convention Presentation - August 5, 2017

- Loneliness is deadly

- AARP figures from 2014
  - 42.6 million Americans over age 45 suffer chronic loneliness
  - 25% of population lives alone
  - 50% of population is unmarried
  - Shrinking American family

- Greater social contact is associated with 50% reduced risk of early death
Social Disconnectedness

- Living alone
- Loss of a spouse/partner
- Loneliness
- Interpersonal discord
- Low social support- unemployment, low socio-economic status
- Seen in increasing suicide rates among “Baby Boomers”

Being unwanted, unloved, uncares for, forgotten by everybody, I think that is a much greater hunger, a much greater poverty than the person who has nothing to eat.

Mother Teresa
Social Disconnectedness

- Person
- Telephone
- Email or written
- 11,000 participants 50 and older for 2 years
- Depressive symptoms by contact type
- In person every couple of months 11.5%
- In person 1-2 times per month 8.1%
- In person 1-2 times per week 7.3%

Risk Factor: Physical Illness

- Cancers, seizure disorders, CHF, dementia, COPD
- 3 illnesses had a 3 fold risk
- 5 illness had 5 fold risk


- Studies have found 82% of elderly suicides were complicated by existing chronic medical issues

Physical Illness

- Risk of suicide is highest early in the course of treatment for serious medical illnesses
  

- Patients suffering chronic pain have 2-3 times the risk of suicide

- Type, intensity, duration, co-existing insomnia

- Especially in men
  
Risk Factor: Functional Impairment

- Deficits in instrumental activities of daily living elevated suicide risk higher than psychiatric disorders

- Hospitalizations, home health nurses- perceived lack of autonomy

- Preserved autonomy and social connectedness can act as buffers to functional decline

Figure 1
Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

ADLs
- Getting In and Out of Bed
- Eating
- Bathing
- Getting Around Inside
- Toileting
- Getting Dressed

IADLs
- Housework
- Grocery Shopping
- Money Management
- Getting Around Outside
- Laundry
- Medicine
- Preparing Meals
- Going Places Outside of Walking Distance
- Telephone Use
Risk Factor: Cultural

Cultural Risk Factor: Rural America

- Isolation – farther from resources, mental health care, medical care
- Higher rates of drug/ETOH use
- Increased access to lethal firearms
- Population in rural areas older
- Stigma of mental health treatment in rural areas

Solutions:

- Integrated Primary Care
- Telehealth (ECHO Project)
- Community Based Initiatives
- Counseling on Access to Lethal Means (CALM)

Prevention

- Physician education
- Screening
- Response
Physician Education

- Focus on physician recognition and management of late life depression
- 28 primary care physicians
- 73000 patients - Southwest Hungary – very high suicide rate 59/100,000
- Significant reductions in fatal and non-fatal suicide activities

**Screening**

- Patient Centered Medical Home
- All 65 and older screened with PHQ-2 yearly
- PHQ-2 can identify those patients suffering depression
- Question #9 from PHQ-9 will identify those patients with suicidal ideation
- Lower the cutoff number, lower the age, add Question #9


Thoughts that you would be better off dead or of hurting yourself in some way 0 1 2 3
Screening

- Geriatric Depression Scale 5-item

- Looks at hopelessness, emptiness


<table>
<thead>
<tr>
<th>Table 5. Five-Item Geriatric Depression Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you basically satisfied with your life?</td>
</tr>
<tr>
<td>2. Do you often get bored?</td>
</tr>
<tr>
<td>3. Do you often feel helpless?</td>
</tr>
<tr>
<td>4. Do you prefer to stay at home rather than going out and doing new things?</td>
</tr>
<tr>
<td>5. Do you feel pretty worthless the way you are now?</td>
</tr>
</tbody>
</table>

NOTE: A “no” response to question 1, or a “yes” response to questions 2 through 5 each counts as one point. A score of two or more points is considered a positive screen.

*Information from reference 26.*
Response

- **No Suicidal Ideation**
  - Periodic screening

- **Passive Ideation**
  - Further evaluation/treatment

- **Active Ideation**
  - Treatment/consultation

- **Detailed Intent and Plans**
  - Admit to I/P Psychiatry

**Treatment Goals**

- Improved emotional, social, and physical functioning
- Improved quality of life
- Improved self-care
- Reduced mortality

Treatment

- **Pharmacotherapy**
  - Individualize to the patient
  - Treatment trial of up to 12 weeks
  - Expect response rate of 40-65%
  - Continue for 6-12 months due to high rates of recurrence after early discontinuation
  - No increased rates of suicide in elderly started on medications (as opposed to previous warning with young adults)

# Pharmacotherapy Overview

<table>
<thead>
<tr>
<th>SSRIs</th>
<th>Initial Dose (mg/day)</th>
<th>Usual Dose Ranges (mg/day)</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>10</td>
<td>20–30</td>
<td>Few drug interactions</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>5</td>
<td>5–60</td>
<td>Long half-life, may cause agitation and insomnia</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>25</td>
<td>100–300</td>
<td>GI side effects common, weight gain</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>5–10</td>
<td>10–40</td>
<td>Discontinuation effects, sexual side effects, increased anticholinergic effects</td>
</tr>
<tr>
<td>Sertraline</td>
<td>25</td>
<td>25–200</td>
<td>Few drug interactions, may be agitating</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>5</td>
<td>10–20</td>
<td>Newer agent, similar to citalopram</td>
</tr>
</tbody>
</table>

**Other Agents**

<table>
<thead>
<tr>
<th>Venlafaxine</th>
<th>37.5</th>
<th>75–225</th>
<th>Effects on blood pressure, discontinuation effects, wide effective dose range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupropion SR</td>
<td>100</td>
<td>100–150 b.i.d.</td>
<td>Agitation, insomnia, lowered seizure threshold, less sexual dysfunction</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>15</td>
<td>30–45</td>
<td>Weight gain, sedation</td>
</tr>
<tr>
<td>Desipramine</td>
<td>10–25</td>
<td>50–150</td>
<td>Anticholinergic and cardiovascular side effects; needs therapeutic drug monitoring</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>10–25</td>
<td>75–150</td>
<td>Anticholinergic and cardiovascular side effects; needs therapeutic drug monitoring</td>
</tr>
</tbody>
</table>

*modified from www.geriatricsatyourfingertips.org (website of American Geriatric Society)*
Treatment

- **Psychotherapy**
- Cognitive behavioral therapy
- Interpersonal psychotherapy
- Problem-solving therapy
- 6-12 sessions
- 45-70% improvement in depression and 50% reduction in symptoms

Other Treatments

- **Group exercise therapy** - data is positive; use as adjunct

- **Electro-convulsive therapy** - data is positive; use as last resort when others have failed

- **Magnetic pulse therapy** - data lacking at this time

  Wilkinson (2007). Psychological treatments in the management of severe late-life depression: at least as important as ECT. *Int Psychogeriatr.*, 19:10-24
Suicide in the Elderly

- A problem that is on course to worsen—men, chronic diseases, population, rural trends

- Currently focused on depression—part of the puzzle

- The health centers need improvement
  depression screening, palliative care

- PHQ-2 vs. PHQ-3 (?) vs. GDS-5

- A robust plan of action in place for clinics
References

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