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How Physicians Can Help Prevent Elder Suicide

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Patients' severe functional limitations, disability, increasing dependence on others, and the fear of becoming a burden are significant risk factors for elder suicide. Physicians must make efforts to ascertain their older patients' mental status and potential suicide ideation.

Mr. A, aged 86, shot himself to death shortly after his wife died and he was diagnosed with cancer. He had seen a doctor a few days before, but the physician did not recognize the depth of his grief, loneliness, and hopelessness. Mr. A didn't mention he was considering suicide, and his physician did not ask questions or use a screening tool that might have raised alarm. The physician also had no knowledge that Mr. A owned a gun, the most common means of suicide for men. Could the physician have helped prevent Mr. A's death if he had known about his psychological suffering, isolation, and gun ownership? That is not certain; but it is possible.

Ever since the realization that most older adults who complete suicide have seen a physician within the prior 30 days, primary care has been regarded as a critical point of preventive intervention.¹ It is believed that physicians can identify suicide risk and become proactive in preventing suicide.

This is far easier said than done. Most people who kill themselves do not disclose their intentions; of the nearly 25% who do disclose, most tell a family member or friend but not a medical professional,² even when directly asked.³ In addition, a significant proportion of suicides are impulsive,⁴ without a prior intention to reveal.

It is a problem for physicians that if they fail to identify significant suicide risk, there may be little they can do. For patients at imminent risk, physicians must take protective actions, such as referring them to an emergency department. But for patients who don't raise that level of alarm, many physicians can do little more than prescribe psychotropic medication. Most physicians don't have the time or training to provide psychotherapy, and most primary care practices don't include behavioral health services. In addition, most communities in the United States don't have adequate geriatric behavioral health resources to which doctors can make referrals.⁵

So what can physicians do to help prevent suicide? There are three specific goals of suicide prevention: (1) interrupting individuals' specific plans to take their lives, (2) reducing the risks that affect particular individuals, and (3) reducing the overall number of suicides. Physicians can help by implementing the following strategies:

- Addressing suicide risks in the direct care of patients,
- Modifying the practice of their medical groups,
- Joining public health efforts to reduce suicides, and
- Advocating for changes in public policy.

Background

Suicide is the 10th leading cause of death in the United States. Although it's a less significant cause for older adults than for younger people because elders usually die from physical illnesses, in the five-year period from 2011-2015, an average of more than 7,000 adults aged 65 and older or about 16 per 100,000 died annually from suicide.⁶

Suicide attempts by older adults are more likely to result in death than attempts by younger people.^{7,8}

Suicide is disproportionately a white male phenomenon. White men aged 85 and older have the highest rate of suicide. During the five-year period from 2011–2015, the rate was approximately 50 per 100,000.⁹

Suicide is more common in rural than in urban or suburban areas.¹⁰ Guns are the most common means of suicide, especially among men in rural areas. Hanging and drug overdoses are the next most common but are comparatively infrequent.⁷

The reasons for suicide are extremely complex. Risk factors include the following:^{8,11,12}

- Psychiatric illness—most commonly major depression; but bipolar disorder and PTSD are also high risk;
- Substance abuse including prescription medications as well as alcohol and/or illegal drugs;
- Gun ownership/access;
- Chronic physical illness, especially illnesses that are permanent, disabling, and/or terminal;
- Chronic severe pain;
- Recent onset of dementia;
- Grief;
- Being a victim of ongoing violence;
- Social isolation;
- Homelessness;
- Lack of engaging, satisfying, and/or meaningful activities;
- Experience of discrimination, especially for LGBT individuals;

- Prior suicide attempts (although 60% of suicide decedents have never previously attempted suicide);¹³
- Family or spousal history of suicide; and
- History of childhood trauma or being bullied.

According to the interpersonal theory of suicide, two critical factors are a lack of "social connectedness" and a sense of "burdensomeness."¹⁴

The more risk factors, the greater the risk,¹¹ but statistically significant risk factors do not indicate that patients are likely to take their own lives. Completed suicides are unusual even among people with several risk factors. It's accurate that 80% to 90% of suicide decedents suffer from depression, but, on average, only 5% of people with major depression will complete suicide in their lifetimes.¹⁵

There are warning signs¹² that call for immediate intervention. Threatening self-harm or suicide is especially ominous if a patient has a plan and other existing risk factors. It is a myth that people who state an intention to hurt or kill themselves do not follow through; any threat must be taken seriously.

Preventive Interventions Physicians Can Provide

Addressing Suicide Risks in Direct Care

Demoralizing health conditions: A major contribution physicians can make to suicide prevention is effective treatment of health conditions that result in demoralization.¹⁶ Particularly important are conditions that cause severe functional limitations and/or are terminal. Disability and growing dependency frequently breed hopelessness and fear of becoming a useless burden, which are significant risk factors for suicide. Providing effective treatment for such physical health conditions is a preventive intervention. However, many older patients fear death less than disability. It may be more important to address disability than acute disease.

Treating pain: Effective pain management is critical for many at-risk patients. But drugs for pain, particularly opiates and benzodiazepines, carry significant risks of addiction, accidental overdoses, and falls—the major cause of premature disability and death in old age. And they can be used for suicide.

When possible, physicians should use alternatives to depressant and addictive drugs, including nonpharmacological interventions such as biofeedback, physical therapy, routine exercise, and pain-focused cognitive behavioral therapy, as well as relatively safe medications such as Cymbalta, Lyrica, or prescription NSAIDs.

Mood and anxiety disorders also can exacerbate pain and increase suicide risk. Treating them is an important part of addressing pain. Sometimes alternative treatments of pain are ineffective, and addictive painkillers may be required. It is important to try to prescribe quantities too small to be used for suicide.

Screening: Identifying major depression or substance abuse is exceedingly difficult. Even primary care physicians who pay attention to their patients' moods and look for signs of substance abuse will probably miss people at risk. For example, in older adults, depression can present as cognitive impairment that may be mistaken for an early sign of dementia.

Screening can help identify people with behavioral conditions associated with suicide, most importantly depression. Some experts recommend screening specifically for suicide, as is required for facilities accredited by The Joint Commission. This is quite controversial. According to the US Preventive Services Task Force, there is substantial evidence for the use of screening for depression,¹⁷ but little evidence that screening specifically for suicide is useful.^{17,18}

Useful screens include the Patient Health Questionnaire (PHQ-9) and General Anxiety Disorder-7 (GAD-7) among others, which can be completed by patients, their aides, or relatives prior to seeing the primary care provider. Screening may result in either false positives or false negatives, so it must be supplemented by face-to-face interviews with physicians or other professional staff.

In addition to exploring symptoms of major depression to accurately diagnose, primary care professionals should ask about active suicide intentions and plans as well as access to lethal means. Treatment plans should include pharmacological and nonpharmacological therapy, and a safety plan for patients with active suicidal ideation.

Safety plans¹⁹ are developed with patients and/or families. The plan focuses on what patients should do if suicidal thoughts become impulses to act. This should include how to contact the physician, an emergency department, and supportive friends or family. Plans should include removal of guns from a patient's home during depressive episodes or safe storage, possibly including provision of gun locks.²⁰ The plan should also address safe storage of potentially lethal medications and poisonous substances. It can additionally include identification of experiences that reduce depression, such as spending time with people and engaging in satisfying activities. Some patients will be able to identify specific experiences that reduce the wish to die, such as listening to favorite music.

Behavioral treatment: Treatment for depression, substance abuse, or other behavioral disorders can be effective and reduce related suicide risks. Sometimes primary care physicians can provide effective treatment themselves, but often it is preferable to refer patients to mental health professionals.

In some areas, of course, there are virtually no providers with expertise in geriatric mental health. Useful resources include the following:

- Telepsychiatry, which may be available and reimbursable in these areas,²¹ and

- Online information for physicians with diagnostic or treatment questions such as the Johns Hopkins Psychiatry Guide, which is written in brief bullet point format for use by general practitioners. It is available at www.hopkinsguides.com or in mobile app stores.

In some treatment-sparse areas, there are geriatric mental health professionals who will not accept insurance (particularly Medicare) but will provide treatment for people who pay. Ask patients whether they are able to do that.

Upstream factors: In addition to treatment, it can be useful for physicians to talk with their patients about "upstream" contributors to suicide risk including social isolation, family estrangement, inactivity and boredom, bereavement, and/or lack of a sense of self-worth, meaning, or purpose.

Changing Medical Practices

Some suicide prevention activities diverge from standard medical practice and are difficult for physicians to include in their schedules, particularly in solo or small group practices. The emergence of ever larger medical groups—especially those using the model of "medical homes"—should make it possible to address a broader range of risks, particularly by adding staff members with behavioral health expertise.

Information for patients: A simple step is to provide relevant information in waiting rooms—especially the telephone number and URL of the National Suicide Prevention Lifeline:

1-800-273-TALK (8255)
<https://suicidepreventionlifeline.org>

Information about depression, the effectiveness of treatment, and availability of depression screening may make patients more open about emotional issues with their physicians.²²

Free informational materials are available from the Substance Abuse and Mental Health Services Administration at www.store.samhsa.gov.

Staff training: Many primary care providers are uncomfortable dealing with suicide risk. Some shrink from any conversation about personal or emotional matters. Others balk when suicidal ideation emerges. Staff training is critical for a practice to deal effectively with suicide risk. There are several trainings available including Applied Suicide Intervention Skills Training and SAFETALK. Learn more at www.livingworks.net/programs.

Behavioral health staff: Medical practices should add behavioral health staff such as psychiatrists, psychiatric nurses, psychologists, clinical social workers, and mental

health counselors who have expertise on the developmental dimensions of old age and can provide the following:

- Assessment of psychological condition and of suicide risk;
- Motivational interviewing;
- Conversation about life circumstances and satisfaction;
- Behavioral activation and problem-solving therapy; and
- Coordination of care.

Integrated treatment: Severe chronic co-occurring physical and behavioral health conditions require integrated treatment, which is critical to effective management of demoralizing health conditions but is rarely available.

Co-location of physical and behavioral health services in one building or even one office is not integrated treatment, nor is having an electronic medical record. True integrated treatment involves the use of multidisciplinary treatment teams that meet routinely to develop treatment plans that include assignment of responsibilities for both treatment and care management. A webinar from the American Psychiatric Association to familiarize primary care providers with an integrated mental health practice model can be helpful. (See Resources sidebar.)

Collaborative care management: Such management increases the effectiveness of treatment of depression, substance abuse, and other psychiatric disorders. There are several evidence-based models, including Improving Mood—Promoting Access to Collaborative Treatment, or IMPACT,^{23,24} developed specifically for older adults.

The essence of collaborative care management is the realization that patients often fail to follow through on treatment or referrals. Many need support to continue psychotherapy, take medication, or seek a change if there are medication side effects or medication is ineffective. Many patients benefit from problem-solving therapy, which is often provided as part of collaborative care management. A nurse, social worker, or mental health counselor with appropriate training can provide this form of care management.

Screening, Brief Intervention, and Referral to Treatment (SBIRT):²⁵ SBIRT is an evidence-based model developed to help people with substance abuse problems when they visit an emergency department, urgent care, or primary care setting. The goal is to engage with patients using motivational interviewing techniques to encourage them to go for further treatment.

Telepsychiatry: In some areas, mental health professionals—especially psychiatrists—are in very short supply. Medical practices can use telepsychiatry in two ways: physicians can consult with mental health experts via telephone, and patients can have face-to-face interactions via videoconference.

Promoting successful or healthy aging: Because so many older adults spend considerable time visiting physicians, their practices can usefully address patients' additional needs and promote well-being. In a previous article published in *Today's Geriatric Medicine*, the authors recommended the development of medical practices that function as centers for successful aging.²⁶

Such practices would include patient/family education, onsite activities such as exercise, and life planning. They would build connections with the local aging services system to help patients find people and activities that would counteract social isolation—a major suicide risk.

Public Health Initiatives

Some communities have started public health initiatives to reduce the incidence and number of suicides. One example is the Zero Suicide initiative. To learn more about it, refer to the following website: <https://zerosuicide.sprc.org>.

Primary care physicians can play valuable roles in public health initiatives by gearing their practices to suicide prevention and by participating in the community groups that are necessary to provide leadership to broad efforts to reach, engage, and help people at risk of suicide.

Public Policy Issues

Reduction of suicides among older adults in the United States will take more than attentive physicians, changes in medical practices, and aspirational public health initiatives. Major changes in public policy are needed, including the following:

- Greater control of access to means of suicide, especially guns and potentially lethal drugs;
- Expansion of geriatric mental health services;
- Improved quality of mental health services for older adults;
- Increased integration of physical and behavioral health services;
- Increased use of technology to improve access and quality;
- Increased linkages between the health care, behavioral health, and aging services;
- Modified insurance coverage, especially Medicare and Medigap, to reflect the need for nontraditional services; and
- Public education to overcome stigma and to provide information about the value and availability of mental health services for older adults.

Bringing about such policy changes will take aggressive advocacy. Organizations that represent physicians can make a great contribution to change. We hope physicians will urge their representatives to do it.

RESOURCES

- American Psychiatric Association: "Collaborative Care for Primary Care Providers" webinar: <https://education.psychiatry.org/Users/ProductDetails.aspx?ActivityID=4834>
- Johns Hopkins Psychiatry Guide (website and app for primary care providers with psychiatry-oriented questions): www.hopkinsguides.com
- Suicide Prevention Resource Center: "A Comprehensive Approach to Suicide Prevention": www.sprc.org/effective-prevention/comprehensive-approach
- National Suicide Prevention Lifeline: 1-800-273-TALK (1-800-273-8255), <https://suicidepreventionlifeline.org>
- US Preventive Services Task Force: "Final Recommendations Statement: Screening for Suicide Risk in Adolescents, Adults, and Older Adults in Primary Care": www.uspreventiveservicestaskforce.org/Announcements/News/Item/final-recommendation-statement-screening-for-suicide-risk-in-adolescents-adults-and-older-adults-in-primary-care

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