

A FRAMEWORK FOR SUICIDE PREVENTION in LATER LIFE

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Disclosures

- Conflicts of interest - none

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and many more.....



A Framework for Prevention CONSIDERATIONS

- *Who:* Epidemiology
- *Why:* Risk and protective factors
 - defining targets
- *Where:* Sites
 - points of access
- *When:* Developmental perspective
 - suicide as a process
- *How:* Approaches to prevention
 - and their coordination

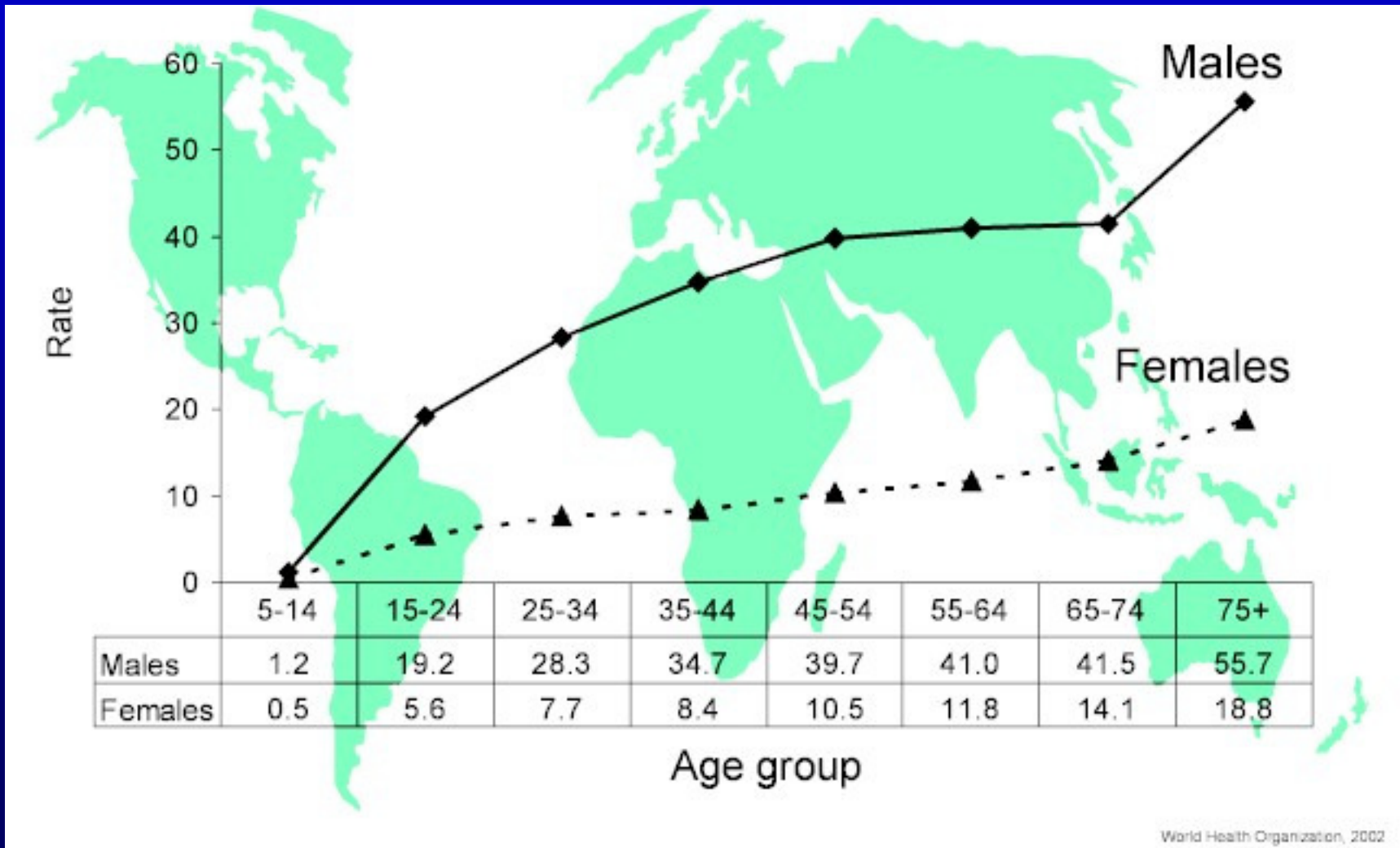


Who...?

THE EPIDEMIOLOGY OF SUICIDE

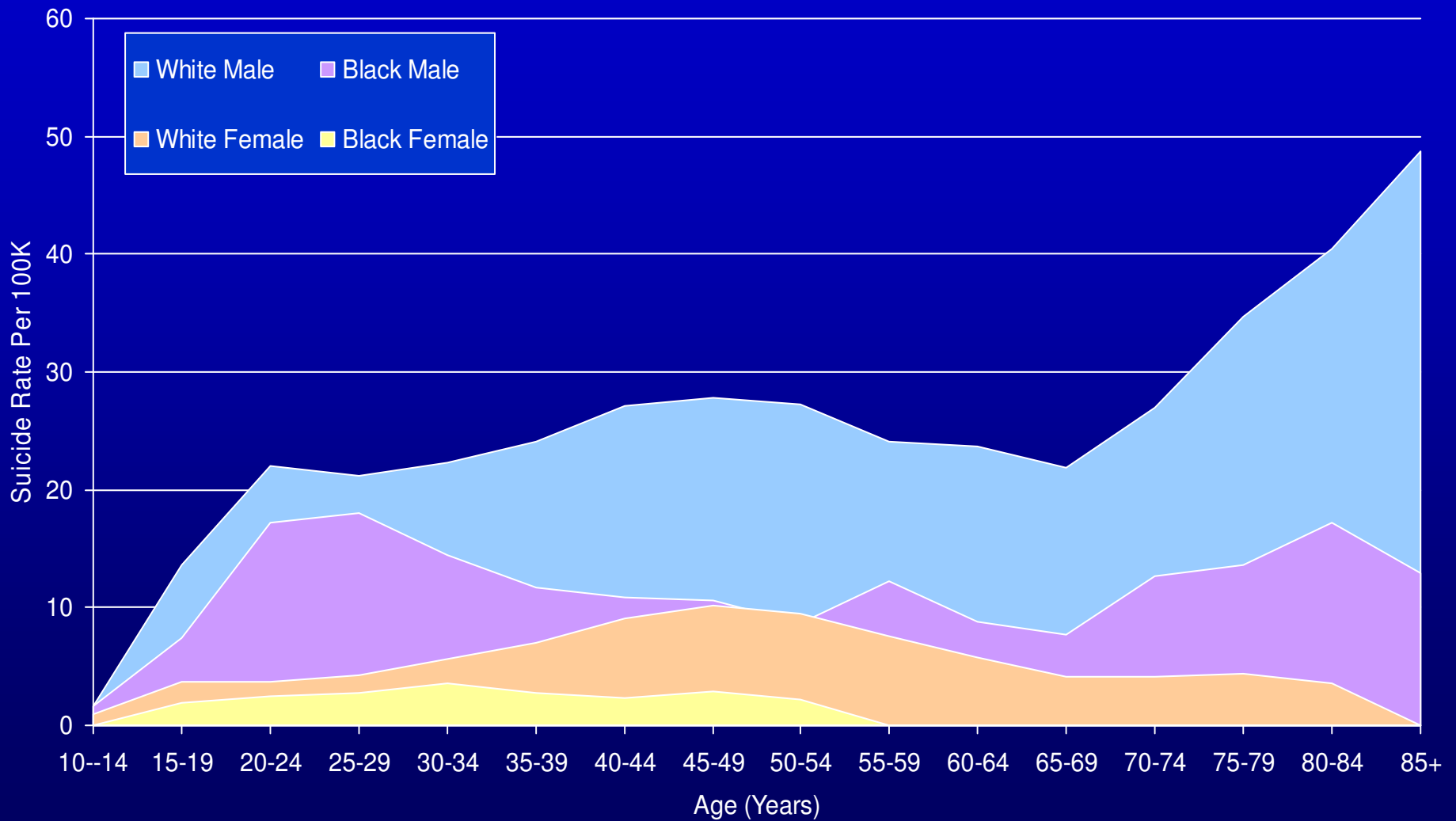


Suicide Rates Worldwide 1998 -- WHO





Suicide Rates by Age, Race, and Gender U.S. -- 2004



Source: National Center for Health Statistics



“My work is done. Why wait?”

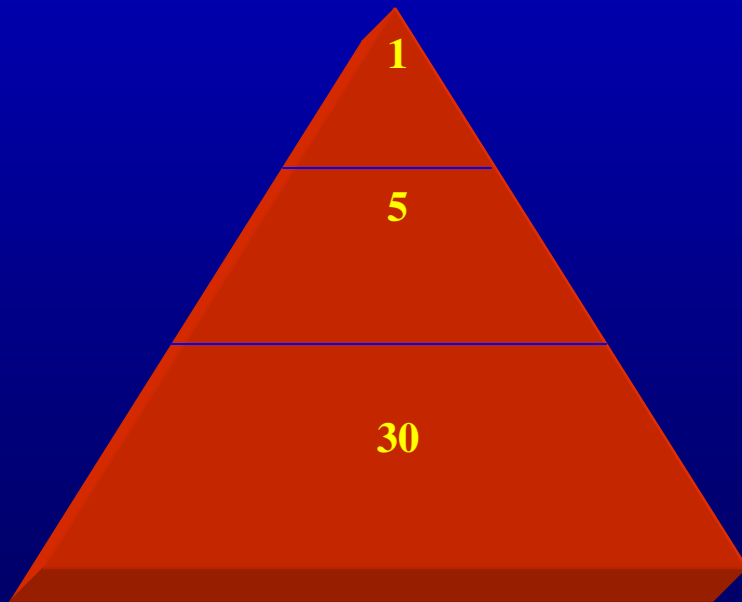
George Eastman
March 14, 1932
Age 77



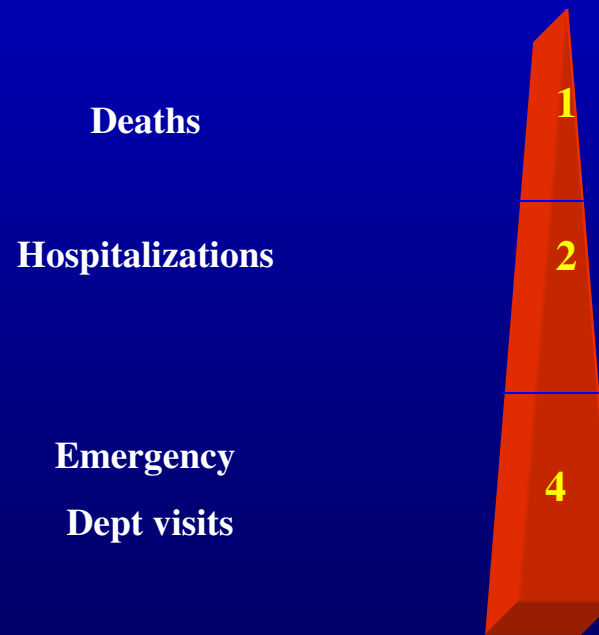


ATTEMPTED:COMPLETED SUICIDE

General population



Older adults





LETHALITY OF LATE LIFE SUICIDE

- Older people are
 - more frail (more likely to die)
 - more isolated (less likely to be rescued)
 - more planful and determined
- **Implying**
 - **interventions must be aggressive**
 - **primary and secondary prevention are key**

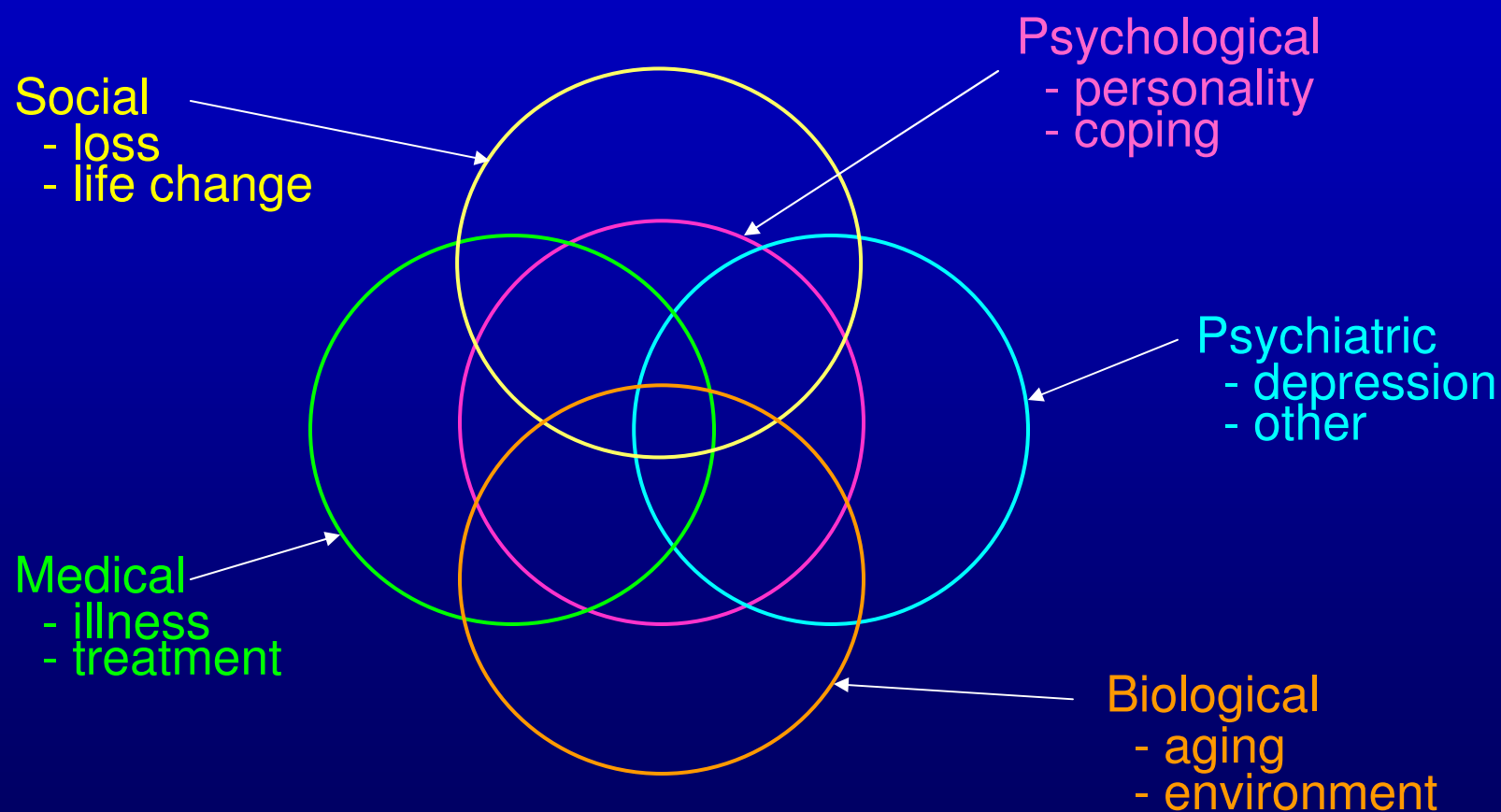


Why...do older adults kill themselves?

RISK AND PROTECTIVE FACTORS



DOMAINS OF SUICIDE RISK IN LATER LIFE



Adapted from Blumenthal SJ, Kupfer DJ. Ann NY Acad Sci 487:327-340, 1986



RISK (and PROTECTIVE) FACTORS FOR SUICIDE AMONG ELDERERS

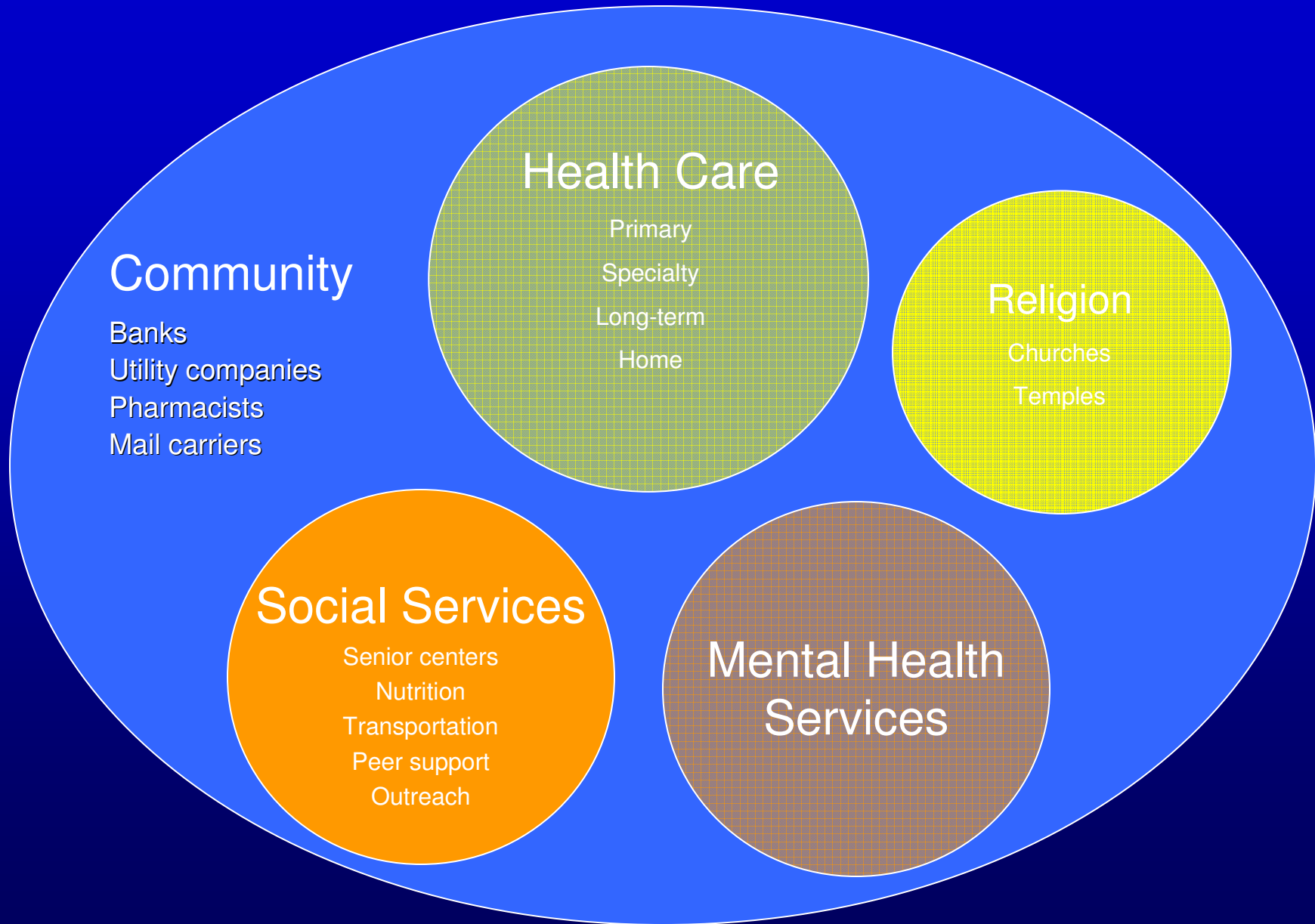
- Affective disorder
- Prior suicide attempts
- Medical illness [esp. with pain and role function decline]
- Social dependency or isolation
- Family discord, losses, financial strains
- Personality inflexibility, rigid coping
- Access to lethal means
- (Spirituality; religiosity)
- (Supportive social networks)



*Where...do we find older adults at risk
of suicide, so that we can intervene?*

POINTS OF ACCESS

Points of Access



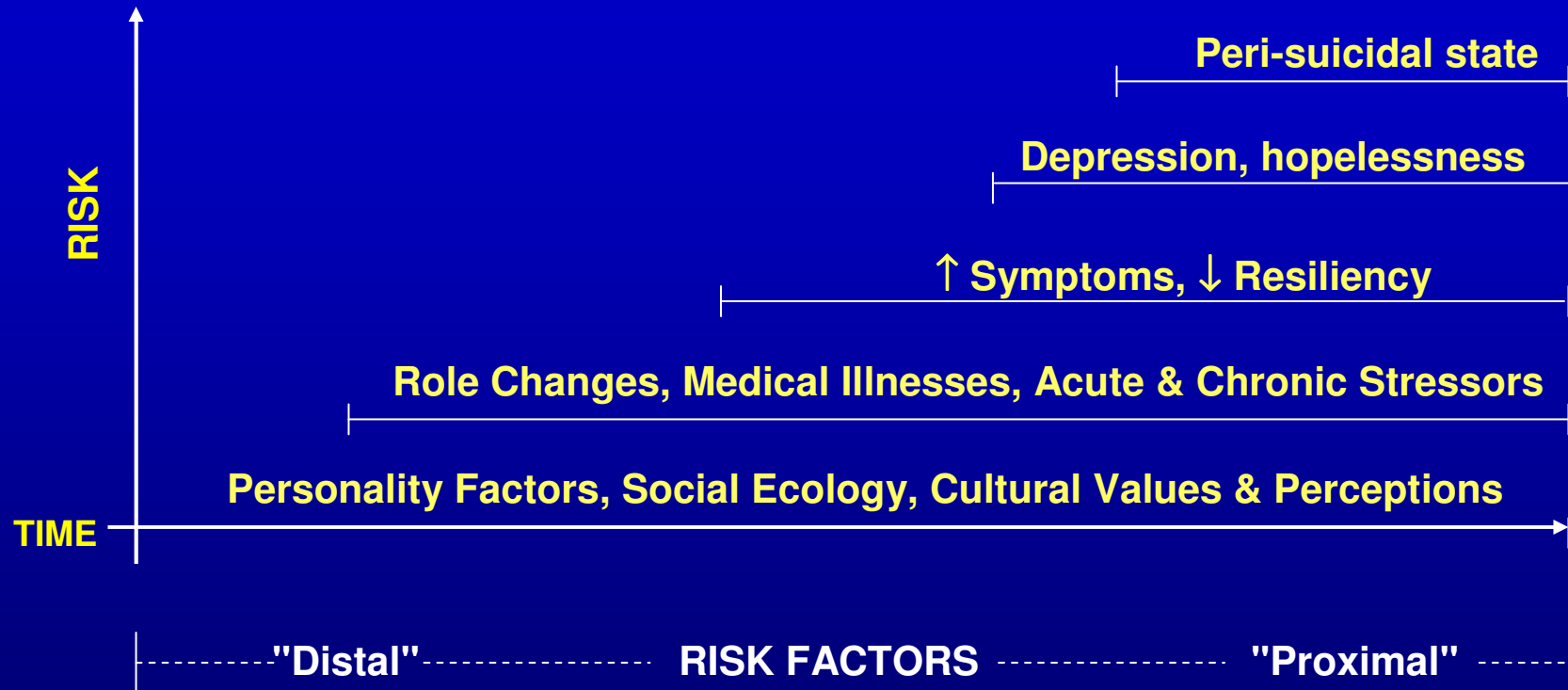


*When...do older adults kill
themselves?*

DEVELOPMENTAL EPIDEMIOLOGY

DEVELOPMENTAL PROCESS OF LATE LIFE SUICIDE

SUICIDE





*How...do we prevent suicide in
later life?*

APPROACHES TO PREVENTION



Institute of Medicine Terminology:

“LEVELS” OF PREVENTIVE INTERVENTION

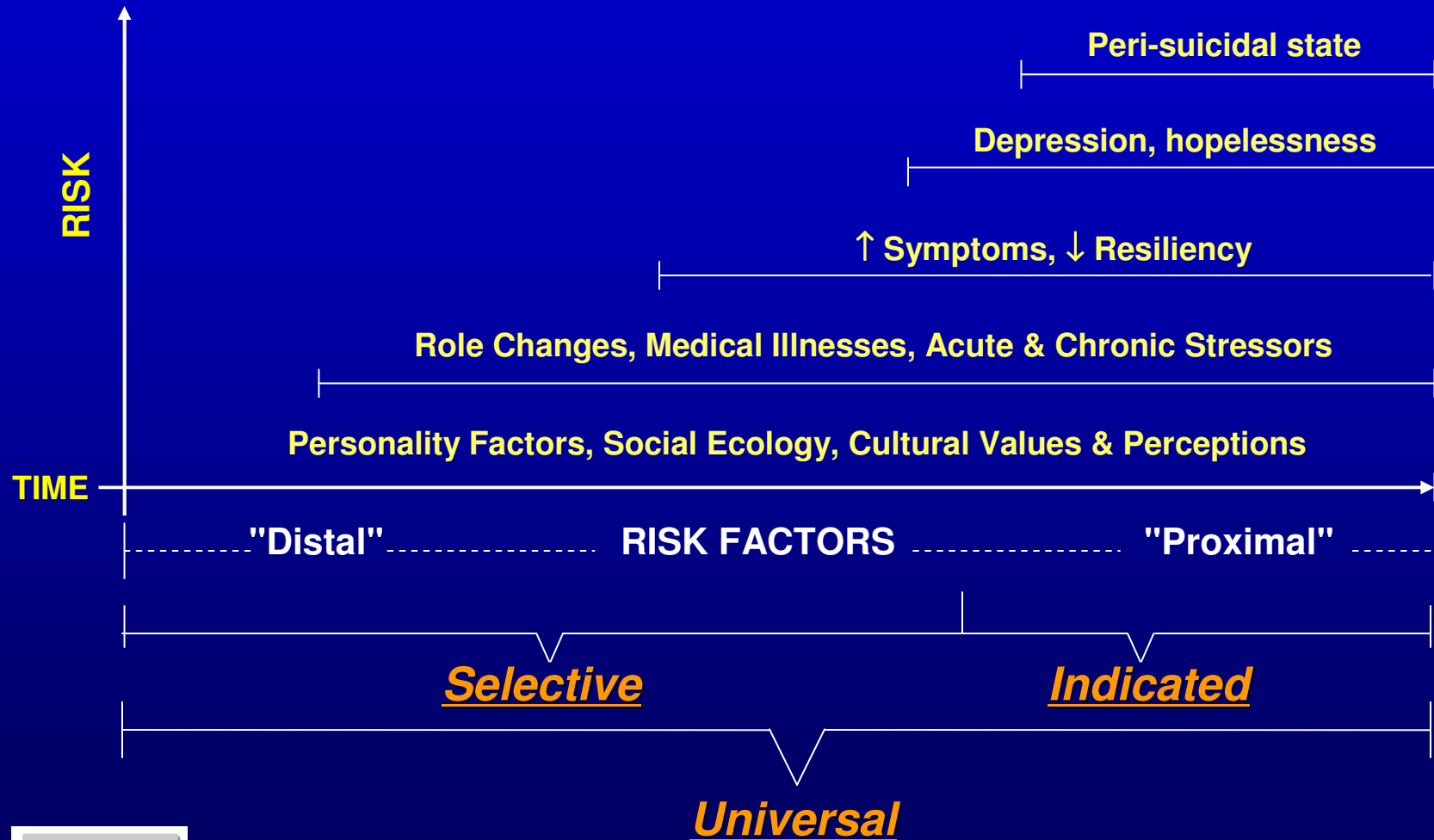
“**Indicated**” – symptomatic and ‘marked’ high risk individuals – interventions to prevent full-blown disorders or adverse outcomes.

“**Selective**” – high-risk groups, though not all members bear risks – prevention through reducing risks.

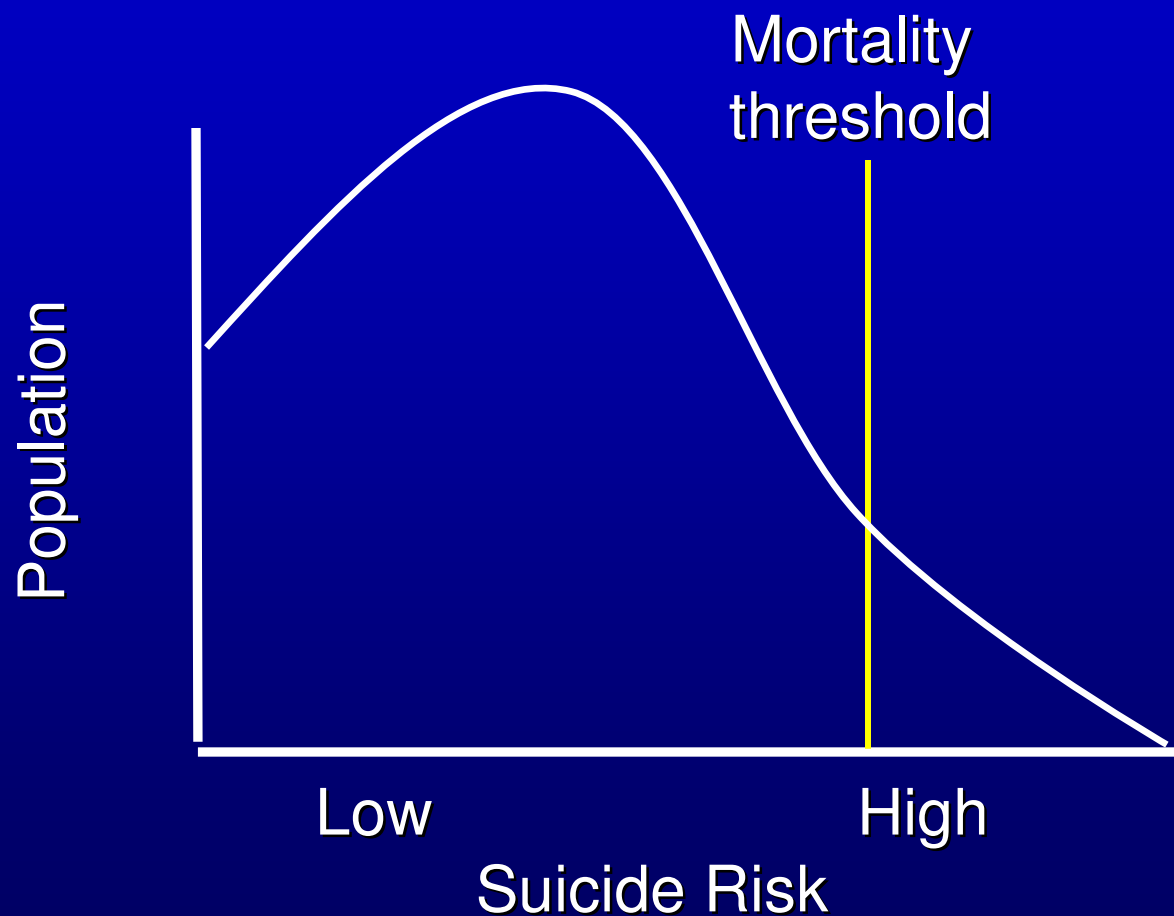
“**Universal**” – focused on the entire population as the target – prevention through reducing risk and enhancing health.

DEVELOPMENTAL PROCESS OF LATE LIFE SUICIDE

SUICIDE



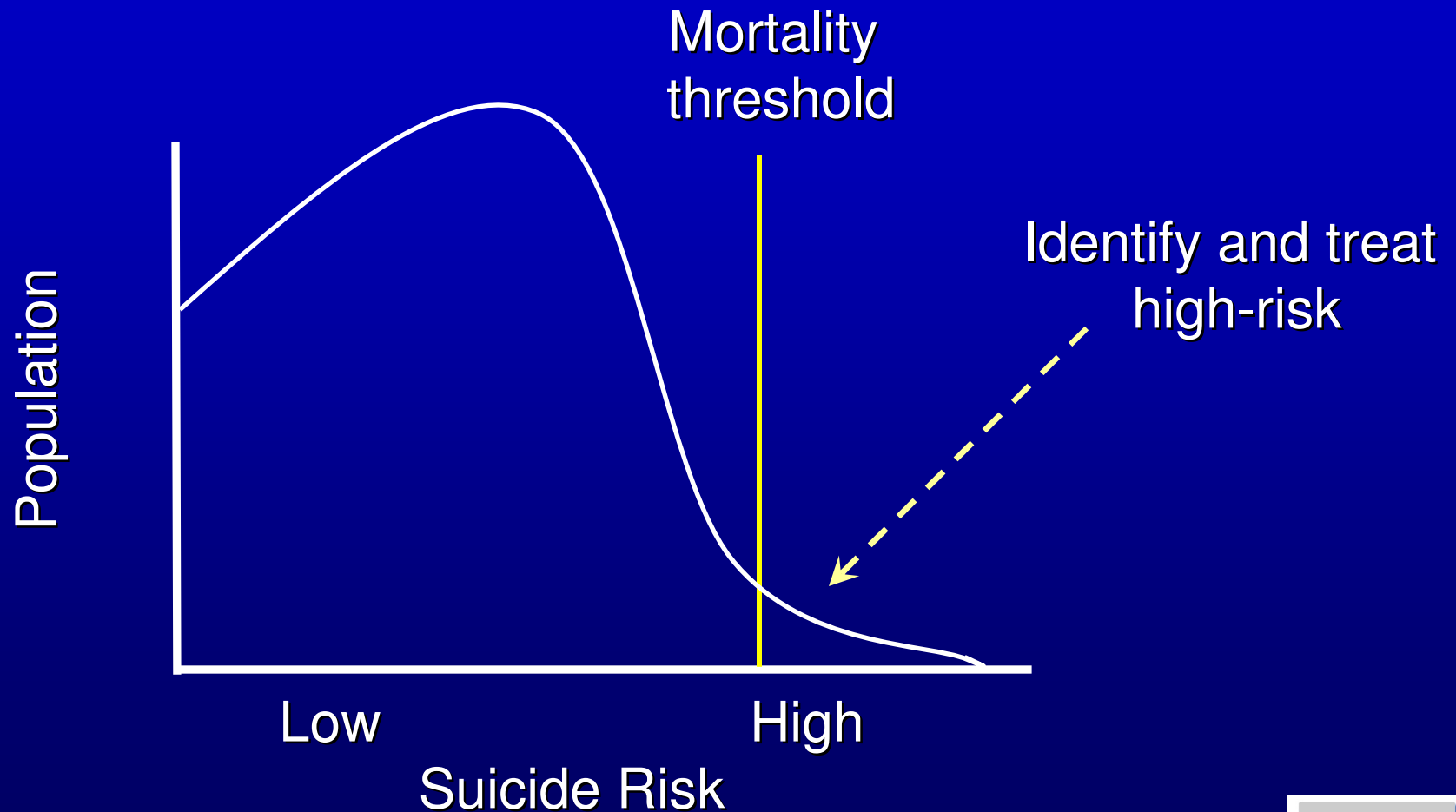
POPULATION DISTRIBUTION OF SUICIDE RISK



Modified from Crosby



INDICATED/SELECTIVE APPROACH



Modified from Crosby



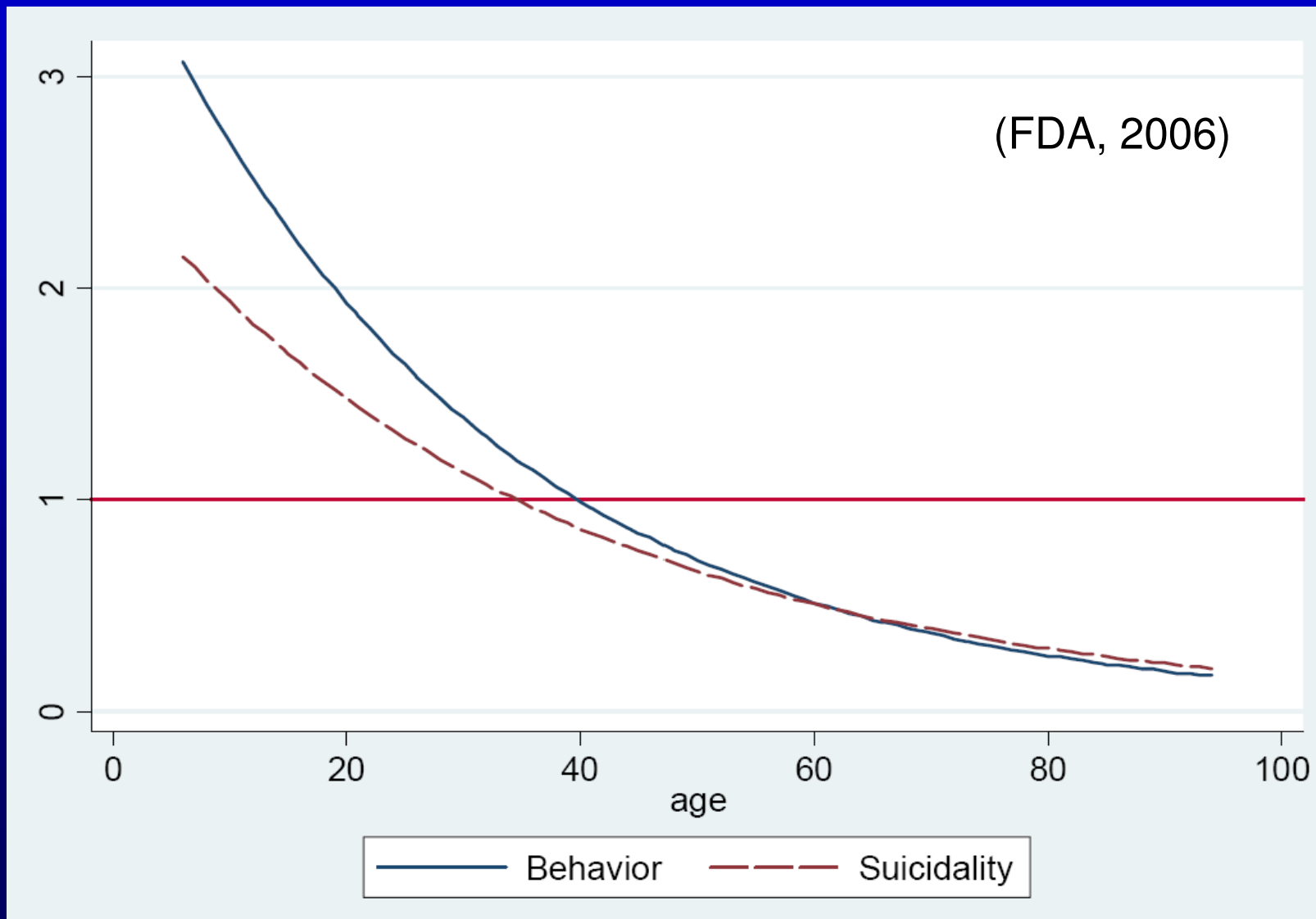


INDICATED PREVENTION

- Because of the close association between depression and suicide in older adults
 - *detection and effective treatment of depression are key*
- Routine screening for depression
 - PHQ-9
 - GDS
 - CES-D
- Depression treatment is effective
 - Including at reducing suicidal ideation and *maybe* suicide rates
- Primary care most common venue



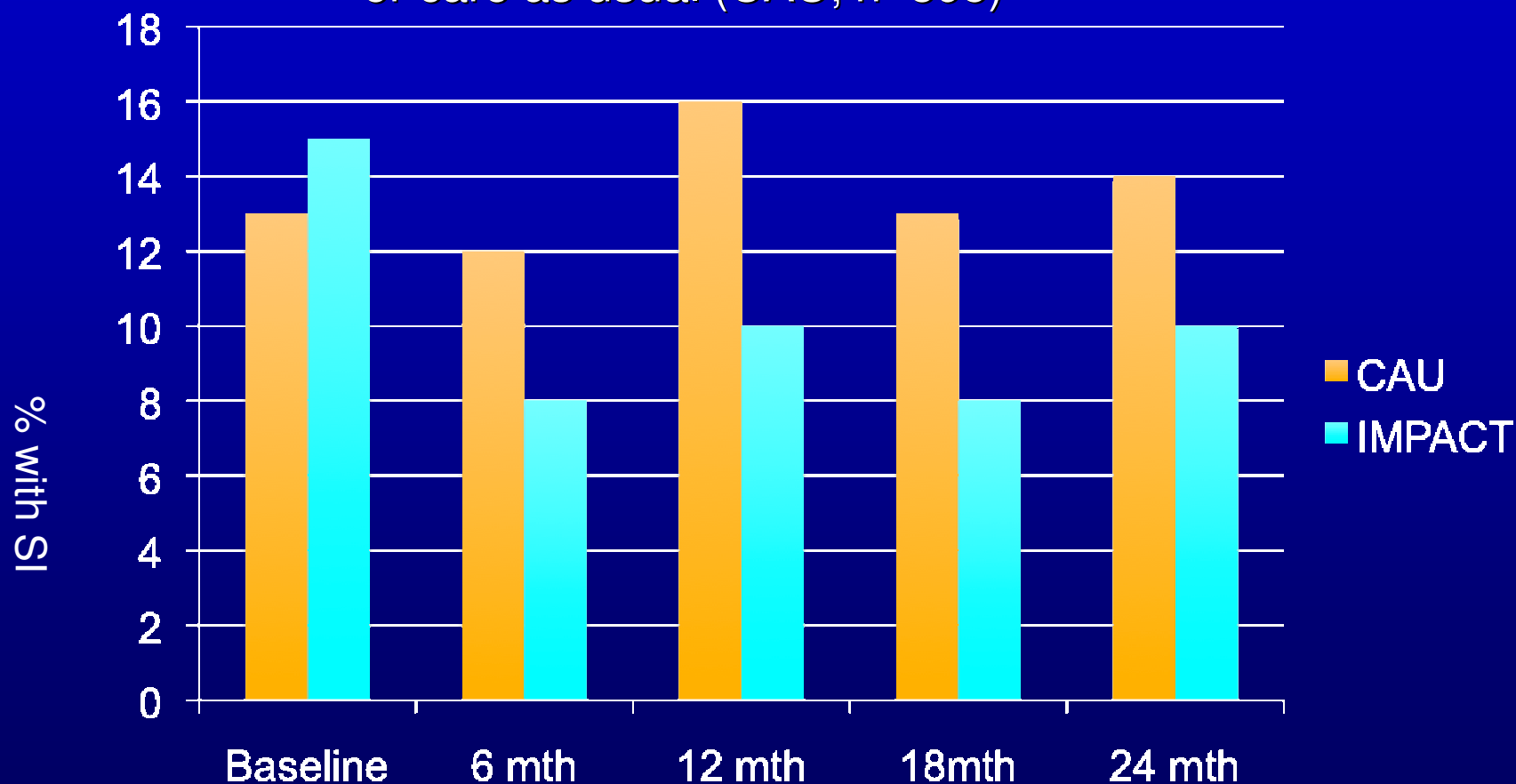
Odds Ratios for Suicidality and Suicidal Behavior for Active Drug Relative to Placebo by Age





The IMPACT Study

N=1801 subjects >60 yrs with major depression or dysthymia
Randomized to -- collaborative care (depression care manager; n=906)
-- or care as usual (CAU; n=895)



SELECTIVE PREVENTION

- High-risk groups, though not all members bear risks – prevention through reducing risks.



Tele-Help/Tele-Check Service for the Elderly

- 18,641 service users in Padua, Italy
- January 1, 1988 thru December 31, 1998
- Mean age = 80.0 years
- 84% women, 73% lived alone
- Suicides observed = 6
expected = 20.9
SMR = 28.8% ($p < .0001$)
- *Among women*

UNIVERSAL PREVENTION

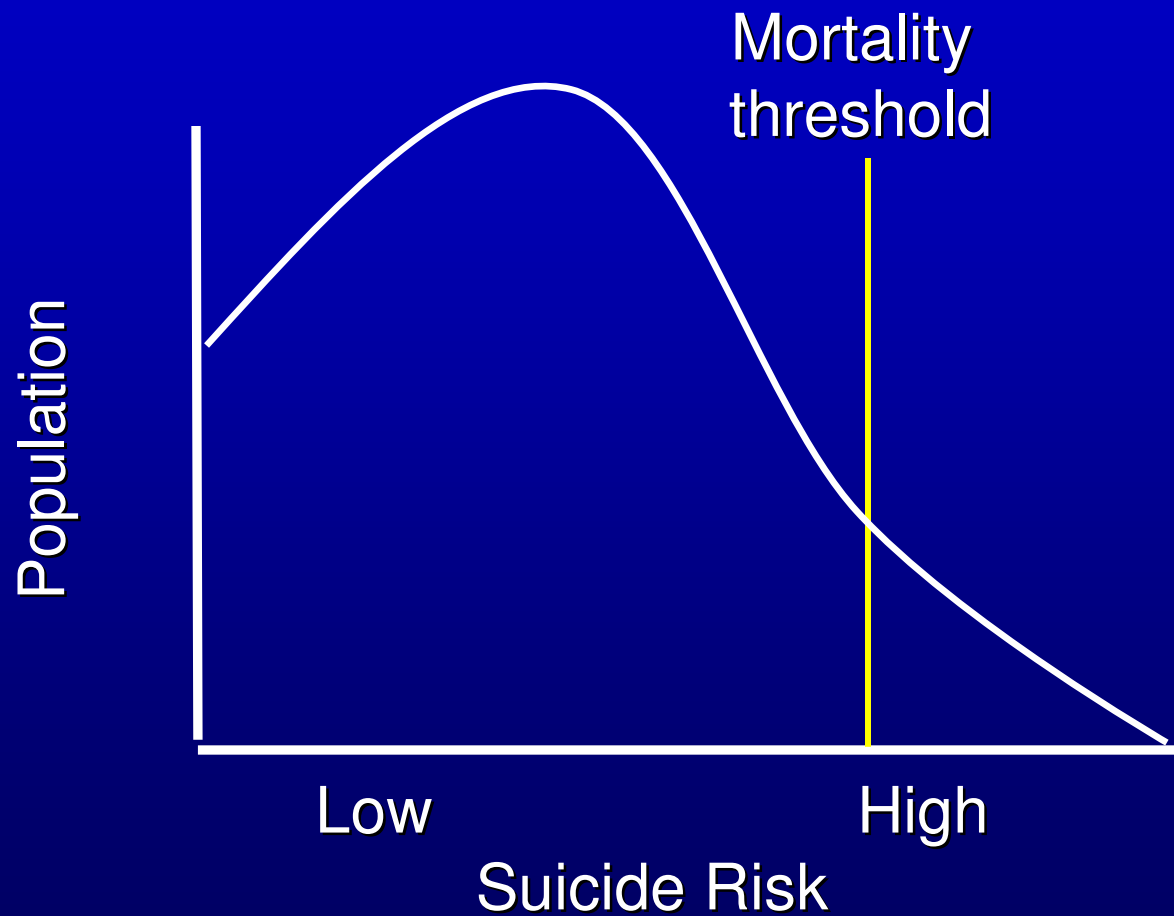
- Focused on the entire population as the target – prevention through reducing risk and enhancing health.

Rose's Theorem:

“...a large number of people at small risk may give rise to more cases of disease than a small number who are at high risk”

(Rose 1989)

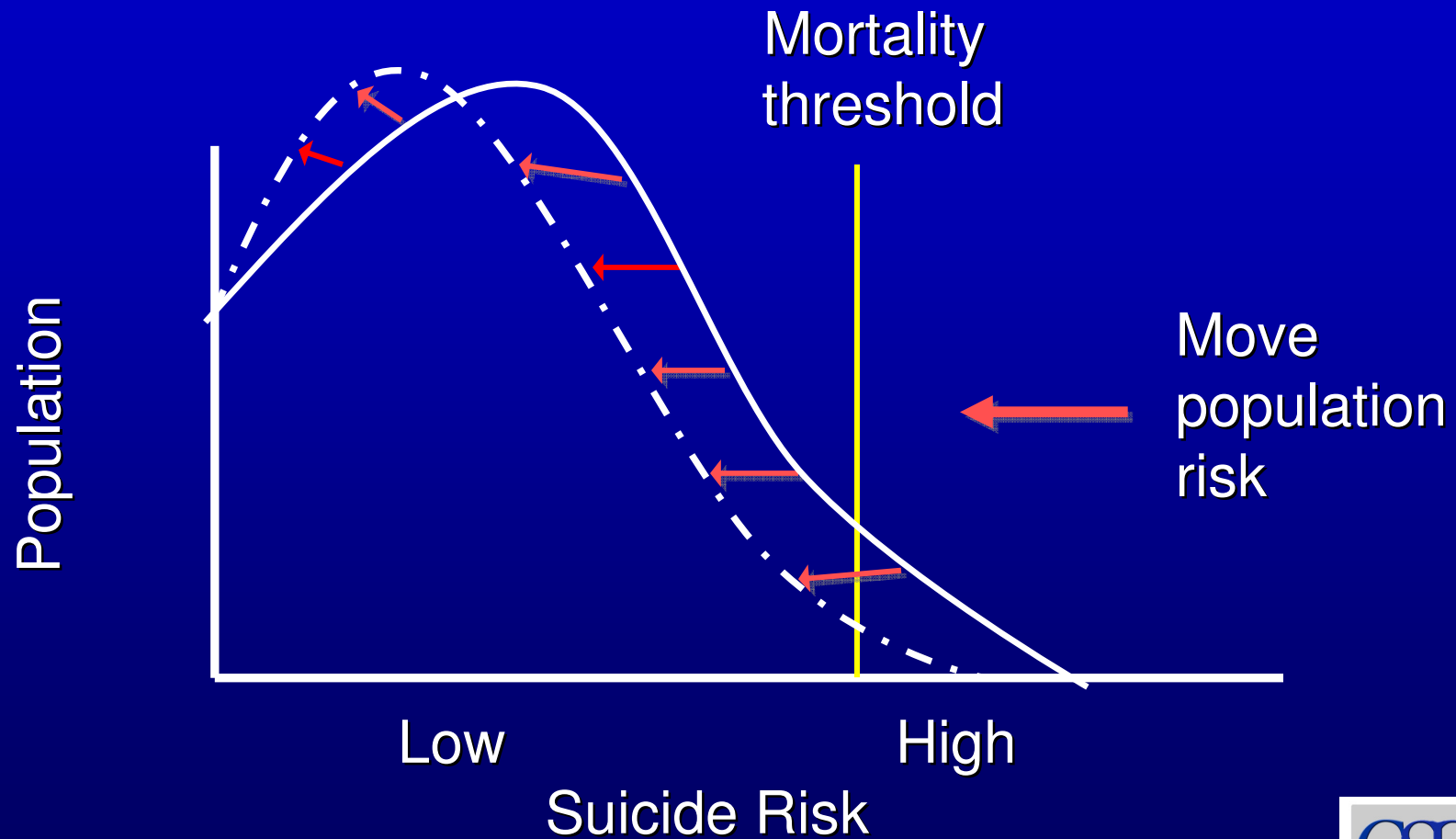
POPULATION DISTRIBUTION OF SUICIDE RISK



Modified from Crosby



UNIVERSAL APPROACH



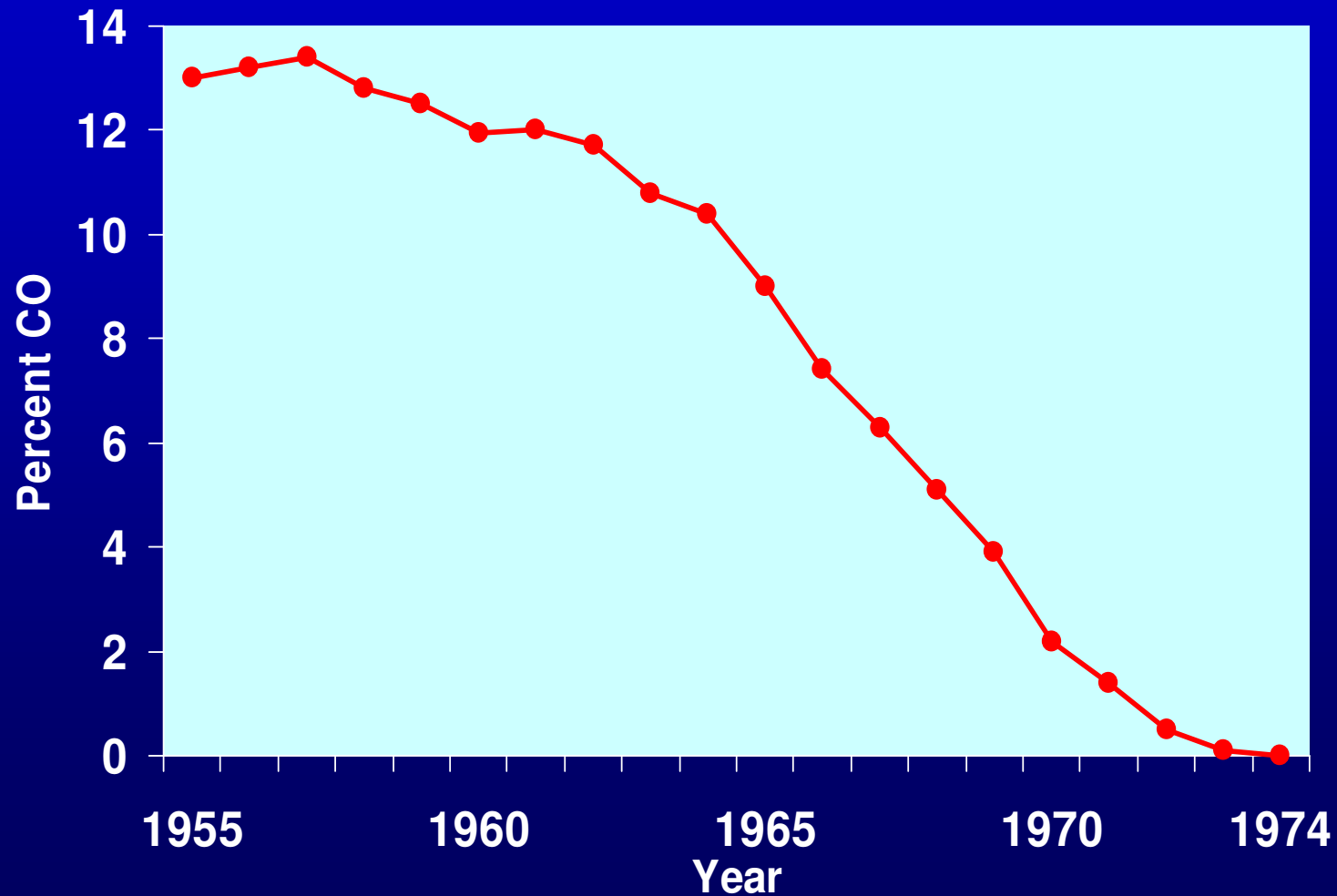
Modified from Crosby



THE COAL GAS STORY

(Kreitman, 1976)

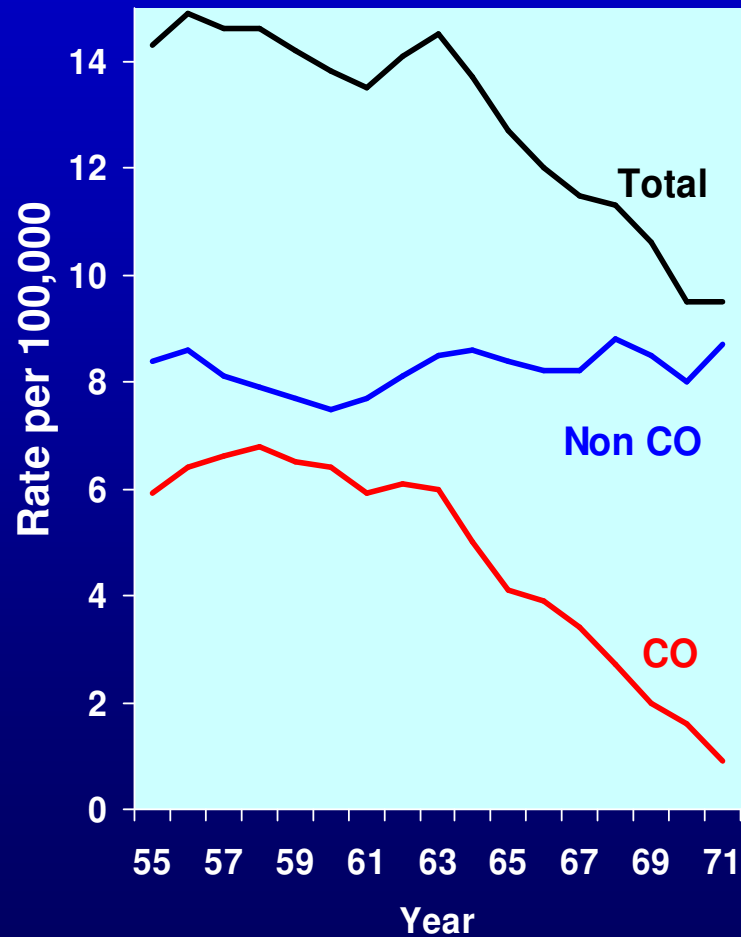
Percentage of CO in domestic gas, United Kingdom 1955-74



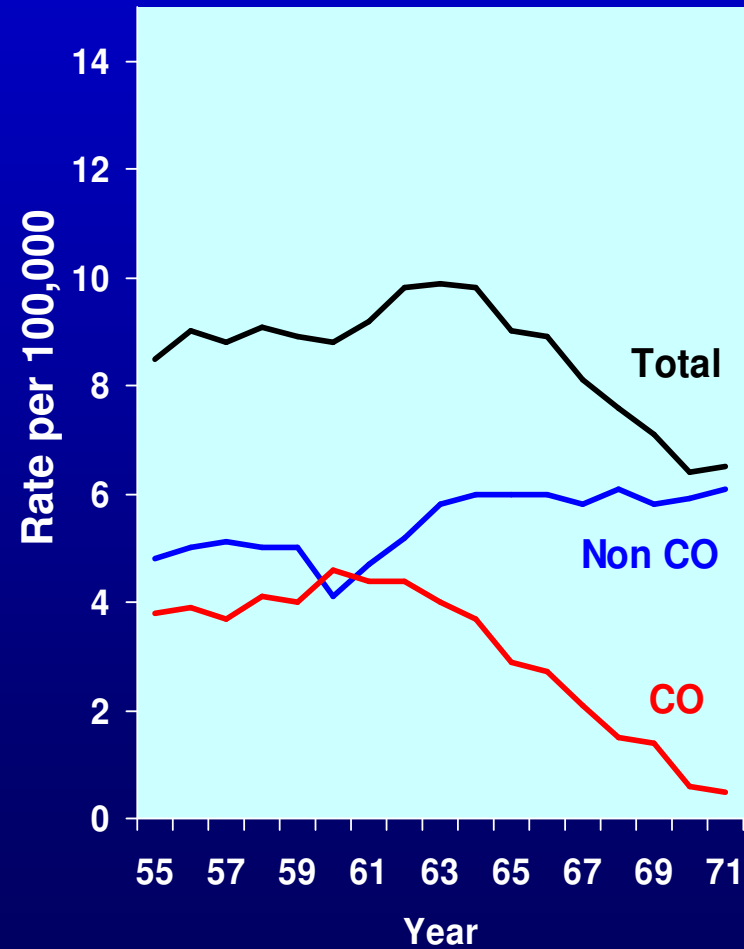
THE COAL GAS STORY

Suicide rates by mode of death: England & Wales

Males



Females





OPTIMAL SUICIDE PREVENTION =

Indicated

+

Selective

+

Universal

“MULTI-LAYERED SUICIDE PREVENTION”



OYAMA ET AL., Gerontologist 46:821-826, 2006

- All residents age ≥ 65 in Yasuzuka, Japan
- Pre/post and comparable town reference cohort
- Intervention – 7 yrs
 - Mental health education workshops
 - Annual, voluntary screening of depression
 - 2-stage screening and referral to general practitioner for treatment with psychiatric consultation available
- 64% \downarrow in suicide risk for **women**
- Nonsignificant for men
- No change for men or women in reference region

Framing Questions for the Designers of Suicide Prevention Programs

- What are the broad goals and specific objectives of the intervention and the program?
- Where does this program fit in an overall framework (schema, model) of suicide intervention?
- Who do we expect to reach with this effort?
- Who will we miss?
- What will we be changing?



Framing Questions for the Designers of Suicide Prevention Programs

- How will we measure those changes, and use that information to evaluate the program?
- How confident are we of our findings?
- Can the program and its results be “exported” widely?
- Can the program be sustained after its ardent founders have moved on?





Thank you

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