

Suicide Prevention in Patients with Late Life Depression

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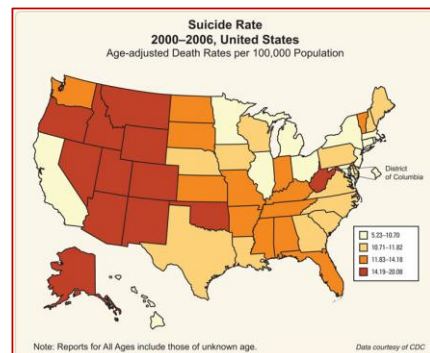
Montana Geriatric Education Center's 9th Annual Conference
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Disclosures

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the National Institute of Mental Health

Outline

- Epidemiology of Late Life Suicide
- Risk Factors and Prevention Strategies
- Assessment of depression and suicide risk
- Models for managing depression and suicide risk



The Good News and Bad News

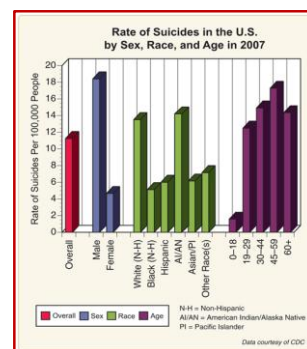
Late life is generally characterized by:

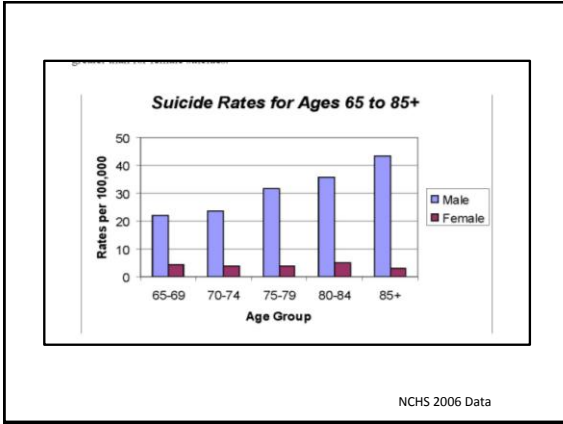
- *Greater well-being,*
- *Greater meaning to life, and*
- *Better capacity to manage emotions.*¹

But, for both men and women in most countries in the world, suicide rates are:

- *higher in later life than younger age*
- *peak in old age*²
- *Highest for men above age 75*³

1. (Charles, Carstensen, Annual Rev Psychology, 2010)
2. World Health Organization
3. National Vital Stat Report, 2009





We can Think of Suicide in Late Life

...the outcome of veering off the expected developmental path due to:

- several risk factors
- absence of protective factors¹

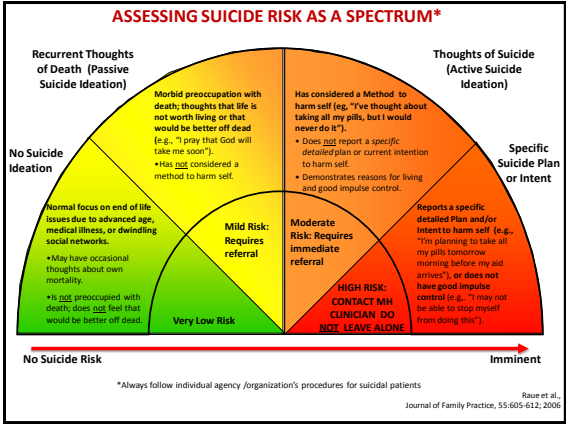
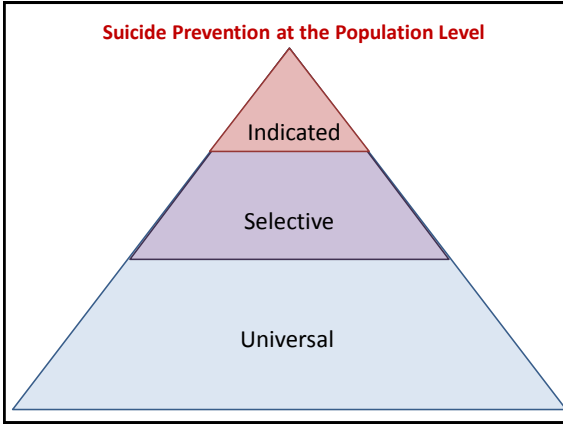
1 Van Orden and Conwell, Curr Psych Review, 2011

- ### Risk Factors for Suicide in Older Adults¹
- Suicide Ideation
 - Psychiatric illness
 - Mood disorders are the most common
 - Social Disconnectness
 - Living alone
 - Loss of spouse
 - Loneliness
 - Low social support
 - Physical Illness and Pain
 - Functional Impairment
- Van Orden and Conwell, Current Psychiatry Reports, 2011

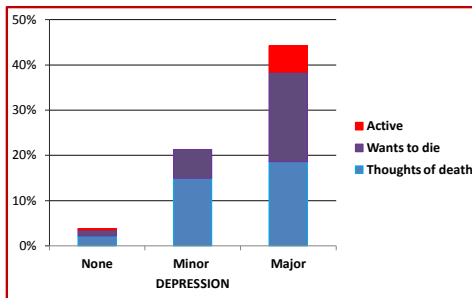
IOM Spectrum of Prevention Applied to Suicide Risk

Level	Target	Objectives	Examples
INDICATED	Individuals with detectable symptoms or syndromes – "suicide ideation"	Prevent initiation of suicide	PROSPECT, Stepped Care, Care Management
SELECTIVE	High-risk groups (proximal risk factors)	Reduce or treat risk factors	Outreach & services to homebound seniors
UNIVERSAL	Entire population	Broadly initiatives to reduce rise of risk factors; enhance protective factors	Senior centers, volunteer programs

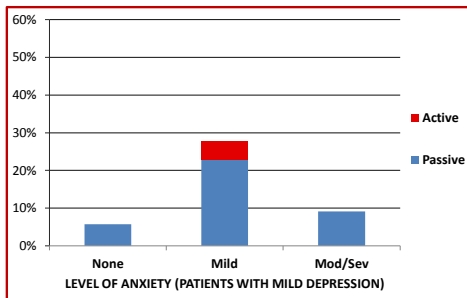
Adapted from: Conwell Y, Psychiatric Times, 2007



Prevalence of Suicide Ideation by Levels of Depression: Home Healthcare Patients (N=539)



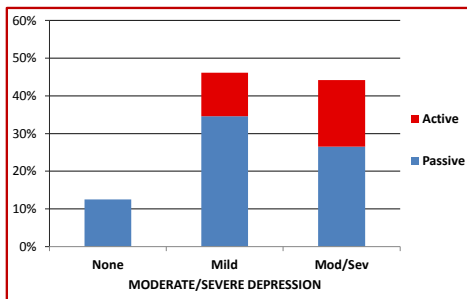
ANXIETY
Prevalence of Suicide Ideation by Anxiety and Mild Depression: Home Healthcare Patients (N=172)



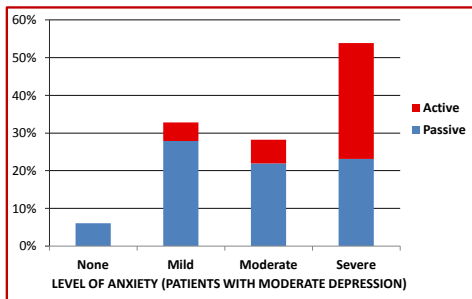
Levels of Suicide Risk Among Study Samples with Major Depression

	Homecare N=74	Primary Care N=396
High (Intent or Plan)	6.9%	3.2%
Intermediate (Thoughts of Suicide)	21.9%	8.4%
Low (Thoughts of Death)	18.2%	20.5%
No suicide ideation	53.0%	67.9%

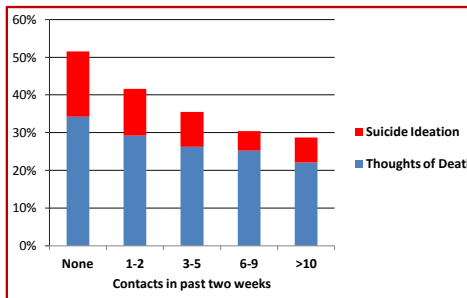
Prevalence of Suicide Ideation by Levels of Anxiety and Moderate Depression: Home Healthcare Patients (N=172)



ANXIETY
Prevalence of Suicide Ideation by Anxiety and Moderate Depression: Home Healthcare Patients (N=172)



Suicide Ideation by # Contacts with Friends or Relatives (Older Primary Care Patients WITH Major Depression: N=840)



Bartels et al., Am J Geriatr Psychiatry, 2002.

Screening for Suicide Risk

The majority of older adults who die by suicide were seen by a primary care physician: ¹

- *within one month of death (66%)*
- *within one week of death (50%)*

However, US Preventive Services Task Force decided in 2004 that:

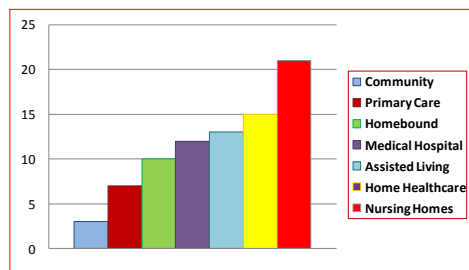
“the evidence is insufficient to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population.”

Conwell et al., J. American Geriatrics Society, 2000

Common Solutions

- Screen for clinically significant depression
- Screen for suicide ideation in “high risk” settings, defined by:
 - *High prevalence of depression*
 - *Social Isolation*
 - *Medical burden, disability*

Prevalence of Major Depression Among Older Adults By Setting



Background: What is Depression?

- **Everyday Blues to Clinical Diagnosis**
- **DSM-IV Major Depression**
 - Five or more persistent symptoms, including
 1. *Depressed Mood* and/or
 2. *Loss of interest or pleasure*
 - Symptoms cause distress or impairment in function

Depression, of course, is itself Important

- Impact on Older Adult:
 - *Suffering, poorer quality of life*
 - *Declines in cognition and medical status*
 - *Increased disability and self-neglect*
 - *Risk for falls*
 - *Suicide and non-suicide mortality*
- Impact of Provision of Care
 - *Excess use of services, higher annual costs*
 - *Increased nursing home placement*
 - *Greater burden to medical care providers*

Factors That Increase the Risk Of Depression (and are increasingly common with aging)

- **Medical Illness**
- **Disability**
- **Cognitive Decline**
- **Social Isolation**
- **Loss And Other Negative Events**

Challenges to Identifying Depression in Older Adults

- **Belief that depression is:**
 - "Normal" & Acceptable part of aging
 - A reflection of poor moral character not treatable
- **Symptoms overlap with medical illness & treatments**
 - Misattribution of physical symptoms to depression
 - Misattribution of depression sx to medical illness
- **Masked by:**
 - Atypical symptoms of depression like irritability
 - Co-existing psychiatric symptoms like anxiety
 - Co-existing disability, pain, cognitive impairment

Challenges of Adding Depression Assessment to Routine Care

- Already overburdened by primary focus
- Over-taxed by paper work
- Not enough time
- Insufficient Training about Referral and Treatment
- Stereotypes & Assumptions about Depression
- Scared of Depression (and Suicide)

Two Item Screen In the Context of Physical Assessment

- 1 - Depressed mood (e.g., feeling sad, tearful)

"How has your mood been in the past couple of weeks? Have you been feeling depressed or down? How about sad or blue?"
 - 2 - Loss of Pleasure or interest in Usual Activities

"In the past week, have you found yourself losing interest in your activities [that you are able to do]?"
- If Yes to either question, ask:
- "How long have you been feeling this way?"
- Two weeks or more?
 - How much of the day?"
 - Much of the day (not just transient thoughts)?

Bruce ML et al. A Randomized Trial of Depression Assessment Intervention in Home Health Care. J Am Geriatr Soc. 2007; 55, issue 11, 1793

PHQ-9 and PHQ-2

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

1. Little interest or pleasure in doing things?
 2. Feeling down, depressed, or hopeless?
- Not at all
Several days
More than half the days
Nearly every day

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001; Sep;16(9):606-13.

Scoring the PHQ-9

PHQ-9 Score	Severity Level (NOT Dx!)
< 5	No Depression
5 – 9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Severe Depression
> 20	Severe Depression

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Using the PHQ-9 with Older Adults: Depressed Mood



Video Clip



Video Clip

Using the PHQ-9 with Older Adults: Anhedonia (Lack of Interest or Pleasure)



Video Clip

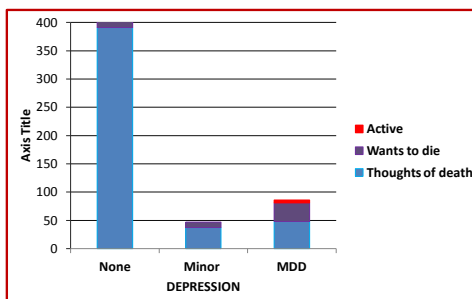


Video Clip

Common Solutions

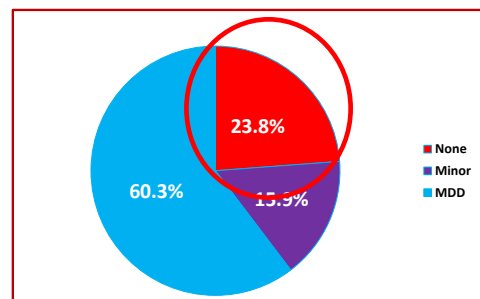
- Screen for clinically significant depression
- Screen for suicide ideation in “high risk” settings, defined by:
 - *High prevalence of depression*
 - *Social Isolation*
 - *Medical burden, disability*

Number with Suicide Ideation by Levels of Depression: Home Healthcare Patients (N=539)



Raue PJ, Int. J. Geriatric Psychiatry 2006.

Depression in HH Patients with Suicide Ideation:



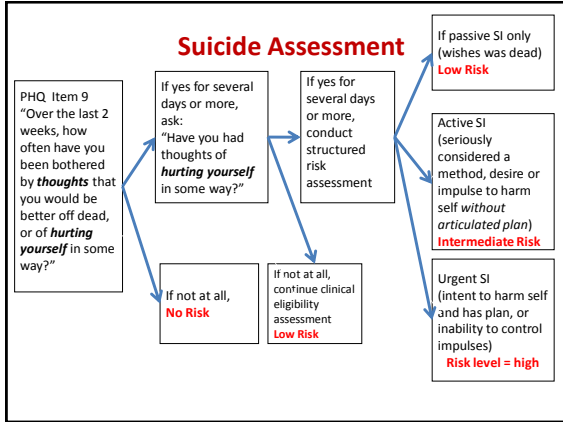
Raue PJ, Int. J. Geriatric Psychiatry 2006.

Challenges in Assessing Suicide Ideation In Older Adults

- Belief that Asking about Suicide:
 - *Will MAKE someone suicidal (it will not)*
 - *Will CAUSE a suicide attempt (it will not)*
 - *Will upset the person*
- Differentiating
 - *“Appropriate” thoughts about death*
 - *Wanting to die*

Suicide Risk Assessment Protocol

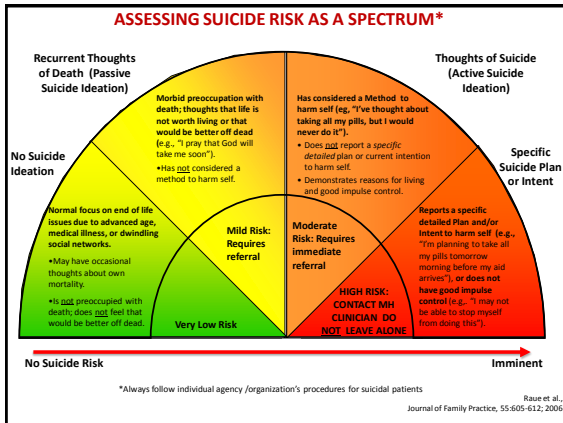
- Step 1: PHQ-9 – Item 9 “thoughts of being better off dead or hurting yourself in some way”
- Step 2: Structured Additional questions and risk algorithm
 - *Nature & frequency of thoughts of inflicting self-harm*
 - *Past suicide attempts*
 - *Specificity of current plans & means to implement*
 - *Strength of death wishes*
 - *Intensity of hopelessness*
 - *Impulse control*
 - *Presence or absence of preventive deterrents*



Sequential Questions to Determine Level of Suicide Risk

1. "In the past couple of weeks, were things ever so bad that you had thoughts that life is not worth living or that you'd be better off dead?" [Passive suicide ideation]
 - If Yes, continue with Question 2
2. "Have you had any thoughts about hurting yourself or suicide in the past couple of weeks?" [Active suicide ideation]
 - If Yes, continue with Questions 2a-2g
- 2a. "What have you been thinking of doing?" [Type of method]
- 2b. "How often do you have these thoughts? How long do they stay in your mind?" [Frequency and persistence]
- 2c. "What is going on in your life right now?" [Life stress (eg, loss, change in health status)]
- 2d. "Do you have a plan for doing this?" [Specific detailed suicide plan]
- 2e. "Do you intend to harm yourself?" [Suicide intention]
- 2f. "Is there anything preventing you from harming yourself? For example, how strong is your desire to live? Do you feel you have a purpose in life? Do you have hope for the future? Do you consider suicide morally wrong or against your religious beliefs? Do you want to avoid causing family and friends pain?" [Reason for living]
- 2g. "Do you feel you can resist these thoughts? Have you ever done anything to harm yourself? How often do you drink alcohol or use street drugs?" [Impulse control]

Raue PI, Brown EL, Meyers BS, Schubert HC, Bruce ML. Does every allusion to possible suicide require the same response? J Fam Pract. 2006 Jul;55(7):605-12.



- ### Before Screening For Suicide Risk, Agencies/Organizations Should:
- Have agency-specific protocols in place for use when older adults at risk for suicide are identified;
 - Such protocols should include, e.g.:
 - Steps for each level of risk
 - Strategies to ensure patient and assessor safety
 - Identification (with phone numbers) of whom assessor should contact
 - Telephone numbers for emergency services
 - Plans for formal clinical assessment

Sequence of Suicide Risk Assessment.

1. No Suicide Ideation

(Click on picture to start film)

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2. Recurrent Thoughts of Death: Mild Suicide Risk

(Click on picture to start film)

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3. Active Suicide Ideation



(Click on picture to start film)

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5. Very High Suicide Risk



(Click on picture to start film)

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Screening is Only the First Step

- Referral
 - Whom to contact and how
 - How to Present the “Case”
 - Accuracy
 - Clarity
 - Availability (information all in one place)
 - Timeliness
- Treatment and Management

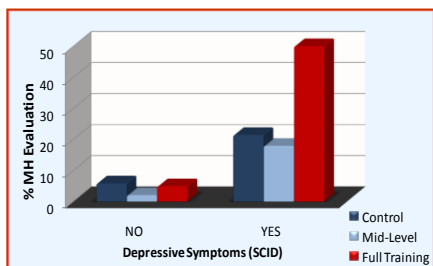
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Communication Referral Guide

- Reason for the call
- Age, marital status, race, gender
- Symptoms of depression, (duration, severity)
 - Suicidal ideation, psychiatric history(if any)
- Psychosocial: living situation/social support, stressors
- Medical illnesses, Medications
- Recommendation for further evaluation by MD or psychiatric nurse

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Randomized Trial of Depression Assessment (M0590) and Referral



Evidence Base for Improving Quality of Care for Geriatric Depression

- Treatment:
 - Antidepressants as effective in older patients as younger patients ¹
 - Psychotherapy also as effective in older patients as younger patients ²
 - NIH research on complex depressions (severe, psychotic features, bipolar, executive dysfunction)

1. (Reynolds et al, 2003, JAMA)
2. (Arelán & Cook, 2002 Biol. Psych.)

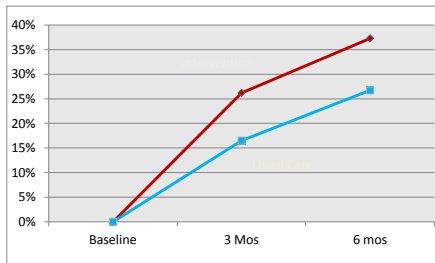
Chronic Illness Requiring Long Term Management

- Evidence-Base Interventions in Primary Care
 - PROSPECT (Bruce et al, 2004, JAMA)
 - IMPACT (Unützer et al, 2002, JAMA)
 - PRISM-E (Bartels et al, 2004, AJP)
 - RESPECT (Dietrich et al, 2004, BMJ)
- Key Elements:
 - Guideline-based treatments (antidepressants, psychotherapies)
 - New Role: Depression Care Manager

Depression Care Management Functions

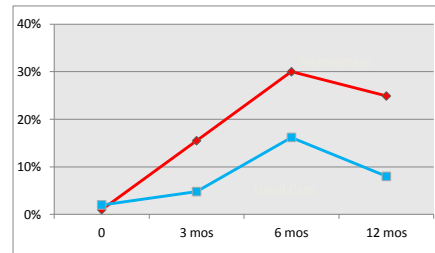
- Monitor symptoms,
- Monitor side effects, adherence
- Communicate with MD, consult specialist
- Patient self-management, activation,
- Patient and family education

Remission (HSCL <.5) from Major Depression RESPECT Study



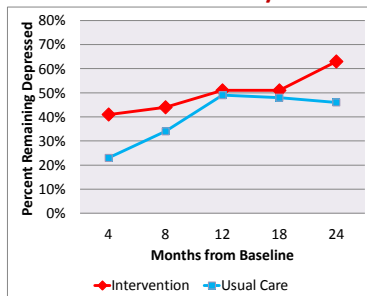
Dietrich AJ, et al BMJ. 2004

Remission (HSCL <.5) from Major Depression IMPACT Study



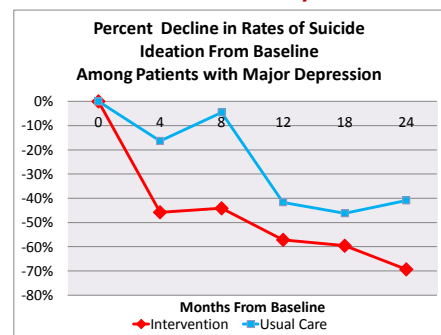
Unützer et al. JAMA. 2002.

Remission from Major Depression PROSPECT Study



Bruce et al. JAMA, 2004
Alexopoulos et al., Am J Psych 2010

PROSPECT Study



Bruce et al. JAMA, 2004
Alexopoulos et al 2010

Suicide Ideation and 5-Year All-Cause Mortality (PROSPECT Data)

Baseline depression status	Adjusted hazard ratio (Passive suicide ideation vs. No Suicide ideation)	
	Usual Care	
Major Depression	1.62 [0.75, 3.47]	
Minor Depression	1.66 [1.11, 2.49]	
Non-depressed	1.71 [1.11, 2.62]	

Hazard ratio estimates are adjusted for baseline disability, Hamilton Depression Score, and baseline smoking status. 95% confidence intervals shown in brackets N=1202
Raue et al., Am J Geri Psych 2010

Suicide Ideation and 5-Year All-Cause Mortality (PROSPECT Data)

Baseline depression status	Adjusted hazard ratio (Passive suicide ideation vs. No Suicide ideation)	
	Usual Care	Intervention
Major Depression	1.62 [0.75, 3.47]	0.68 [0.40, 1.18]
Minor Depression	1.66 [1.11, 2.49]	1.06 [0.64, 1.76]
Non-depressed	1.71 [1.11, 2.62]	1.64 [0.74, 3.65]

Hazard ratio estimates are adjusted for baseline disability, Hamilton Depression Score, and baseline smoking status. 95% confidence intervals shown in brackets N=1202
Raue et al., Am J Geri Psych 2010

Increasing Importance of On-Going Management: Changes Over the Past Decade (Home Healthcare):

	2000*	2007**
Diagnosis of depression	3.0%	6.4%
Taking an antidepressant	11.5%	39.5%
• Depressed	23.0%	69.1%
• Not Depressed	14.6%	27.1%

* Research data
** 2007 National Home and Hospice Care Survey

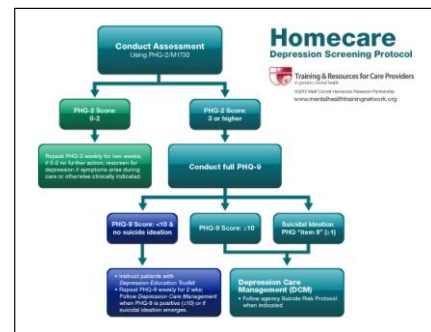
Translation of Depression Care Management from Primary Care to Other Settings: Case of Home Health

1. Every nurse provides basic Depression Care Management (DCM)
 - Teach DCM in context of other chronic disease management
 - Provide clear signals for consultation or referral
 - Teach to refer patients using "MD-ese"
 - Do not ask Nurses to give psychotherapy
2. Intervention has two components
 - Depression Care Management Protocol
 - Implementation Strategy

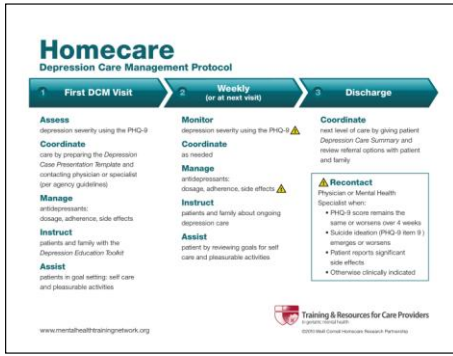
Depression CAREPATH (Depression Care for Patients at Home)

Depression Care Management Functions	
DCM Functions	CAREPATH Term:
Monitor symptoms,	Assessment
Monitor side effects, adherence	Manage
Communicate with the MD, consult specialist	Coordinate
Patient self-management, activation,	Goal Setting and Self Care
Patient and family education	Instruct

Screening Protocol

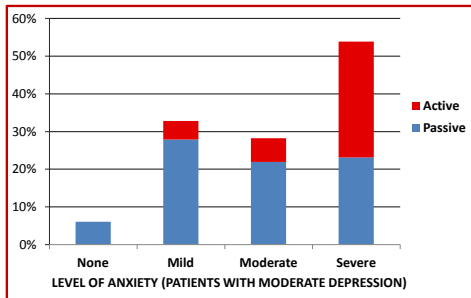


Depression Care Management Protocol

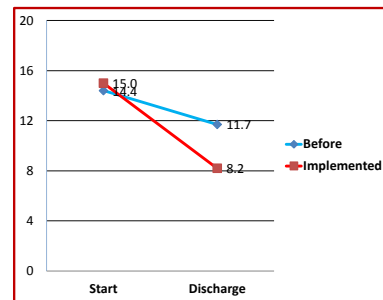


Depression CAREPATH (CARE for Patients AT Home) Implementation Strategy

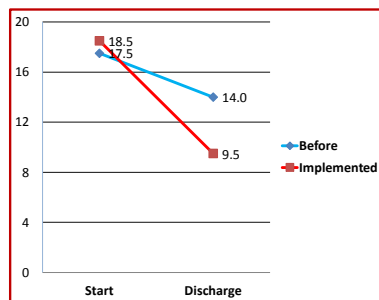
- Integration of Protocol into Clinical Information System
- Suicide and Referral Protocols
- Mental Health Resources
- Nurse Supervision



Change in PHQ-9 Scores Over Time, Before and After Implementation of CAREPATH intervention (Patients with PHQ-9 ≥ 10, N=84)



Change in PHQ-9 Scores Over Time, Before and After Implementation of CAREPATH intervention (Patients with PHQ-9 ≥ 15, N=42)



The Good, Bad and Good News

Late life is generally characterized by:

- Greater well-being and meaning to life,
- Better capacity to manage emotions.¹

But, for both men and women suicide rates are:

- higher in later life than younger age
- peak in old age

However:

- We know the major risk factors for suicide in late life
- Older adults at high risk can be
 - identified through systematic screening and assessment
 - Helped through treatment or reduction of risk factors
- We can strive to ensure meaning and wellbeing in the lives of all older adults.

Thank You