Fact Sheet: Geriatric Suicide Prevention and the Role of Primary Care Providers

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Geriatric Suicide Prevention

Introduction

The rapidly growing proportion of older adults worldwide is an achievement of modern medicine and public health initiatives. Epidemiologists project that the number of older adults living in the United States will nearly double by the year 2060, increasing from 52 million to 95 million people. Yet, providers are tasked with meeting the needs of increasingly large numbers of older adults. Those needs stem from a broad diversity of health-related changes, role substitutions, social and family developments, environmental demands, and relational losses. For many, such needs evolve after decades of challenges and experiences, including lifelong traumas and vulnerabilities related to systemic and everyday oppressions, family conflict, poverty, and countless other determinants of health and wellness. For these reasons, aging-specific competencies are recommended for providers working with older adults in every field of medicine, therapy, and social services.

Unique Concerns in Geriatric Mental Health and Depression

The mental health considerations for supporting older adults are as varied and complex as they are for any other population group because people reach late life with the full range of human experiences and varied potential aging-related experiences ahead. However, gerontology offers considerable research-based insights regarding mental health strengths and challenges in late life, and there are many important lessons to learn from this body of evidence. For example, older adults are generally satisfied with life. Relatedly, they are less likely to experience major depression than people at younger ages but more likely to experience some depressive symptoms. Yet, geriatric depression is a serious concern for older people and their families as well as their providers. Depression in late life is associated with significant detrimental impacts on quality of life, relationship status, functional and cognitive abilities, successful community living, and rehabilitation after traumatic injuries.

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For many older adults, depressive disorders are part of a recurring pattern that begins much earlier in life. For others, depressive disorders appear for the first time in late life. Many acute and chronic conditions are associated with geriatric depression including heart disease, hypertension, stroke, dementia, diabetes, cancer, chronic pain, hypothyroidism, vision loss, and osteoarthritis. Depressive symptoms also commonly occur with bereavement, anxiety, and dementia. While rates of Major Depressive Disorder are low among older adults (about 5%), clinically significant depressive symptoms are common (about 23%) and require treatment. The prevalence rate is even higher among older adults with serious medical problems, those living in nursing homes, recent immigrants, and those with more social stress. The stressors that can contribute to geriatric depression have been exacerbated by the COVID-19 pandemic and its impacts on communities, families, and older adults.

Depression presents differently among older adults than among younger people. Somatic complaints of bodily pains and vague discomfort are more common than reports of depressed mood or emotions described as sadness. Cognitive symptoms are prominent in older adults during major depressive episodes including disorientation, memory loss, and distractibility. When the initial onset of depression is in late life there is a higher likelihood of psychotic symptoms, hypochondria, and cognitive impairment than when onset is in young adulthood or middle age. Depression at any age can be reduced with treatment but, unfortunately, we know that treatment rates for older adults are abysmally low. Fewer than 4% of older adults with behavioral disorders receive treatment from primary care providers and less than 1% receive treatment from mental health professionals.

The Crisis of Suicide in Older Adults

One of the most important reasons for assuring that the primary care system improves to serve as an effective safety net for identifying and addressing geriatric depression is the high rate of suicide completion among older adults experiencing suicidal ideation. The elderly population comprises about 16% of the U.S. population today but account for 20% of all suicides. In 2019, there were about 8,000 suicides of older adults, or approximately 22 per day.

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Although older adults attempt suicide less often than those in other age groups, they have a much higher completion rate. Approximately 1% of suicide attempts lead to death in the general population whereas 25% of attempts lead to death among older adults. These high rates of death are driven by older adults' health problems and frailty, tendencies of keeping their plans private and avoiding interventions, and lower likelihood of being discovered immediately after an attempted suicide. Importantly, they are twice as likely as younger adults to use firearms as a means of suicide. The rate of suicide among older men is 6.11 times higher than that of older women. These alarming statistics are compounded by our knowledge of the underreporting of elderly suicides since passive self-harming behaviors that result in death for older adults, including refusing food, liquids, or medications, are rarely recorded as suicides.

How Primary Care Providers and Their Teams Can Help

The research evidence on the effectiveness of interventions for geriatric depression and suicide clearly supports the use of primary care-based collaborative care, pharmacological management of symptoms and monitoring of medication side effects, and a number of psychotherapies including problem solving therapy, and solution-focused brief treatment.

The pathway into any such treatment begins with the primary care provider who will conduct depression *and* suicide screening as well as provide continuity of care over time. Routine depression screening should be followed up with a suicide risk screening when indicated. Provider responses to suicide risk are based on the level of risk and should include the scheduling of follow-up visits while patients are currently being seen; addressing access to lethal means of suicide, and conducting safety planning—and at the most severe levels of risk—evaluating the need for emergency hospitalization.

Training for providers and their staff members is essential for knowing how to use the recommended screening tools and assessments, recognizing the risk of late life depression, conducting effective safety planning discussions with patients, deciding about the need for hospitalization, linking patients and their loved ones to appropriate interventions, and providing compassionate and ongoing treatment and reassessment. Learn more about the tools and guiding principles of Suicide Safer Care and the steps of suicide prevention. Such training demands time and commitment, yet the stakes could not be higher.

Related Resource

Suicide Prevention in Primary Care: A Toolkit for Primary Care Clinicians and Leaders: This publication provides further details on common screening and risk assessment tools, including the PHQ-9 and Columbia-Suicide Severity Rating Scale (C-SSRS), as well as clinical pathways and evidence-based interventions. An accompanying webinar, **"Suicide Safer Care for Primary Care Providers and Their Teams,"** is also available.