Aggressive Interventions Backed to Prevent Suicide

Long-term care facilities, home health care agencies, aging services providers are possible places to intervene.

BY JEFF EVANS
Senior Writer

STOCKHOLM — Interventions aimed at preventing suicide in older adults should target asymptomatic individuals and groups at risk for becoming depressed and suicidal to save the greatest number of lives, Dr. Yeates Conwell said at the 12th Congress of the International Psychogeriatric Association.

"There has been a tremendous amount of progress in recent years, largely from case-controlled, psychological autopsy studies, which have revealed an evidence base that I think provides a firm foundation for us to design preventive interventions," said Dr. Conwell of the Center for the Study and Prevention of Suicide at the University of Rochester (N.Y.).

Preventive interventions could be created to match trajectories toward suicide that some individuals experience as they age. Strategies could be tailored to address the particular mix of personality strengths and weaknesses, social contexts, and cultural values of a person or group.

Early intervention could be appropriate in selected individuals who, as they age, begin to develop rigid responses to stress that trigger symptoms and then develop into syndromes of depression and hopelessness.

Preventive interventions could be indicated in the people who drop into a perisuicidal state, Dr. Conwell said.

Some of the risk factors for suicide that have been identified in older adults include psychiatric illness (especially depression), prior suicide attempts, comorbid medical conditions, social dependence and isolation, family discord, personal losses, inflexible coping skills, and access to a means to commit suicide.

About 1 in 30 suicide attempts made by people in the general population is completed. But among the elderly, this proportion rises to 1 in 4.

About 1 in 30 suicide attempts made by people in the general population is completed. But among the elderly, this proportion increases to 1 in 4.

The rate of completion is greater among the elderly than among younger people because older adults are more frail and isolated, and they tend to be more deliberate and make plans about their self-destructive act. About 75% of older adults who attempt suicide do so with a firearm, compared with about 50% for all suicide attempters combined, Dr. Conwell noted.

These factors imply that "the interventions that we mount to prevent suicide in older adulthood have to be very aggressive but also suggest that we need to push preventive interventions" away from the suicidal crisis toward the realms of secondary and primary prevention, he said.

The primary care setting is an important place to intervene, given that many studies have shown that about 70%-75% of older people who have committed suicide saw a primary care provider in the month before the attempt; one-third to one-half of suicide completers had seen a primary care provider in the week before, he said. Mental health centers do not seem to be the place to intervene, since older adults are found at such centers in much lower proportions than younger adults.

Potential places to intervene outside of the medical setting include long-term care facilities, home health care agencies, and aging services providers. The highest number of lives may be saved by prioritizing intervention resources to four of nine possible ways of addressing suicide in older adults, Dr. Conwell said:

- In high-risk people who show no symptoms, depression could be screened for and treated by primary care providers in an office-based setting or by social services or home health care providers in the community. The Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) study used this design to detect and treat depression in primary care.
- To target high-risk but asymptomatic, groups of patients who may be socially isolated, in pain, or low functioning, geriatric physicians could assess and address problems to improve social and functional limitations. Good home health care and social outreach programs could maintain independence at home and reduce social isolation, he said.
- In order for preventive interventions to reach everyone, the entire population would have to be educated about normal aging and the fact that older age does not need to be "a negative time of life," Dr. Conwell explained. Access to care and social services would need to be increased for all older adults through legislative means and social engineering, according to Dr. Conwell.
- Universal outreach to the entire population to help those who are depressed would entail reducing the stigma associated with receiving mental health care and restricting access to lethal means, such as firearms. ■

Depression Triples Chest Pain Rates in Medicare Patients

DENVER — Depression significantly increased the rates of four types of cardiovascular conditions among Medicare patients aged 65 and older, compared with Medicare patients without depression, reported Dr. Lawson R. Wulsin in a poster presented at the annual meeting of the American Psychosomatic Society.

Dr. Wulsin, professor of psychiatry and family medicine at the University of Cincinnati, and his colleagues reviewed data from 177,760 Medicare patients who were enrolled in the 1998 Medicare Health Outcomes Study. Self-reported depression for at least 2 weeks during the year prior to the study was strongly associated with chest pain at rest (relative risk 2.79), myocardial infarction (relative risk 1.49), congestive heart failure (relative risk 1.81), and stroke (relative risk 1.78).

The significant increases in risk for these four conditions persisted when the patients reported depression or sadness either "much of the past year" or "most days during any 2 years of your life" —a finding that suggests a similar effect for both recent and long-term depression in older patients.

The results support the need for depression screening among older patients with cardiovascular disease and the need to identify factors that can mitigate these effects, the investigators reported. Their analyses of covariates, including age, gender, physical and mental functioning, smoking status, and diabetes status, are pending.

—Heidi Splete

Potentially Inappropriate Meds Prescribed For 39% of Managed-Care Elderly

BY KATE JOHNSON
Montreal Bureau

ORLANDO — Up to 39% of geriatric patients are taking potentially inappropriate medications, and this trend is associated with increased drug-related problems and health care costs, according to a recent study.

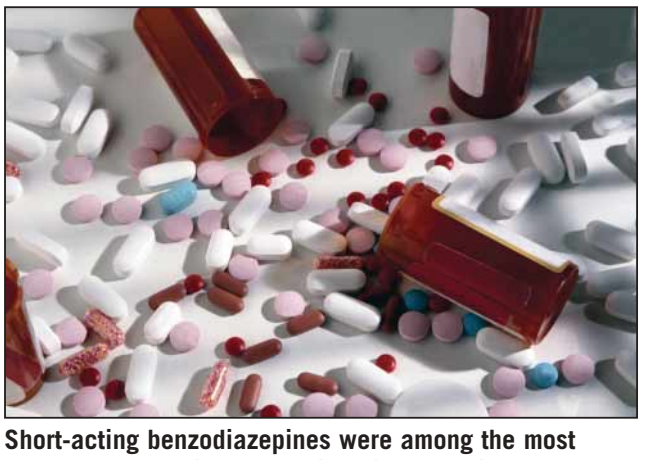
The findings should encourage physicians to be more critical in their prescribing decisions, said Diane M. Spokus, one of the authors of the study, which was presented as a poster at the annual meeting of the Gerontological Society of America.

The retrospective examination of medication use among 17, 971 managed-care patients aged 65 or older found that 6,875 (39%) were using at least one potentially inappropriate medication (PIM), including 13% who were using two or more PIMs.

PIMs were defined by the revised Beers criteria (Arch. Intern. Med. 2003;163:2716-24) as either "medications or medication classes that should generally be avoided in persons 65 years or older because they are either ineffective, or they pose unnecessarily high risk for older persons, and a safer alternative is available."

The finding of a 39% rate of PIM prescriptions is higher than what has been previously reported, "but we attributed that to the fact that we included oral estrogen as a PIM, and that accounted for almost 10%," Ms. Spokus said in an interview. After estrogen, the two most commonly prescribed PIMs were propoxyphene and combination products, as well as short-acting benzodiazepines (7% each), followed by digoxin (4.7%) and long-term, nonsteroidal anti-inflammatories (4.6%).

By using principal and secondary discharge diagnoses occurring within 30 days of the medication prescription, the study found a nearly threefold higher rate of drug-related problems among patients taking at least one PIM, compared with those not taking such medications (14% vs. 5%).



Short-acting benzodiazepines were among the most commonly prescribed potentially inappropriate meds.

The most common drug-related problems were syncope (3.6%), malaise and fatigue (3.5%), dehydration (1.8%), sleep disturbances (1.5%), and any cognitive impairment (1.5%). PIMs were associated with increased costs, including facility-paid, provider-paid, and prescription costs (about $2,250 per patient over 6 months), compared with patients who were not taking the medications (about $1,000), with patients taking more than one PIM accounting for the highest costs.

A larger, prospective study is needed to determine which drugs are associated with the most problems, Ms. Spokus said. The researchers also noted that their measures were limited in their ability to infer causality—something that might be achieved in a prospective study. ■