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Committee Secretary
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Re: Inquiry into Suicide in Australia

My submission focuses on suicide in old age as I believe it remains a neglected topic. I have structured my submission around the terms of reference.

- a) Despite an overall reduction in late life suicide, men aged 75 years and over remain a high risk group, particularly in rural areas in circumstances of drought, poverty and lack of a younger generation for support and in older migrants from some cultural backgrounds (e.g. Eastern Europe) where isolation is accentuated due to an absence of compatriots. The circumstances leading up to a suicide attempt in old age frequently involves declining health including chronic pain, in combination with social isolation, lack of social support, and evolving depression & hopelessness. The factors that determine why specific older individuals with the above-mentioned circumstances attempt suicide while most do not may be influenced by personality issues, childhood events (e.g. abuse, deprivation, genes) and mid-life events (e.g. substance abuse, relationships, health behaviours). In other words late life suicide prevention is about a 'whole of life' philosophy. Primary or Universal Suicide Prevention in Old Age should be part of a Healthy Ageing Health Promotion Strategy. Basically any strategy that will improve the health of people in old age will be consistent with reducing late life suicide.
- b) Suicide is likely to be under-reported in the elderly with GPs and other doctors being more likely to record deaths in frail elderly as being due to natural causes to avoid stigma for families and possibly in some circumstances to cover up assisted suicides. There is an issue of overlap with euthanasia but this would affect less than 10% of late life suicides.
- c) The majority of older suicides have a mental disorder at the time of death, usually severe depression. Suicidal older people are more difficult for doctors and other health professionals to detect than younger persons at suicide risk even though they are very likely to consult a GP in the months before death. They are less likely to discuss suicidal thoughts with the GP, have fewer immediate life events, more chronic disorders. Yet even if the GP diagnoses depression, older people are also less likely than younger adults to be referred for specialist mental health treatment. Factors that might contribute to this include stigma, ageism and lack of appropriate old age mental health services especially in rural & regional Australia. The recent National Health & Hospital Reform commission report highlighted this deficiency & recommendation 78 was for 'collaboration of governments to develop a strategy for older Australians to have adequate access to specialty mental health and dementia care services'
- d) These programs seem to focus on younger people rather than older age groups so they lack relevance to the older population. Our recent published research (see attached paper) has found that often there was concern about suicidality in the weeks before suicide that was not adequately assessed due to the lack of communication between families & health professionals – often the family assumed the doctor knew the person was suicidal when they didn't because the suicidal communications have only been made to family members.
- e) GPs acknowledge that they have difficulty in detecting depression in late life and lack confidence in treating it – there is a training need that remains inadequately met. Tertiary or Indicated Suicide prevention should focus on detection of depression & suicide risk in older individuals – more training of GPs and other health professionals in identifying potentially high risk individuals and just as importantly how to better treat depression and

suicide risk in these identified individuals. Such training should emphasise the importance of communication with family & close friends & vice versa.

- f) To some extent this exists within aged care and old age mental health programs around Australia but there are problems with co-ordination between programs where the mental health needs of older people can fall between the gaps due to jurisdictional divides and inadequate resources for old age mental health. Some strategies for older people that should focus on those at high risk (e.g. older people with chronic pain, socially isolated migrants & rural elders, older persons with a history of depression, older persons recently diagnosed with life-threatening illnesses such as cancer or dementia) can be implemented by training gate keepers (Aged care services, emergency ward workers, home care workers, clergy, ambulances, nurses) about the risk & ways of reducing it.
- g) There has been relatively little research into late life suicide in Australia compared with other age groups. Our research program with an ARC funded psychological autopsy study is about to disseminate its findings of the last contact health professionals had with middle-aged and older suicide victims (the attached paper was the pilot study). It will be important for us to ensure that we target GPs and other health professionals in an effective way that will assist their practice as the findings illustrate the relative difficulty of identifying suicidal older people in comparison with those in middle age as there are relatively few acute warning signs.
- h) The Australian Suicide Prevention strategy has grown out of a youth suicide strategy of the 1990s and has yet to fully grasp a lifespan approach other than in the words used. Few specific strategies targeting older people have been implemented. A similar problem exists in overall mental health policy such as the 4th National Mental Health Plan where older people are there in words but not actions.

I trust that these opinions will assist the Senate Inquiry.

Yours sincerely

Brian Draper

A Pilot Study of the Suicide Victim's Last Contact with a Health Professional

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Abstract. Suicide victims frequently have contact with health care professionals in the months before death. The primary aims of this pilot psychological autopsy study were to determine the feasibility of undertaking a full study and to describe the characteristics of the last health care professional contacts with suicide victims aged > 34 years. We interviewed the informants of 52 suicides. Interviews were obtained from 37 health care professionals who had contact with 28 of the suicides during the 3 months before death. The primary reasons for the last contact with the health care professional were mental health (62%), physical health (22%), and social (14%). 87% of health care professional contacts occurred within 1 month of death. Symptoms of depression were noted in 49% of health care professional contacts. Consensus psychological autopsy diagnoses of depression were made in 64% of suicide victims. Overall suicide risk was assessed by 38% of health care professionals during their last contact. This was more likely to occur when the deceased presented as depressed, was aged < 60 years or seen by a psychiatrist. None was assessed to be suicidal. The family informants regarded nine of the suicide victims to have been suicidal before death but informed a health care professional in only one third of the cases. Critical information that might have altered the management is not often accessed from family members.

Keywords: suicide, psychological autopsy, risk assessment

Improved understanding of why people kill themselves should help in the prevention of suicide. Suicide is a complex behavior, with biological and psychosocial components. A conjunction of factors may lead to self-harm, and preventive approaches largely depend on recognition of relevant factors, and intervening to diminish their contribution to suicidal thinking (Draper, 1995).

It has long been known that suicide victims have frequently been in contact with health professionals, particularly general practitioners (GPs), in the months before death. One systematic review found that up to 73% of people who die by suicide had contact with their GP in the 3 months before and 22% in the week before (Pirkis & Burgess, 1998). In old age, over one third have seen a GP within the week of their suicide (Pearson, Conwell, & Lyness, 1997), with one recent Canadian study finding that almost one half had visited a physician in the previous week (Juurink, Herrmann, Szalai, Kopp, & Redelmeier, 2004). A more recent review found that 44% of all suicides had contact with a primary care professional in the month before death, increasing to 58% in those aged 55 years and over (Luoma, Martin, & Pearson, 2002). In contrast, while nearly 19% of all suicides had seen a mental health professional

in the month before suicide, this dropped to around 11% for those aged 55 years and over (Luoma et al., 2002). While some authorities have stated that the last clinical contact might have been a missed opportunity for suicide prevention (Obafunwa & Busuttill, 1994; Vassilas & Morgan, 1994), there is only limited information about what occurs during these consultations.

Previous investigations of the last clinical contact with GPs have relied on case notes (Milne, Matthews, & Ashcroft, 1994; Van Casteren, Van der Veken, Tafforeau, & Van Oyen, 1993), police interviews (Obafunwa & Busuttill, 1994) or brief interviews (Isometsa et al., 1995; Vassilas & Morgan, 1994). These studies suggest that between 42% and 70% of contacts were for psychosocial reasons and 30–58% for physical reasons (Isometsa et al., 1995; Obafunwa & Busuttill, 1994; Van Casteren et al., 1993; Vassilas & Morgan, 1994). While the communication of suicidal intent to a health professional has been found to occur in 22–45% of last clinical contacts, it has been reported to occur in only 11% of GP contacts (Isometsa et al., 1995; Obafunwa & Busuttill, 1994). Males are less likely to communicate suicidal intent than females (Isometsa et al., 1995) and older victims are less likely to communicate than

younger victims (Conwell et al., 1998). Detailed descriptions of what occurred in the interviews are lacking. It is unclear how many of the contacts occurred for reasons that were directly or indirectly related to the eventual suicide.

There is mounting evidence, however, that primary care interventions might be effective in preventing suicide largely through more effective assessment and management of depression. Education of general practitioners about depression and suicide in the elderly increases their detection of depressive and suicidal symptoms (Pfaff & Almeida, 2003). Randomized controlled trials of collaborations between primary care and mental health professionals have been shown to improve the management of depression and reduce depressive and suicidal symptoms in the elderly (Alexopoulos et al., 2005; Bruce et al., 2004; Unützer et al., 2002;). In addition, while correlation is not necessarily causation, two reports have linked the increased exposure to antidepressants in the 1990s with falling suicide rates. In Sweden a 3.5-fold increase in use of antidepressants has been accompanied by a fall in suicide rate (Isacsson, 2000), while in Australia an association between the exposure to antidepressants and reduction in suicide rates in older age groups has been reported (Hall et al., 2003). It has also been reported that lower suicide rates in the elderly are associated with increased numbers of general practitioners, mental health staff, and social workers in England and Wales between 1985 and 1998 (Lodhi & Shah, 2005).

In this report we present the findings from a pilot study for a detailed psychological autopsy investigation of the last contact that middle-aged and older suicide victims had with a health professional. The primary aims of the pilot study were to determine the feasibility of undertaking such a study and to describe the characteristics of the last health professional contacts with the suicide victim including the identification of psychological morbidity and suicide risk.

Methods

All suicide deaths determined by the coroner at Glebe Coroner's Court, Sydney, Australia, of persons aged 35 years and over from April 2003 until April 2004 were potentially eligible for inclusion in the study. The age cut-off of 35 years was chosen due to a combination of our interest in mid- and late-life suicide and the fact that the younger suicides were involved in a project with a different research team. After the coronial decision had been made (approximately 6–12 months after the suicide), a letter signed by the coroner inviting participation in the study was sent to the next-of-kin. This was followed up by a phone call from the project research officer.

Following the provision of informed consent, the next-of-kin was interviewed about the suicide victim using a modified version of the Rochester Suicide Behavior Profile in a semistructured taped face-to-face interview (Conwell et al., 1996). The interview included demographic data, in-

formation about what led up to the suicide including expression of suicidal ideation and the Structured Clinical Interview for DSM-IV (SCID; Spitzer, Gibbon, & Williams, 1994). We also obtained information about health professional contacts in the previous 3 months. Consensus psychiatric diagnoses based on DSM IV were obtained between the three authors using the best available information from the SCID and the semistructured informant interview, information from medical records, coroner's files, and health care professionals. Information about physical health, social supports, life events, personality, cognitive decline, and use of formal services was also obtained but will not be covered in this report.

The next-of-kin was asked to give permission for us to speak to the deceased's health care professionals (HCPs) about their last contact with the suicide victim. Where agreement was obtained, interviews were sought with all consenting HCPs with whom the deceased subject had contact during the 3 months before death. The HCPs were offered remuneration for their time in participating with the study. The semistructured interviews about the last contact were flexible in format and included the date and length of the last contact, number of contacts in the 6 months before death, and the period of time the subject had been known to the HCP. Information was obtained about the location, urgency and reason for the appointment, the focus of the consultation, the subject's symptoms described in the contact, and the HCP's management (including medication prescription) and the date of the next scheduled contact (if any).

We also obtained information about the subject's compliance with appointments (and treatments in general), known active and past physical and mental illnesses and their management, active and past substance use, functional capacity, reported sleep problems, the presence of pain and the pain management strategies being used and past history of risk taking behavior, accident proneness, suicide attempts, and nonsuicidal deliberate self-harm.

We inquired about the process and atmosphere of the interview. This included the rapport attained, whether the subject's behavior was in any way unusual, whether the HCP felt uneasy about anything, and whether the health professional was at all concerned about the possibility of suicide. A checklist of known behavioral changes before suicide including such things as intent to change a will, disposing of possessions, stockpiling of pills, acquisition of a firearm, statements of hopelessness, and the response of the health care professional was completed by the HCP about the contact with the subject.

The coroner's files of all suicides excluded due to the lack of informed consent from the next-of-kin were examined using a pro-forma datasheet to extract de-identified demographic data, general and mental health information, issues identified as being important in contributing to the death, substance use, and prior contact with HCPs from medical practitioner reports and police interviews with informants.

Institutional ethics committee approval was obtained from the Research Ethics Committee, Eastern Section, South Eastern Sydney Area Health Service.

All tapes of the interviews with NOK and HCP were transcribed and detailed case notes were written for each case. The quantitative data was managed in SPSS 13.0 (Statistical Package for the Social Sciences, 2004). Descriptive statistics, cross-tabulations, independent *T*-test and χ^2 tests were applied. A probability level of .05 was adopted.

Results

During the study period there were 127 suicide deaths in persons aged 35 years and over determined by the coroner. Persons identified as next-of-kin or close contacts of 52 (41%) of these suicides participated in the study. Of the nonparticipants, 28 refused, 30 were unable to be contacted, 9 lived too far away for face-to-face interviews, 3 were excluded because of safety concerns for the interviewer, 2 had poor English, 2 had no next-of-kin identified, and 1 was known to the interviewer. Fifty-five (73%) of the suicide deaths of nonparticipants were known to have had contact with a HCP in the 3 months before death.

From information supplied by the informants and available from the coroner's files, eleven of the 52 suicides (21%) had no contact with HCPs in the 3 months before death and the remaining 41 suicides had contact with 68 HCPs. Of these 68 HCPs, 37 (54%) agreed to participate in the study, access to 11 HCPs (16%) was not granted by the public health service, 8 (12%) could not be contacted, 7 refused to participate (10%), access to 4 HCPs (6%) was not granted by the next-of-kin, and 1 HCP (2%) had retired. Of the 31 HCPs that did not participate in the study, 17 provided a statement to the police, limited information was available from other sources for another 8, and there was no information available for 6 HCPs. An unknown number of other HCPs had contact with the 5 suicides that had been in hospital or in an aged care facility in the 3 months before death.

The HCP interviews took place between 10–14 months after the suicides. The 37 HCPs were involved in the care of 54% ($n = 28$, males = 17, age range 37–89 years, mean age 55.9 years) of the suicides where we had obtained informant interviews and this represented 68% of the suicides who had contact with HCPs. Details concerning consensus psychiatric diagnoses recorded for these 28 suicides, which did not differ significantly from the informant interview suicides without HCP interviews, are listed in Table 1.

Interviews with HCPs were obtained from one HCP in 20 suicides, 2 HCPs in another 7 suicides, and 3 HCPs in 1 suicide. Twenty-eight of the HCPs were doctors (15 GPs, 10 psychiatrists, 2 nonpsychiatric specialists and 1 emergency ward doctor), 5 were clinical nurse consultants, 2 were psychologists and 2 were counselors. Overall, there were no significant differences in terms of profession between the HCPs interviewed and those who were not. There

Table 1. Consensus psychological autopsy psychiatric diagnoses of suicides seen by health-care professionals ($n = 28$)

	N (%)
Male	17 (61%)
Aged under 60	20 (71%)
Major depression	14 (50%)
Non-major depression	4 (14%)
Schizophrenia/psychotic disorder	4 (14%)
No psychiatric diagnosis (excluding personality & substance abuse)	6 (21%)
Personality disorder	7 (25%)
Substance abuse	9 (32%)

were also no differences in the characteristics of the deceased – age, gender, or presence of depression between those HCPs interviewed and those not interviewed.

Of the 37 HCPs, 22 (60%) were males and 26 (70%) were in private practice. The professional career of the HCPs had median duration of 20–25 years. They were most likely to be the HCP with overall responsibility in the care of the patient ($n = 29$, 78%). Four HCPs had contact with the deceased within 24 h of death, 19 (51%) within one week of death, and 32 (87%) within 1 month of death. Twenty-one HCPs were the last HCP contact the suicide had before death. Police statements had been obtained from 26 (70%) of the HCPs.

The main reason for the last HCP contact was for mental health issues in 23 (62%) contacts; this included 5 contacts after recent psychiatric hospitalization, of which 3 involved suicide attempts. Eight HCP contacts (22%) were for physical health; 5 (14%) for social problems, and 1 was a review in a nursing home. The median and modal duration of the last HCP appointment was 50–60 min with only 12 (32%) being less than 20 min. There was a trend toward older patients having shorter appointments. For appointments lasting less than 20 min the mean age was 62.5 (compared to 52.7 for appointments longer than 20 minutes), $F(1, 35) = 2.02$, $p = .055$. In the last month before death, 13 HCPs (35%) reported multiple contacts with the deceased, while 24 HCPs (65%) had multiple contacts in the 3 months before death including 12 (32%) with more than 4 contacts. In 28 HCP contacts (76%) the deceased had received treatment for mental health problems previously; in 26 (70%) there was a known current mental health diagnosis, and in 27 (73%) the deceased was being treated for mental illness at the time of death.

The HCPs were asked about what happened during the last contact with the deceased. The deceased presented as being depressed in 18 (49%) contacts and this was significantly more likely to occur in contacts < 60 years of age ($n = 26$) (Pearson $\chi^2 = 14.830$, $df = 2$, $p = .001$). Of note, in each of the 3 depressed presentations = 60 years, the depression had been gradually improving. Seventeen of these contacts that were noted by the HCP to be depressed

(94%) were given a principal consensus diagnosis of major depression in the psychological autopsy study. Four HCP contacts (21%) with a principal consensus diagnosis of major depression did not present to the HCP as being depressed. However, none of the 4 HCP contacts with a principal consensus diagnosis of nonmajor depression or the 6 contacts with a principal consensus diagnosis of schizophrenia/psychotic disorder, or the 6 contacts with no psychiatric diagnosis presented to the HCP as being depressed. The deceased was noted to be anxious in 20 of the HCP contacts (54%) and this did not vary with age. Of those contacts, 9 were also depressed. The principal consensus diagnosis in the psychological autopsy of the anxious presentations was major depression ($n = 8$, 40%), schizophrenia/psychotic disorder ($n = 4$, 20%), nonmajor depression ($n = 2$, 10%), and no psychiatric diagnosis ($n = 6$, 30%).

Thirty-one HCPs (84%) reported that they had attained good rapport with the deceased while 4 described the interviews as 'difficult,' and 2 stated that the deceased was disengaged, more guarded, or subdued. In 4 of the HCP contacts (11%) hopelessness was a theme. In 34 (91%) there was no evidence of unusual behavior. Three were feeling "more hopeless than usual". No HCP contacts discussed disposal of possessions, purchasing of firearms, stockpiling of pills, or making a will.

In 14 interviews (38%), a suicide risk assessment was formally undertaken by the HCP (see Table 2), but in none of these did the HCP believe that the patient was suicidal, although, in at least 2 cases, patients were assessed as being suicidal by the HCP in an earlier contact they had with the patient in the previous month. Four (21%) of the contacts that did not present as being depressed were formally assessed regarding suicidality. These contacts involved 3 suicides (2 contacts were the same case) and each had complex psychiatric comorbidity. All had a history of substance abuse, 2 had a diagnosis of psychotic disorder, 2 were cognitively impaired, and 1 had a borderline personality disorder. Eight of the suicides were seen by multiple HCPs and the reports of the different HCPs were generally consistent with each other.

Family informants reported a change of behavior in 11 of the 28 suicides (39%) though they had been aware of it at the time in only 3 cases – each had a borderline personality disorder and had been noted to be stockpiling pills. Other behaviors mentioned in hindsight included disposing of possessions ($n = 3$), stockpiling of pills ($n = 6$), intent to change will ($n = 4$), and acquisition of firearm ($n = 1$). Fifteen (54%) mentioned statements of hopelessness and in 8 of these cases (29%) the family interpreted the statements as a suicide threat. Overall, the family informant was aware that the deceased was feeling suicidal in 9 cases (32%), and in 3 of these cases the family member had attempted to communicate this concern to a HCP. On 2 of these occasions, both within 48 h of death, the family member was reassured. The family informant had no indication of behavior change or suicidal preoccupation in 9 cases (32%).

Information obtained from the interviews with family

Table 2. Suicide risk assessments by HCPs

	SA by HCP (%)
All contacts ($N = 37$)	14 (38%)
Depressed presentation ($N = 18$)	10 (56%)
Anxious presentation ($N = 20$)	7 (35%)
Consensus diagnosis major depression ($N = 21$)	13 (62%)
Consensus diagnosis non-major depression ($N = 4$)	0 (0%)
Consensus diagnosis schizophrenia/other psychosis ($N = 6$)	3 (50%)
No psychiatric diagnosis ($N = 6$)	0 (0%)
GP contact ($N = 15$)	3 (20%)
Psychiatrist contact ($n = 10$)	7 (70%)
Nurse contact ($N = 5$)	0 (0%)
Mental Health professional ($N = 19$)	10 (53%)
Non-mental health professional ($N = 18$)	4 (22%)
Family aware that patient potentially suicidal ($N = 11$)	6 (55%)
Family unaware that patient potentially suicidal ($N = 26$)	8 (31%)
Contact aged = 60 years ($N = 11$)	2 (18%)
Contact aged < 60 years ($N = 26$)	12 (46%)

SA = suicide assessment.

informants about potential suicidality and unusual behavior was compared with the HCP reports. On each of the 4 occasions that the HCP noted the patient to be hopeless, the family informant had also noted the hopelessness and had been concerned that the deceased was suicidal. However it seemed that family members were more aware of behavior change associated with possible impending suicide and acute suicide threats of the deceased than the HCPs. There were 16 contacts for whom the family member felt that the deceased was suicidal but a suicide risk assessment was undertaken by the HCP in only 10 of them.

Nineteen of the last contacts (51%) were taking antidepressant medication and 9 (24%) were on antipsychotics, some in combination ($n = 5$, 14%). Overall 8 (22%) were not prescribed psychotropics. Twelve of the contacts took psychotropic medication as prescribed (32%), but poor compliance with medication was noted in 12 contacts (32%), and in a further 5 contacts (14%) 'doctor shopping' for medication was reported. Further appointments were made for 22 (60%) of the contacts; of these 13 (35%) were for the following week.

It was noteworthy that 6 of the HCPs (16%) had been unaware of their patient's death at the time of the study, while another 1 was unaware that the death was suicide.

Discussion

Before discussing the results of this pilot study, there are a number of limitations that should be noted when interpreting the results. The HCP interviews took place an average of

10–14 months after the suicides, because the coronial process had to be completed before we were allowed to recruit subjects. This gap between the death and the interview could have affected the accuracy of the HCPs' recall of events. In addition, we do not know whether HCPs glossed over any information that might have suggested that their management had been substandard. We also do not know whether knowledge of the suicide biased the HCPs' recall of the events. The pilot was uncontrolled, so we do not know whether these last contacts were different from other HCP contacts on any parameters. The sample size is small, representing only 22% of the total sample and 29% of suicides that had HCP contact, which limits the conclusions that can be drawn from the results. We only recruited HCPs with the consent of the next-of-kin of the deceased, so this might have introduced a bias in the HCPs that participated and also contributed to the low rate of participation. Our sample was limited to suicides aged 35 years and over, so the results may not be applicable to younger suicides.

The primary aim of this pilot study was to determine the feasibility of undertaking a full psychological autopsy that focused upon the last contact that HCPs had with suicide victims. Overall, we believe that the pilot demonstrated that such a study was feasible. We were pleased that over 54% of eligible HCPs participated in the study and that over 86% of the HCPs had contact within 1 month of the death. The refusal rate by the HCPs was only about 10%, with some being due to fears of litigation. We did not expect to have our access to just over 16% of HCPs blocked by public mental health services as the NSW Centre for Mental Health funded us. We did have a letter of support from the NSW Centre for Mental Health that was circulated to the various health services requesting their cooperation with the study, but some were concerned about their staff participating. In the full study we hope to overcome this problem by having the main area health services that cover the regions from which the sample will be drawn as formal study partners. To increase the number of participating HCPs, we will access HCPs from deaths where there is no contactable next-of-kin, and will also allow the next-of-kin to give consent to us contacting HCPs without actually being interviewed themselves.

On the whole, the HCP interviews went smoothly. With the aid of their notes, most of them appeared to remember the last contact they had in sufficient detail to answer our queries. For some, the interviews had a debriefing function, as they had had little, if any, previous opportunity to talk about the death of their patient. Surprisingly, before being contacted to participate in the study, 7 (19%) of the HCPs had been unaware that their patient had committed suicide.

Some studies have suggested that HCPs' failure to recognize depression is a critical issue, but our findings only lend partial support to that view (Suominen, Isometsa, & Lonnqvist, 2004). About 75% of the deceased had diagnosed and treated mental illness at the time of death. The majority was prescribed antidepressant medication though compliance was an issue in nearly one third of

cases. In the last contact, over 60% of the contacts with major depression were assessed for suicide risk and none was felt to be suicidal. Assessment of suicide risk was more likely to occur when the HCP was a psychiatrist. Situations where suicide risk was unlikely to be assessed despite the presence of depression included when the depression was improving, the type of depression was non-major, the patient was aged over 60, and the HCP was a GP or a nurse. Each of these situations is known to present particular challenges for depression management.

It has long been known that some suicide victims reach a state of apparent contentment once they have decided on a definite plan to take their life and, thus, appear to be improving. This does raise the basic question of how often during the course of a depressive episode should a clinician formally check whether their patient is harboring suicidal thoughts, and how to do this in a way that elicits signs of high risk in a person who is claiming to feel well. This is also a difficult proposition in patients with chronic less severe depressive states. Older depressed patients are more likely to have atypical presentations of depression and to be less likely to communicate suicidal intent (Conwell et al., 1998). Furthermore, older depressed patients are more likely to be seen by GPs. GP depression education is frequently mentioned as an imperative in suicide prevention strategies, and these data lend some further support to that (Pfaff & Almeida, 2003).

Family informants appeared to have more detailed knowledge of behavior suggestive of potential suicide risk than did the HCPs. Yet they infrequently attempted to communicate concerns to HCPs. This might have been partially due to lack of awareness of the potential seriousness of the behavior. It is possible that knowledge of such behavior might have changed the HCP management plan and prevented the suicide. Some of these informants seemed unaware that they possessed unique knowledge about the suicidal state that was evolving and failed to pass on the information to HCPs, partly because they had presumed that the HCP was aware and, hence, was managing the situation. Others reported failed efforts to tell HCPs about their concerns. These findings suggest that education of families of depressed patients and the general public about behavior associated with suicide, and what they should do if it were to occur, remains an important strategy that might prevent suicide.

In conclusion, we are currently undertaking a controlled psychological autopsy study involving interviews of informants and HCPs that will have an adequate sample size to address a number of the issues raised in this pilot.

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