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Perspective

Considerations for the assessment of suicidal ideation and behavior in older adults with cognitive decline and dementia

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Abstract

Introduction: Better understanding of suicide risk and its management in older adults with cognitive impairment and/or dementia remain significant unmet public health needs. Urgency to address them derives from concern that CNS treatments for dementia may impact suicide risk. Regulatory guidances requiring assessment of emergent suicidal ideation and behavior (SI/SB) at every clinical trial visit emphasize the need for understanding their prevalence.

Methods: The literature regarding SI/SB in older persons with cognitive impairment or dementia was reviewed by an Alzheimer's Association Taskforce with emphasis on epidemiology, classification, assessment, and regulatory requirements.

Results: Gaps in our knowledge were identified, challenges discussed and recommendations for future work provided.

Discussion: Currently available SI/SB data from geriatric persons with dementia do not provide adequate understanding of its epidemiology, identification, assessment, or management. The growing public health burden of this population requires greater attention from clinicians and researchers on tactics and assessment tools to meet these needs.

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1. Introduction

Persons with Alzheimer's disease (AD) represent a rapidly expanding portion of the world's population. Its prevalence doubles every 5 years after age 65 years and its treatment accounts for an increasing proportion of national health care budgets. Finding safe treatments and better

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disease management is a global priority. One aspect of dementia care that has received limited focus is the identification and management of comorbid suicidal ideation (SI) and suicidal behavior (SB).

Older adults make up 12% of the US population but account for 18% of all suicide deaths. This is an alarming statistic, as the elderly are the fastest growing segment of the population. Furthermore, elder suicide may be underreported by ≥40% as "silent suicides," like deaths from overdoses, self-starvation, or dehydration, and "accidents" are often not reported as suicides [1]. SI and SB remain inadequately understood, under-recognized, and undertreated in this population [2]. Additional concerns that medications affecting the central nervous system (CNS) may increase the risk of SI/SB have led the US Food and Drug Administration (FDA) to take a position that SI/SB should be assessed at each visit during clinical trials when developing drugs for neurologic and psychiatric conditions. This includes clinical trials of drugs used to treat patients with AD and related dementias. This increases the urgency for knowing the background risk for SI/SB in various segments of this population. However, there is no consensus on how SI/SB is best assessed in patients with the cognitive impairment of dementia-spectrum disorders.

In this review article, the information gathered by the Task Force on Suicidal Ideation and Behavior in Persons with Dementia Spectrum Conditions as part of the Alzheimer Association Research Roundtable (AARR) (AARR Task Force members: Larry Alphs (Chair–SIB Task Force), Janssen Scientific Affairs; Robert Brashear, Janssen Alzheimer's Immunotherapy; Phillip Chappell, Pfizer; Yeates Conwell, University of Rochester; Sarah DuBrava, Pfizer; Dean Hartley, Alzheimer's Association; Ni Aye Khin, Food and Drug Administration (FDA); Nick Kozauer, FDA; David Miller, Bracket; Rachel Schindler, Pfizer (Chair of AARR); Eric Siemers, Eli Lilly & Co; Michelle Stewart, Pfizer; Kristine Yaffe, University of California San Francisco.) are summarized, gaps in our knowledge are identified, and directions to advance this research provided.

2. Methods

As part of its mission to overcome barriers to the development of safe and effective treatments for AD, the AARR convened a task force to discuss issues related to the assessment of SI/SB in AD clinical trials. Over a 2 year period, the task force met regularly to identify key considerations related to SI/SB risk in the healthy elderly and older persons in the dementia continuum. Concerns related to SI/SB nosology, classification, assessment, epidemiology, and regulatory science were identified. The relevant geriatric and dementia literature in these subject areas was reviewed, and consensus on its interpretation was obtained from experts on the task force. In addition, a survey was conducted to determine how SI/SB is currently being assessed in AD clinical trials [3]. The results of this work are summarized here.

3. Issues of definition, classification, and measurement

Clear, broadly accepted and carefully defined terminology is critical to understanding and effectively communicating information regarding the complexities of SI/SB in patients with mild-cognitive impairment (MCI) and dementia. Yet, refinement of definitional distinctions and development of a common vocabulary for SI/SB remain unmet goals.

Some data indicate that, even when active thoughts about taking one's life (SI) are absent, death ideation (defined as thoughts that life is not worth living or as the desire for one's own death) is associated with increased suicide risk [4]. Given the prevalence of death ideation among the elderly, it is important to distinguish death ideation from active SI (defined as thinking about self-harm with the intent to take one's life) and to understand the strength of any linkage to increased suicide risk. Furthermore, to reliably assess changes in SI/SB, distinctions must be drawn between passive and active SI, suicide attempts, suicide, and self-injurious behavior not associated with SI. Clinically meaningful and reliably identified gradations of SI and associated modulatory factors for suicide risk must be better studied; boundaries between suicidal thinking and normal end-of-life preparations for death must be defined, and terms such as method, plan, intent, and preparatory acts must be clearly distinguished. Conditions prevalent throughout the lifespan can also be seen in older persons. Thus, for this population too, nonsuicidal incidents of self-harm arising from cognitive disability or psychosis, or self-mutilation associated with personality disorders must be differentiated from behaviors whose intent is death. Although FDA guidance [5] calls for distinctions among preparations for suicide, aborted suicide attempts, and interrupted suicide attempts, in practice such distinctions are not readily apparent.

To better design and interpret studies that address outstanding questions, it is also important to distinguish among methodologic terms such as a suicide risk assessment that is performed with a scale or similar tool, population-based suicide risk that represents an observed risk based on a study of a defined population (often reported as an odds ratio or a hazard ratio), an individual's actual suicide risk (which can only be estimated), and a clinician-based suicide risk assessment that represents a clinician's best estimate of suicide risk.

3.1. Efforts toward standardization of terminology

Repeated efforts have been made to encourage widespread adoption of standardized definitions for SI/SB [6–9]. However, significant barriers remain. Acceptance of common terminology has also been impeded by the heterogeneous nature of SI/SB as manifested by its disparate cultural, demographic, and clinical subgroup meanings across the lifespan.

In 2002, the Institute of Medicine called for universally accepted definitions of suicide, suicide attempts, and SI

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