When growing old becomes a burden

Preventing suicide in old age

A publication of the working group for older people in the national suicide prevention programme for Germany

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Nobody likes to talk about it. The problem nevertheless remains. All the facts point to an increased risk of suicide in old age. Of the nearly 10,000 people who take their own lives in Germany each year, 40% are aged 60 or older. They represent, however, only 24% of the total population. Someone over 60 dies by their own hand in Germany almost every two hours. Often this is a quiet death, scarcely noticed by others. Behind the intention to kill oneself and the decision to carry out a suicidal act there often hides a restricted living situation which appears to be hopeless. Problems are experienced as being no longer soluble. They mount up to create a severe crisis which either had its origin long ago or has been sparked by critical life events today. Subjectively there is no longer any hope of change. To go on living under such conditions no longer seems to make sense. Severe loss of quality of life, for example through physical or mental illness, experiences of loss and social isolation, can grow into an unbearable situation. Suicide attempts in old age can frequently be understood less as a cry for help to others than, often, the last act in a living situation which seems hopeless.

Because of the often negative image of old age, a suicide attempt by an older person is often seen as more acceptable than one by a younger person. Synonyms for suicide in the German language such as "Freitod"('free death') or "Bilanzsuizid"(rational suicide) suggest a freely taken decision to take one's own life. They are used especially in relation to older people, because many conceive of extreme old age as a personal and societal burden. Taking one's life at the end of a 'worn out' life seems to many to be more plausible and acceptable than the suicide of a younger person, whose life can apparently change for the better.

It is therefore not surprising that in spite of the higher risk of suicide in old age, only a few efforts are made to prevent the causes of suicidal crises and suicide attempts in this age group. There is also the fact that investment in suicide prevention – if made at all – appears to be more worthwhile for younger than for older people. There are too few offers of help for older people in crisis, and those that are available are taken up too infrequently.

The purpose of this information brochure is to make readers familiar with the conditions which can lead to suicidal tendencies among older people and to indicate options for suicide prevention and crisis intervention. It is intended to stimulate consideration of an appropriate life style and engagement with existential questions at life's end. Suicide prevention in and for old age begins very early; at its heart is a conscious preparation for old age.

This information brochure is intended for

- people who are not uninvolved in the subject of suicide and suicide prevention, and who want to be informed
- people who are burdened with thoughts of suicide or who find themselves in a life crisis
- dependents and other carers who know older people in their vicinity who are at risk of suicide
- people who work professionally or voluntarily with older people

Three important questions are at the forefront in these situations:

1. How can the risk of suicide among older people be recognised?
2. How can it be prevented?
3. What options for help are there?

It is possible to prevent suicide. A poem by Reiner Kunze brings out very empathetically what can be effective.

SUICIDE

The last door of all

But no-one has yet knocked on them all

Reiner Kunze (1984)

The authors of this information brochure are members of a working group which is part of the National Suicide Prevention Programme for Germany; it deals with suicidal tendencies and suicide prevention among older people and makes a contribution to the improvement of the care situation.

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The life situation of people in advanced old age and at life's end

There have always been old people. What is completely new in recent years, however, is that large segments of the population are now able to live to a great age. Today the high-aged are the fastest growing group in the population. People in industrialised nations are thus coming ever closer to the age-old wish for a long life. On the other hand there are many unresolved problems and anxieties because humanity up till now has had no experience of this new situation. Will old age bring good years or bad? What will the health situation be like? What social changes will come to old people in particular and to society in general?

Today, perceptions of old age still often have a negative tinge, although the idea of a 'general decline' in old age has been proved wrong. The image of old age today includes more colours. People are seeing more clearly the possibilities which this phase of life opens up and are taking advantage of them. It is however also true that, especially in extreme old age, the likelihood grows of falling ill or needing care.

Connected to this is the hard task of accepting a growing number of cuts in independent living, cuts which threaten or may injure the sense of self-esteem.

However, it is worth remembering that a good 50 percent of over-nineties lead independent lives and 70 percent suffer from no or only minor impairments in mental performance. Many old people live in their own home, relying on their own resources or able to organise outside help when required. Others, among them those requiring home care, can no longer handle their life as independently as they would like.

To some extent people carry on their lives in old age as they used to do when they were younger. But now they have new opportunities and tasks. If children and/or job previously took up a lot of time and energy, it now makes sense to organise the newly-won free time. The day will be structured in a new way, and new horizons have to be opened up for the remainder of life. Goals and plans contribute to people's well-being. In confronting the changed conditions it is right to develop personal capacities and choices, and to make use of the life experience gained in earlier tasks and crises. Accepting old age and the finiteness of life are further tasks which challenge people in advancing old age. Development in old age means recognising that one's own living situation also goes on changing.

Everyone has a life history which is entirely personal. There are no norms for a contented ageing. Right up to advanced old age it is the individual situation that provides the benchmark. Excessive demands can affect health and well-being, but so can being under

challenged.

Thoughts about life's end are often bound up with existential questions about the meaning of the life lived so far and the ever-shrinking prospects for the future. Many people find their own answers to these questions, their own life supports. There are, however, also people who feel so burdened by their living situation and the future that they see no solution to their problems and can find no answer that makes sense to the existential problems of their life. This existential crisis can, together with other burdens, lead to thoughts of bringing life to an end.

Early indicators and signals of a risk of suicide

The onset of a suicidal mood is often announced though a feeling of 'constriction': sufferers report that they no longer have any interests, not even in their hobbies, their favourite sport or cultural activity. They withdraw themselves from interpersonal relations. In their thoughts they feel themselves constricted 'as if in a vice' and they tend to brood. Sufferers in the early stage of the suicidal crisis also often express indirect suicidal thoughts such as: 'Nothing makes sense anymore...'; 'It would be best if I was no longer alive...'.

Direct suicidal thoughts ('I want to leave this life') or the insistent feeling that they have to kill themselves ('Do it first thing tomorrow...') have to be taken extremely seriously. But the 'lull before the storm' can also be a dangerous warning signal for the risk of suicide. That is to say, if a person who earlier has had thoughts of suicide or who has expressed concrete suicidal intentions suddenly seems to relax and does not talk about suicide anymore, this can signify that he or she has by this point already decided on suicide. Up to this moment they have been in a tormented state in which they swung back and forth between 'I want to kill myself' and 'Maybe I will be helped'. The decision to commit suicide allows such people suddenly to appear relaxed. It is all the more shattering, then, if soon afterwards they take their life.

Early indicators and signals of a risk of suicide:

- feeling of constriction
- brooding, suicidal thoughts
- giving up familiar interests and activities
- withdrawal from interpersonal relations
- announcement of suicide (direct or indirect)
- unexpected appearance of calm after suicidal remarks ('lull before the storm')

The emergence of suicidal thoughts and behaviour in old age

Humiliations and crises

The process of becoming older is accompanied by social and physical changes, many of which can be experienced as restriction, loss or humiliation. One's own options are, in many life situations, increasingly limited. The demands which arise out of this can usually be managed quite well by drawing on one's own life experience. Self-assurance and inner security can increasingly compensate for external limitations and dependencies.

Example:

Before his wife's illness, thoughts of taking his own life had never come into the 70-year old office worker's mind. Her breast cancer had been confirmed some eighteen months previously. There followed an operation and then radiation therapy. The thought that his wife would die and that he would be left alone seemed unbearable to him.

After the operation and the radiotherapy it looked at first as if his wife had been cured. They made new plans together because there were still so many things they wanted to do, although his health too was quite severely impaired after a kidney operation. They wanted to deal with the cancer together, just as they had coped with their more or less serious illnesses in the past. When a suspiciously cancerous lung condition was found in a follow-up examination of his wife, that made immediate hospitalisation necessary, he thought once more of taking his life. Since that time, he said to his family doctor, this thought had never left his head. He simply could not be on his own. The thought of bringing his life to an end once his wife died had become ever stronger and grown into a certainty. He had already considered how and where he would do it. He had no-one, he wept. He could not get through it alone. The only reason he had not killed himself so far was that he did not want to burden his wife. He had to wait until she herself was dead, and then he would be 'deadly serious' about dealing with the matter. Why should he then go on living, for whom and for what? 'We have always done everything together. Without my wife, my life makes no more sense to me.'

The life situation can, however, become unbearable if there are not enough good and reliable counterbalancing choices and memories available. When contemporaries die, or life in the partnership changes in a distressing direction, a feeling of being left alone or of inner alienation can arise. If tasks become impossible or can no longer be done in the old way, the feeling grows now and then of no longer being needed. Health problems can detract from the quality of life in fundamental areas of life. There is concern at being dependent in future on the help of the family or on professional helpers. Anxieties, the feeling of no longer being taken seriously, a sense of powerlessness, can all be experienced as unbearable. Then, in despair, there comes the wish to take one last decision into one's own hands and bring one's life to an end. This is often connected with the phantasy of finding endless rest and peace. One's own death then appears to be the only way of becoming free of this tormenting situation. What is decisive here is less the severity of the external situation than the thought of no longer being able to deal with such a conflicted situation. Some older people find this kind of conflict insuperable. They nevertheless express hope of a change in their situation, even if they have no concrete phantasy of what that might look like.

This sometimes appears to outsiders as a contradiction: on the one hand these desperate people hope for help, but on the other hand they put across that they only want to be left in peace and quiet.

If this ambiguous experience and behaviour can be better understood, many kinds of help are possible. An ultimate understanding of why people in stressful life situations think about taking their own lives only comes from understanding their individual situation. We often encounter a repetition of stressful experiences beginning in childhood (e.g. separation, loss, illness, lack of appreciation, dependency and helplessness), each of which is dealt with in an individual way according to our previous experiences and chances. Especially in old age, when one is concerned about holding on to one's independence, the room for manoeuvre in living and dealing with life can appear forbiddingly restricted. From this angle older people do not find it easy to ask for the support and help which could contribute to making their current living situation more bearable.

Mental illness in old age

Approximately one in four people over 65 suffer from mental illness. This is mostly a matter of depression. Other mental illnesses among older people include brain disorders (dementia), anxiety, delusion and addiction. Of these, it is the rate of dementia that increases in old age.

Every psychiatric illness contributes to a higher risk of suicide. This applies particularly to depression. What appears to be responsible for this is that depression is typically accompanied by feelings of not being worth anything, no longer being able to be productive, suffering from life-threatening physical illness, having made oneself guilty. Thoughts like this lead to a dead end. No hope of help through treatment can be seen. Taking one's own life appears to be the only conclusion as a way escaping from

these tormenting thoughts.

In the same way it is noticeable that people suffering the early stages of dementia, who see themselves as powerless in the face of the loss of memory and independence, fall into suicidal crises. On the other hand, people already suffering from advanced dementia rarely go on to commit suicide. This probably stems from the fact that people with advanced dementia are no longer in a position to be conscious of their state of health. They can no longer draw the consequence of attempting suicide.

It is therefore important to recognise mental illnesses in old age, especially depression, and to get across to the sufferer that this is in fact an illness and that therapy can help. The proper treatment of mental illness can cause the risk of suicide to diminish.

Signs of depression among older people:

- low spirits, particularly in the morning
- joylessness, numbness
- diminishing drive and interest (typically, indifference to favourite things and activities)
- withdrawal from social relations

- reduced ability to concentrate
- fatigue and rapid exhaustion
- reduced feelings of self-worth and self-confidence
- feelings of worthlessness and irrational feelings of guilt
- negative expectations of the future
- unfamiliar anxiety

- sleep disturbance
- loss of appetite
- weight loss
- digestive disorders
- anxious body apperception
- pains without organic causes
- thoughts of suicide

Physical illnesses in old age and their consequences for independence and the experience of life

Well-being and independence largely depend on maintaining bodily and mental functioning. Limitation or loss are usually experienced as major turning-points. Physical illness has a particular significance in this respect. In old age it is the chronic physical illnesses that are especially important. The consequences of these eventually result in a considerable reduction of quality of life and independence in the sufferer.
In the experience of geriatrians the following conditions have a particularly lasting effect on the lives of older people:

- chronic pain
- dyspnoea
- restrictions of movement, paralysis
- loss of excretory control (incontinence)
- reduction or loss of visual acuity
- reduction or loss of hearing
- falling and fear of falling

Initially it is mobility that is especially affected by these conditions; later, daily life activities such as dressing and bodily care are also affected. The resulting loss of social contact can lead to loneliness and depression.

Blindness separates from things, deafness from other people

It is not only the actual restriction of activity but often its anticipation which is a source of anxiety, diminished feelings of self-worth and helplessness. This process of working through demands special efforts for one to learn at least to accept the new situation, if not to be reconciled to it.

Loss of the partner

Loss of the partner, whether through separation or death, is an experience that can deeply disturb both lifestyle and well-being. This applies particularly when the prospects for a fresh start or change are diminishing. Losing a partner in old age often leads to loneliness, with the risk of isolation, and the task of having to reorganise life under the conditions of advancing old age. In terms of practical living this often presents greater problems for men than for women. Reorganisation is especially difficult if the partner was the sole emotional support. This essential dependency makes it very hard as time goes by to find the space to stabilise oneself and organise life differently. That is why it is so important to maintain other social contacts right into advanced old age.

Loss of independence

A primary motivation for the onset of the wish for suicide and death in old age is the feared or actual loss of independence (autonomy).

By this is usually meant:

- losing the option of independently conducting everyday life and human relationships
- losing the ability to control bodily functions
- the feeling of being dependent on others and being at the mercy of someone else

Regarding the fear of losing autonomy, it is not generally understood in our culture that there is no such thing as absolute independence in life: longings for autonomy and for being sheltered are complementaries in a polarity that continues through every stage of life. Each individual has to find their own position between these poles and, of necessity, to adapt to the changing phases of life. Nobody can live permanently in complete autonomy or in absolute dependency. Instead, what is required is to balance a certain amount of communal belonging with room for independent decision, even if – in the last resort – one or the other can now only be lived out in fantasy. Autonomy also often means – and this is particularly true in old age – being thrown back on oneself, while security almost always also means unwanted dependency. Striving for poise and balance between the needs for autonomy and dependency is helpful in meeting the challenges of old age.

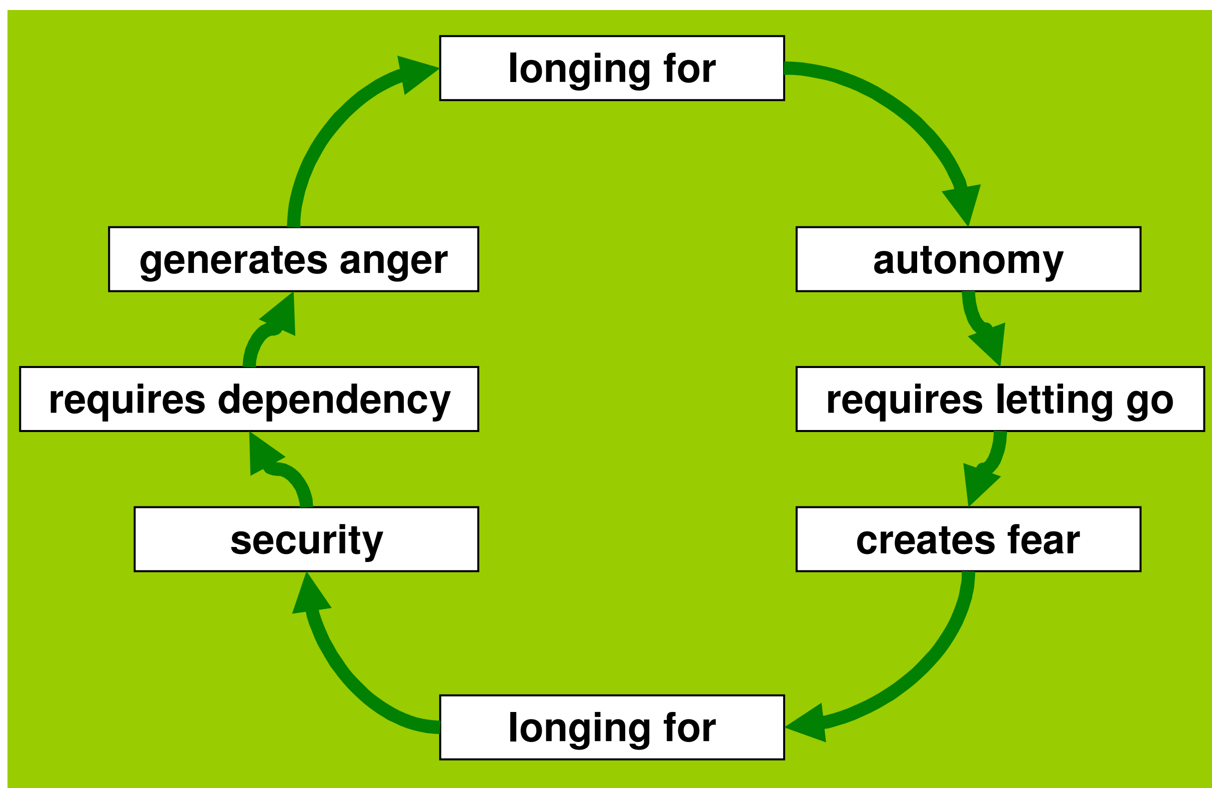

Figure 1: Conflicting needs for autonomy and for dependency (Wedler, 2001, p. 169)

‘Does life in old age still mean anything?’

The further life moves towards its end the more does it become clear to each individual that the meaning of life does not come from the acquisition and hoarding of ‘goods’, because these all become worthless at death. To base the meaning of life on the passing on of a ‘legacy’ can lead to bitter disappointment. Rather does life’s meaning arise in every phase of life, including old age, from the independent creation of one’s own life within a social context, i.e. in contact with and in exchange with this society.

Anyone who gives up on themselves, or only waits for others, or escapes from the feelings and thoughts of the present loses the meaning of life. The question of the meaning of life is thus independent of age. Advancing years can however contribute to giving up illusory, unfounded life goals, thus freeing up energy for the independent creation of one’s life.

The experience of meaning in life includes

- reflecting on oneself
- activity (and own will)
- readiness to adapt
  (to ones own limitations,
  disability, illness,
  to social circumstances,
  to living conditions,
  to one’s fellow men)

Religion and faith

In relation to suicide prevention, religiousness and spirituality can represent both a problem and a help. Especially when religious or spiritual experiences support a narrowing of personal outlook, it is appropriate to broaden this again. On the other hand, the possibilities opened up by faith can help to break out of the narrowness of the current situation.

Suicide prevention, crisis help and longer-term therapeutic options

Preparation for old age

It is always better to prevent a life crisis than to have to deal with it once it has taken hold. In terms of primary suicide prevention it is vital that old age and its consequences should not come as a surprise. Even if no-one knows how it comes in each case, it is good to be prepared for what can come. Everyone has to make their own efforts for this.

1. Timely engagement with the second half of life

By the middle years at the latest, everyone should become aware that they too will be old one day. Even before retirement and the associated loss of everyday working life it is important to set oneself sufficiently fulfilling tasks for the time after retirement. There are proven advantages, even during working life, of not standing on 'one leg' (work) only but growing a 'second leg': an activity that provides fulfilment.
In retirement it is vital to provide oneself with constant mental and physical activities for as long as it is at all possible. If the children have left home the partnership also needs to be newly defined in later years. Roles and tasks in the family undergo change.

Most people seek communication and support primarily within their own age group. That applies in old age, too. It is however advisable to maintain contact with people of other age groups. Expectations of being supported exclusively by children and their families not infrequently turn out to be a source of lasting conflict and disappointment.

2. Acceptance old age and mortality

Health in body and mind requires care and foresight. However, these should be directed to the actual needs of each age and not to fostering the illusion of remaining forever young.

More than younger people, most older people can calmly and neutrally recognise that they have to die. Others accept these facts while avoiding having to confront the associated conflicts, especially when their own life situation appears hard to bear. Others again can accept relatively easily the fact of having to die. They believe in a happy hereafter.

Most old people, though, have considerable fear of a long drawn out and wretched process of dying, in pain and dependent on machines.

To ensure that the future, with its increasing limitations of physical, mental and social living conditions, does not suddenly surprise the aging person, preparatory planning is needed. This includes the preparation of a home that is suitable for old age, bearing in mind possible periods of illness and disability. The possible loss of the partner through death, with the subsequent life lived alone, must also be considered.

Acute illness can always, in old age, be the harbinger of death, and having a trusted and reliable family

doctor available for this eventuality is of inestimable value. The extent of medical intervention at life's end should be discussed with him in good time and specified in a living will.

Finally, arrangements for one's own death are essential: burial, insurance matters, access to bank accounts, inheritance. They are a social aspect of provision for old age which should be made in good time.

3. Maintaining communication and social involvement

People need to talk and engage with others. That holds good for ageing people who not only – as popular lore has it – need peace but also communication. This should be cultivated and as far as possible maintained until the end of life. It includes contact with neighbours and friends in particular, as well as participation in community activities. Communication with children and other relatives should not be such that appealing to them for support is out of the question. Only then can the communication, when it takes place, be the wonderful and joyful gift that everyone secretly expects from it.

Accepting help when ill or disabled

Early warning signs of illness should neither be ignored nor constantly worried over. No situation in the lives of old people should be the trigger for permanent withdrawal and self-anaesthesia. It is therefore important to use medicines and alcohol carefully, to maintain a daily rhythm, eat a balanced diet and make sure of good, natural sleep.

Many aids are available to compensate for handicaps, including adaptations to the home, mobility of the bed, and help with hearing. Anyone who is disabled should take special care that they receive competent information. Even before the onset of a disability the importance of notional and material assets and the possible relinquishment of them should be thoroughly considered. If it is needed, help through suitable social facilities such as outpatient services or a home should be accepted.

After the onset of illness or disability it is advisable to use the available offers and resources of help for their relief. This can prevent the sufferer become overtaxed, which in turn can lead to a further worsening of the health. It is always good to adapt oneself to what has happened and not want to play the hero. Many people find it hard to accept they need help and to receive help. In the normal course of life, however, there are time and again situations in which this ability can be learned.

Talking with suicidal old people

It is not easy to make contact and carry on a conversation with an old person who is intent on taking their life. Suicide is still a taboo subject which is not spoken about. It awakens fears and insecurities about doing the wrong thing or even increasing to some extent the other's risk of suicide. In addition, the conversation can touch on those critical experiences in the helper's own life which have not been thoroughly dealt with.

Options of help in crisis

If a crisis situation arises, for example through loss, grief or constricted social interaction, contact has to be sought with friends and trusted individuals, especially with the trusted family doctor. In some cases psychotherapeutic help is appropriate. If the crisis becomes acute, telephone services such as the Samaritans are the first point of contact, along with other local specialist crisis agencies.

You will find national, regional and local contacts at the end of this brochure.

If there has already been an attempt at suicide the emergency doctor must be called and a hospital admission initiated.

What to keep in mind when talking to suicidal old people:

- Non-judgemental conversational exchanges in which openness and trust predominate and the suicidal old person feels themselves accepted in their emergency
- Wishing for death, suicidal thoughts and intentions openly expressed
- Suicidal tendency taken seriously, not played down, but also not dramatised
- Reasons, attendant circumstances and acute triggers discussed
- Connections with life history understood and incorporated
- Possibilities of support in the social environment explored (e.g. carers, social services, medical help)
- Offer made of continuing the conversations (responding to fears; identifying further options for advice and help)

After surviving the acute phase following a suicide attempt, crisis intervention comprises

- clarification of the current (psycho-social) situation
- a direction: Where do I go from here?
- motivation to accept ongoing help
- and support with reorientation in the changed, post-crisis situation.

Psychological disturbances require appropriate treatment (with psychotherapy and, if necessary, psychotropic drugs). Afterwards the psycho-social network offers many choices for receiving help.

In the crisis situation relatives and carers also often need to talk things over and be supported (e.g. to relieve feelings of guilt).

Help at the end of life

Many people are afraid of a long drawn out and wretched process of dying, especially when this is connected with pain and helplessness. It is not widely known that help is available in the event of terminal illness and in the death phase.

Accompanying a person at the end of their life is not only a matter of a short period of a few hours or a day before the onset of death, but can stretch over a comparatively long period of months or even years. In hospice care and care which reduces suffering (palliative medical), attention is given to the physical, psychic / mental, social, spiritual and practical needs and wishes of the

Special terms:

Palliative medicine: Palliative medicine can be distinguished from healing (curative) medicine by its aim. Healing and prolonging life are no longer the goal, but rather minimising discomfort and maintaining the quality of life. Palliative medicine can be employed in the home situation as well as in hospital and in special facilities.

Hospice work: Care at the very end of life takes place either in the home situation (accompanied by predominantly voluntary, specially trained personnel) or in specialist hospital facilities (hospice).

Terminal care: This comprises on the one hand medical help for reducing suffering, pain therapy and care, and on the other, psycho-social help for ensuring the provision of psycho-social care, mobilising available resources and for conversation.

Help with dying: Refraining from or abandoning life-maintaining measures, insofar as these contradict the aims of palliative medicine (passive help with dying). Medical and nursing alleviation of suffering, including acceptance that life might by this means be shortened (indirect help with dying).

incurably ill person. The aim of this care is to make possible for the dying person, by alleviating physical / mental distress, a life that fits all their personal needs and their own particular way of encountering the prospect of their own death. Out-patient care attempts to accommodate the wish of more than two thirds of the population to be able to die at home. Terminal care also includes the care of relatives or the bereaved.

The German doctors association, the Bundesärztekammer (most recently on 30.04.2004) has established basic principles for terminal medical care, in which the treatments offered by doctors are described in detail. Next, the wishes of the patient – according to the choices made earlier in a living will – is always decisive and authoritative for all medical interventions. Relatives can be helpful by communicating to the doctor the supposed wishes of the patient in the event that he or she is no longer capable of making their own decisions.

Help for relatives

The loss of someone, especially through suicide, is a very heavy physical and mental burden for dependents. Following the death surviving relatives can be quite disoriented, both mentally and in their social relations. There is often an increased tendency to fall ill and – especially in the first months – a heightened risk of suicide. The bereaved therefore need their own support and counselling to help them through this difficult time.

At the end of this brochure you will find contact names and addresses of those who specialise in taking on the problems of the bereaved. It is helpful to join a group whose members have suffered a similar loss.

Legal help and rulings

From the legal point of view there are several options for making provision for life's end, especially for the case that one is limited in the ability to express one's own will.

Care, health care power of attorney, living will

By making a living will anybody can at any time informally declare their wishes as to which medical interventions they want or do not want in the event that their capacity for self-determination is impaired. Living wills are valid regardless of the date they were written, unless there is concrete evidence that the person concerned has changed his mind. The living will must relate to specific illness and treatment situations. It must be presented to the attending doctor if the eventuality arises.

To meet these criteria it is advisable to consult in detail the trusted doctor or a specialist advisory agency such as the Deutsche Hospiz Stiftung (see contact addresses) on the writing of a living will. Ethical, legal and medical questions concerning the drawing up of a living will are thoroughly and practically dealt with in the report of a working group 'Patient autonomy at the end of life', set up by the Bundesministerium der Justiz (www.bmj.bund.de).

Relatives or other trusted people need a health care power of attorney if they are to act on behalf of the person concerned when he or she is no longer in the position to make decisions on their own authority and to order their own affairs. The power of attorney can relate above all to the living situation, medical provision and property matters. Civil authorities and banks as a rule only recognise powers of attorney if they have been notarised.

If a person is no longer in the position to make decisions on their own authority and to order their own affairs, they or another person can nominate a health care proxy to be appointed by the local court (court of guardianship) to take over the ordering of the patient's affairs. By appointing a health care proxy any citizen can specify in advance who, if necessary, should take over their representation. The court is required to observe the wish of the person concerned.

The law relating to suicide prevention and assisted death

The basic law in our society enshrines as top-level ethical, fundamental principles on the one hand the protection of life, and on the other free self-determination. With increasing age, and close to the end of life in particular, these two principles can collide if the old person's increasingly and irreversibly shrinking scope for independent action calls into question for them the meaningfulness of continuing life. At present there is still in this country no unanimous ethical position on the legal assessment of this

situation. There are a few unlegislated or non-legally binding areas and a not entirely uniform legal position. In September 2006 the 66th German Jurists Forum drew up proposals for both the criminal law and the civil law with the aim of ensuring patient autonomy at the end of life, the binding character of living wills, and greater legal protection for the attending physician. In some European countries there is a differing legal regime. So, for example, in Holland and Switzerland medically assisted suicide is allowed under defined circumstances if the relevant regulations are observed.

The legal framework currently in force in Germany is as follows:

- Actively assisted death (i.e. with the aim or the intention or death) is forbidden and a criminal offence.
- Refraining from or ending life-prolonging therapeutic measures is allowed under specific circumstances. The aim is to relieve suffering.
- The administering of medicines to relieve suffering in the final phase of life is justified, even when it is accepted that this may lead to life being shortened. The aim in this case, too, is exclusively the relief of suffering.
- Suicide and attempted suicide are not criminal offences.
- Assisting suicide is likewise not a criminal offence as long as the helper does not have a specific obligation to protect the patient's welfare (in German: 'Garant status'). Such people include, for example, parents, doctors, care professionals and social workers.
- An attempted suicide is regarded as an accident in German law. Every citizen is entitled, in the event of an accident, to be given help by, above all, the above 'Garant' professions and individuals.

Contacts

In the event of an acute life crisis, which can also include the sharpening of a propensity to suicide, there is a broad spectrum of national, regional and local contacts who can be turned to. It depends on the circumstances of each crisis – its urgency, the local care structures or the availability of helping facilities – as to which facility and helping group (e.g. doctors, psychological psychotherapists, spiritual counsellors) can be consulted.

Nationwide

- Deutsche Gesellschaft für Suizidprävention – Hilfen in Lebenskrisen
  www.suizidprophylaxe.de
  Under 'Hilfsangebote' you find contact addresses of crisis help institutions near you sorted by postal codes. Services are free of charge.
- Telefonseelsorge (crisis line)
  www.telefonseelsorge.de
  hotline in all parts of Germany (without charge)
  0800-1110111 or 0800-1110222
- Arbeitskreis Leben – Hilfe bei Selbsttötungsgefahr und Lebenskrisen
  (In Baden-Württemberg)
  www.ak-leben.de
  Under 'regional' you find contact addresses of the AKL in Baden-Württemberg. Its services are free of charge.
- Bundesarbeitsgemeinschaft Hospiz
  www.hospiz.net
  Under 'Hospizadressen' you find contact addresses of hospices in alphabetical order.
- Deutsche Hospiz Stiftung
  www.hospize.de
  (advice, examination, and registration of precautionary documents / living wills)
  You receive advice via phone on the 'Schmerz- und Hospiztelefon'.
  Europaplatz 7, 44269 Dortmund
  Tel. 0231/738073-0
  Chausseestraße 10, 10115 Berlin
  Tel. 030/2844484-0
  Baldestraße 9, 80469 München
  Tel. 089/202081-0
- Thepiezentrum für Suizidgefährdete am Universitätsklinikum Hamburg-Eppendorf
  Martinistraße 52, 20246 Hamburg
  Tel. 040/42803-4112
  www.uke.uni-hamburg.de/extern/tzs

Regionally and locally

First contact persons on site:

- Crisis line (see above)
- Crisis help institutions (see above)
- Arbeitskreis Leben – Hilfe bei Selbsttötungsgefahr und Lebenskrisen (AKL) (Baden-Württemberg) (see above)

Via local phone book, information leaflets, internet addresses (e.g. 'Wegweiser für ältere Menschen und ihre Angehörigen' of towns and counties)

Psychosocial institutions

- Gerontopsychiatric information centres
- Ambulant hospice services (see above)

- Information centres for the elderly / Senior citizens offices
- Information centres (marriage, family, vital issues, addiction)
- Socialpsychiatric services

Medical, therapeutic, and pastoral facilitities
- General practitioners
- Consultants for psychotherapeutic medicine
- Consultants for psychiatry and psychotherapy
- Psychological psychotherapists
- Ministers (under 'Kirchen' in your local phone book)

In case of emergency
- Emergency medical service (Tel. 112)
- Fire brigade (Tel. 112)
- Police (Tel. 110)
- Acute day ward at hospitals (local phone book)

Help for relatives
- AGUS e.V. – Angehörige um Suizid
  Tel. 0921/1500380, Fax 0921/83343
  www.agus-selbsthilfe.de
- Contact point for surviving dependants after suicide
  www.suizidprophylaxe.de
  Under 'Hilfsangebote' you find such contact points sorted by federal states.

Sources of information, literature

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Zeitschrift “Suizidprophylaxe”, Themenheft “Alterssuizid”, 2001, Jahrgang 28, Heft 4., Themenheft “Alterssuizid”, 2004, Jahrgang 31, Heft 2., Themenheft “Suizidprävention”, 2005, Jahrgang 32, Heft 3/4.

Further information
on suicide and suicide prevention:
www.suizidprophylaxe.de
on the national suicide prevention programme for Germany:
www.suizidpraevention-deutschland.de

When growing old becomes a burden

Suicide prevention in old age

Suicide presents a major problem, both in terms of health policy and individually. In 2002 the Deutsche Gesellschaft für Suizidprävention - Hilfe in Lebenskrisen (DGS) took the initiative for a national suicide prevention programme for Germany. The World Health Organisation's European Network for Suicide Research and Prevention and the Bundesministerium für Gesundheit und Soziale Sicherung are participants. So far the initiative has more than 80 affiliated organisations, associations and institutions in Germany.

Old people are at particular risk of suicide. Their living situation can, through physical and mental burdens, deteriorate to such an extent that they do not want to go on living. The public take very little notice of this. It is easy to overlook that even in old age prevention, crisis help, therapy and reduction of suffering are possible. The working group on old people presents this information brochure with the goal of clarifying the reasons for and signs of suicide risk in old age. It indicates ways of preventing suicidal occurrences.

A publication of the working group for older people in the national suicide prevention programme for Germany