A Multi-Disciplinary Study on the Causes of Elderly Suicide in Hong Kong

by

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Preface

The present study is an extension of a project entitled "Elderly Suicides in Hong Kong" by Iris Chi, Paul Yip and Gabriel Yu in 1997. The 1997 project included three studies: (i) the use of the Census data to reconstruct elderly suicide trend in Hong Kong, (ii) the use of the police records to establish the major reasons for the deaths concerned, and (iii) a small-scale quantitative survey based on hospital records to investigate the reasons for suicide attempts. The project was well received and has been taken as one of the major references for understanding elderly suicides in Hong Kong. However, the 1997 project has its own limitations due to the source of data and the scale of the project. The Health and Welfare Bureau of the Hong Kong Government of the Special Administrative Region has since set up a Working Group on Elderly Suicides after the release of the 1997 report, as they wish to carry out a more detailed study on the issue. Our research team, comprised of an epidemiologist, a social gerontologist and a psychiatrist is honoured to be entrusted with this meaningful and important study. Two out of the three (Chi and Yip) in the present team were responsible for the 1997 report.

The present study is the first of its kind in Hong Kong. It has not only improved on the 1997 study on the monitoring and surveillance system, but also includes the first prevalence and psycho-autopsy studies on elderly suicides in Hong Kong. We have identified the existing reporting problem of suicide information in Hong Kong, as well as the risk factors associated with suicidal ideas in the general population. The psycho-autopsy study also allows us to identify the risk factors associated with elderly suicide. Furthermore, this project serves as a model to demonstrate how the Government can effectively work together with academia.

For the past three years, despite an increase in the overall suicide rate, we have witnessed a fall on the elderly suicide rate, the exact reasons of which have yet to be determined. The improvement of the elderly services provided by the Hong Kong SAR Government, the non-governmnetal organizations (NGOs), and the research done by the universities could probably all have contributed to the reduction. Hong Kong has an ageing population and the elderly suicide rate is higher than that of the general population. An increase in the suicide rate can be expected due to the ageing process alone. Extra effort is therefore needed to keep the elderly suicide rate from rising.

Elderly suicide is not merely a medical problem - it requires the effort of every member of our community in order to prevent the tragedy from occurring. With the continual support from the Government, the NGOs and the entire community, we are confident that the elderly suicide rate can be reduced. The intention of this study on elderly suicides is to provide new ideas and initiatives for further work. Greater challenges lie ahead. Let us join together in our effort to help those elderly who are at risk.

Paul Yip, Iris Chi and Helen Chiu
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Executive Summary

The objective of this study is to provide scientific and research-based information to further the understanding of suicidal behaviour of the elderly population in Hong Kong. The report examines various issues, including a literature review of the elderly suicide problem, the setting up of a monitoring and surveillance system, a population-based prevalence study of elderly suicidal ideation and a psychological autopsy study in Hong Kong.

Chapter 1 gives an overview of the elderly suicide problem, both in Hong Kong and abroad. It identifies and describes some risk factors characteristic of elderly people, which may and do contribute to suicide in late life. These factors include physical and psychiatric illnesses, cumulative losses, lack of social support, stressful life events, and personality traits. This chapter also gives a brief review of how the psychological autopsy study came to being and its usefulness in suicide research.

Chapter 2 identifies and details two possible problems in the current data reporting system in Hong Kong. The first is a reporting delay between the Coroner's office and the Births and Deaths Registry. The reporting delay is caused mainly by an early cut-off date in May (before 1998) or June (since 1998) of each year, imposed by the Census & Statistics Department (C&SD), for collection of the data from the previous year from the Registry. For example, a death which occurred in the fourth quarter of a calendar year, may not be reviewed by the coroner until the second or third quarter of the following year. By that time, the cut-off date will have passed, and the death will not be included in the data for the calendar year in which it actually occurred. A 5%-18% of underreporting of suicide deaths has been found using the known death files from the C&SD.

The second problem relates to the classification of possible suicide deaths as undetermined causes of death files (E980-E989). From our study of the death files in this section in 1997, it appears that about 50% of the cases contained in these files could be classified as suicide deaths. Although the number of E980-E989 deaths has not been large in recent years, it could affect the total number of suicide deaths as much as 10%.

We have constructed a reporting delay function to adjust for the underreporting. The reporting delay function needs to be updated annually in order to provide accurate and timely estimation of suicide death based on the known death files from C&SD each year. We therefore recommend the setting up of a permanent monitoring system, which can be used to monitor the local suicide trend in a more timely fashion.

Chapter 3 gives an international comparison of suicide rates and methods used. In the west, the male to female ratios are around 3 or 4 to 1, for example, Australia (4.2:1) and the United Kingdom (3.6 to 1). However, in Asian countries the ratio is much smaller, around 1 or 2 to 1; for example Japan (2.1:1), Singapore (1.5:1) and Hong Kong (1.2:1). This suggests that the female suicide rate in Hong Kong is relatively higher than that of western countries. On the other hand, Asian male suicide rates are less than their western counterparts. China is the only country in the world where the female suicide rate is higher than the male rate, especially in the 25-34 age group, in the rural regions. For elderly people, the gender ratio remains large in the west but quite small in Hong Kong. The rate of suicide for females in the 65-75 age group is 26.0 per 100,000, which is among the highest in the world except rural China and Hungary.

Comparison is made of methods used in Australia, Hong Kong, Singapore and Taiwan for the period 1984-1994. In Hong Kong and Singapore, 60% of all suicide deaths were as a result of jumping, whereas this method is relatively uncommon in Australia and Taiwan. Over 80% of the population in Hong Kong and Singapore live in high-rise blocks, providing an effective and accessible method for suicide/. In Hong Kong, the rapid rise in inhaling burning charcoal fumes as a suicide method does not seem to appeal to the elderly. In Australia, the use of firearms is more prevalent among rural elderly people, and poisoning is more frequently found among females. The method used is thus very much determined by its availability and accessibility.

Chapter 4 reports the results of a population-based survey study amongst a target population of ethnic Chinese people living in Hong Kong, aged 60 and above. The purpose of the survey was to ascertain estimates of the prevalence of suicidal ideation among elderly people in Hong Kong. The questionnaires contained items that addressed two areas: having suicidal wishes and having a feeling that life is meaningless. The results showed that poor physical health, including poor vision, hearing problems and having a number of diseases; and poor mental health – in the form of depression – are good predictors of suicidal ideation in the local elderly population. Factors that contribute to the feeling that life is meaningless are vision problems and depression. Depression was thus found to be a major psychological factor affecting those elderly who either harboured suicidal wishes, or had the feeling that life was meaningless. Further statistical analysis was carried out, linking individual factors to depression and the results showed that financial problems and relationship problems are significant risk factors. The results also showed that the elderly people who engaged in active coping, that is, those who actively seek to manage or control the negative events in their lives, fare better and have lower levels of depression than those who are passive or have poor coping skills.

Chapter 5 provides the results of a separate psychological autopsy study carried out to retrospectively study the factors and circumstances leading to the suicide of elderly people in Hong Kong. The purpose of the study was to compare suicide subjects with age- and gender- matched controls in the community in an attempt to identify risk factors that were present in the suicide subjects' lives and which were not present in the control group.

The results showed that the presence of psychiatric illness, poor physical health, negative life events, and a past history of attempted suicide distinguished the suicide subjects from the control group. Another distinguishing feature is personality traits. The suicide subjects were found to be more neurotic, less extraverted, less open to experience, less agreeable and less conscientious compared to the control group. An interaction of certain factors, such as current psychiatric disorders, negative life events, and personality trait of being less conscientious appear to be a good predictor of elderly suicide risk.

Recommendations for the government include setting up a surveillance and monitoring system; maintaining an up-to-date suicide archive to facilitate data exchange with other international monitoring organizations, such as the World Health Organization; and designing preventive strategies and programs. Our psychological autopsy study identified current psychiatric illness, certain life events and personality traits, which were significant in the classification of the suicide subjects and the control group. The use of a cut-off figure of 0.15 produced an agreement of 92% with the prediction. This indicates that a diagnostic tool can be developed to identify high-risk elderly people, especially one that includes the identification of personality traits and recent stressful life events.

Another preventive strategy recommended is intervention at the primary care level. This includes further training for primary health care practitioners to help them identify and diagnose depression and suicidal ideation in the elderly at an earlier stage. Community outreach is yet another program that is highly recommended. It has been found by overseas research and the Suicide Prevention Services in Hong Kong that elderly people may not voluntarily seek help even when they need it. It is therefore important for people engaged in the health profession, or those involved with working with the elderly to proactively reach out to those under their care. We recommend scheduled telephone contacts with the elderly, especially those under risk, as a cost-effective way of elderly care.

Finally, education of family members and the public at large is essential. They should be taught to be aware of the prevalence of psychiatric illnesses – in particular, depressive illnesses - among the elderly. Once aware, then early detection and subsequent referral of the elderly at risk to the appropriate family members or authority constitute a good preventive strategy. Healthy ageing should be a message sent to the local community, and our media should be encouraged to help promote this message.

The elderly suicide rate in Hong Kong has been on a decreasing trend since 1997 and remains stable in 2000, despite an increase in the overall suicide rates. We have witnessed the commitment of the Hong Kong Government to invest more funding in elderly services, an increase in the number of volunteers who participate in the prevention of elderly suicide work, and the support of research-based information. All of these could have contributed to the temporary success of a stable, rather than a rising elderly suicide trend. We hope that the current level of support can be sustained and maintained, so that our elderly can enjoy their twilight years. Elderly suicide is not solely a medical or social problem, but a public health problem, which involves all sectors of our community. It is important for a rapidly ageing city such as Hong Kong to improve its elderly services, and for each member of our society to participate in caring for our elderly.

Introduction

This research project is a response to the invitation of the Health and Welfare Bureau for a multi-disciplinary study of the suicide of elderly people in Hong Kong. The research team - comprised of a statistician/epidemiologist, a sociologist and a psychiatrist - has expertise in the fields of epidemiology, mental health, psychology and sociology; and is able to provide a multi-faceted look into the complex problem of suicide. The objective of this research is to provide scientific information to further the understanding of suicidal behaviour among Hong Kong's elderly population. The team aims to assist in the development and implementation of suicide prevention plans and policies. This report is divided into the following sections:

1. Literature Review
2. Monitoring System
3. International Comparisons
4. Prevalence Survey
5. Psychological Autopsy Study
6. Recommendations

Part of the project consists of comparing suicide rates in Hong Kong with that of other countries, including Australia, New Zealand, Singapore, England and Wales, and China. It is hoped that in so doing, trends in these countries can be identified and compared with Hong Kong.

Another section of this project concerns the setting up of a monitoring system, which will be used to observe suicide trends in Hong Kong. Currently, all published statistics under-report suicide rates in Hong Kong. With the assistance of the Census and Statistics Department and the Coroner's Office of the Hong Kong Government, we aim to establish a timely and accurate suicide trend monitoring system.

A prevalence study was carried out as a supplementary part of the General Household Survey in Hong Kong on a sample of elderly people. The objective was to study and provide up-to-date estimates of the prevalence of suicidal desires and behaviour in the local population. This was carried out by way of questionnaires and personal interviews. Statistical analysis was also carried out, to test the significance of the various risk factors.

The final portion of the project consists of a separate psychological autopsy study. This study was carried out to attempt to identify the psychological, physical, social, and financial state of people who committed suicide immediately prior to their deaths. The Hong Kong Police Force provided assistance in contacting the families of the deceased persons, which facilitated the interviews process. Furthermore, the Coroner's office kindly provided information on the suicide cases relevant to this study by letting us study the death reports. It is hoped that the results of this psychological autopsy study will tie in with the prevalence study, and thus reveal crucial information about the states of mind of these elderly people who tragically decided to take their own lives.

The combined sections of this report should provide a wide view of suicide trends among the elderly in Hong Kong, as well as a detailed picture of high-risk variables and persons that should be targeted in future prevention programs.

Chapter 1: Suicides Among the Elderly – A Review

1.1 Introduction

Suicide has been described by one of the world's pre-eminent suicidologists, Edwin Shneidman, as a 'complicated, multidimensional, conscious and unconscious choice of the best possible practical solution to a perceived problem, dilemma, impasse, crisis, or desperation' (Shneidman, 1993).

A recent World Health Organization report estimated suicide to be the cause of 1.8% of the world's 54 million deaths in 1998 (Jamison, 1999). The organization also estimates a worldwide figure of one million suicide deaths in the year 2000 (World Health Organization, 1999). This translates into a global mortality rate of about 16 per 100,000 or one death every 40 seconds. However, actual suicide deaths represent only a small portion of a vast problem. Apart from the people who die, there are many more who make non-fatal attempts on their own lives, or harbour destructive thoughts to that end. Furthermore, each suicidal death and attempt usually involves other people; those who have close ties with the deceased or the person making the attempt - people who will suffer emotionally, socially, and financially as a result of the act. Each year, immeasurable socio-economic costs are associated with self-inflicted injuries (Stoudemire, Frank, Hedemark, Kamlet, & Blazer, 1986).

The study of suicide is made difficult because of the fact that it is often impossible to ascertain the intentions of the person who took his or her own life. Reconstruction of the intentions and desires of the person immediately prior to their death may be possible if that person made a clear statement before they died or left a suicide note behind. But since not all persons who survive a suicidal act intended to live, and not all those who failed to survive intended to die, it is probably wrong to assume a straightforward correlation between the intent and the outcome. Hence, two terms have been proposed - 'fatal suicidal behaviour' for self-injurious acts that result in death and 'non-fatal suicidal behaviour' for those that do not (Canetto & Lester, 1995).

'Suicidal ideation', on the other hand, refers to thoughts of killing oneself. Such thoughts include feelings of being tired of life, a wish to not wake up from sleep, and the feeling that life is not worth living (Kessler, Borges, & Walters, 1999; Paykel, Myers, Lindenthal, & Tanner, 1974). It is important for health care professionals and care providers to identify the presence of these thoughts and to take steps to prevent them from developing into full-blown suicidal behaviour.

1.2 International rates and comparisons

i. Global rates

Suicide rates vary widely around the world. Former Eastern Block countries have some of the highest national suicide rates - in some cases these are three to five times greater than those of developed countries. For example, Hungary recorded a national suicide rate of 32.4 per 100,000 in 1997 whereas the rates for the United States and England & Wales were 11.6 and 6.6 respectively (World Health Organization, 1999). Hong Kong's suicide rate lies in the middle area of the global scale. Among Asian countries, Hong Kong's suicide rate compares with that of Singapore. It is higher than Iran, the Philippines, Thailand, Korea and India but lower than that of Japan and Sri Lanka.

ii. Cross-cultural comparison

Differences in suicide rates between geographic blocks, for example, 'East' and 'West', cannot be attributed to simple or straightforward reasons. Even among western countries sharing a broad Judeo-Christian cultural heritage, rates differ widely. This stems from the considerable differences between the various countries of Western Europe. The same can be said of the Asian countries, between which vast differences in suicide rates also exist: Iran and Sri Lanka for example. Geographic proximity is not a good predictor of similar rates either - Sweden and Finland recorded male suicide rates for 1996 of 20/100,000 and 38.7/100,000 respectively. Geographic, cultural, social, religious, and economic factors all interact to influence the suicide rate and shape the suicide profile of a country.

Consequently, each country has to be understood in its own right before meaningful comparisons can be made. For example, suicide is a major public health problem in China, as it is in the United States. In 1998, it was estimated that 413,000 deaths in China were caused by suicide: 4.4% of all deaths in the country. This equates to a national suicidal rate of 32.9 per 100,000. Statistically, suicide is the fourth most significant health problem in China. However, the pattern of suicides in China is different from that in other countries. Unadjusted mortality data for 1994 (which saw a national mortality rate of 21.22 per 100,000) reported rural suicide rates 4 times that of urban suicide rates (27.02 vs. 6.74); female rates which were 26% higher than male rates (23.72 vs. 18.81); and particularly high rates in young rural females aged 15-44 (34.95), and in rural persons aged 65 and over (97.33) (Phillips, c1999; Yip, 2001; Chan, Hung & Yip, 2001).

In the US, suicide is the eighth highest cause of death (Mościcki, 1996), and in 1998, the elderly accounted for 19% of all completed suicides in that country (Conwell, 2001). The national mortality rate was 11.3 per 100,000, whilst the rate for the 40-44 age group rose to 15.5 per 100,000, and the rate for the 80-84 age group reached 22.9 per 100,000 (National Centre for Health Statistics (NCHS), 2001). White males aged 85 and over appear to be at the highest risk, with a rate of 62.7 per 100,000, representing almost 6 times the country's age-adjusted rate (NCHS, 2001).

In terms of sex distribution, suicide rates are generally higher among men. Between 1950 and 1995 the male to female ratio varied from 3.2:1 to 3.6:1. Ratios appear to be highest in South American nations (3.45:1) and lowest in Western Asia (1.35:1) (Zhao & Lester, 1997). The gender effect, however, is reversed in Beijing, China where a male/female ratio of 0.81 was reported (Zhang, 1996; Yip, 2001). It is commonly acknowledged that the male to female ratio is influenced by the cultural context, going from 1.3 to 1 in India to more than 5 to 1 in several of the countries of the former Soviet Union, and up to 8 to 1 in Puerto Rico.

On average, it seems that men are 3 to 4 times more likely to commit suicide than women (Clark, 1999; Pearson & Conwell, 1995**)**, with substantial consistency throughout different periods of life. This ratio becomes more pronounced in the extremely advanced age groups where men tend to present even higher rates. For people over 85 years of age, the rate for men is over twelve times that of women (Conwell, 1992). Furthermore, with increasing age, more suicide victims are widowed and significantly fewer are single, separated, or divorced (Conwell, Rotenberg, & Caine, 1990). In general, the male to female ratio in suicide rates is smaller in Asian countries, and in China there are more female than male suicides (Yip, 1996a; 2001). These large differences between countries indicate how important it is for each country to monitor its own suicide trends, in order to identify specific high-risk groups.

Suicide rates tend to increase with age (Clark, 1999; Haas & Hendin, 1983; Pearson, Conwell, Lindesay, Takahashi, & Caine, 1997). Globally speaking, as recently as 1995, the suicide rate was lowest for the 5-14 age group, at 0.9 per 100,000, and gradually increased to 66.9 per 100,000 for males over the age of 75 (Table 1.1).

Table 1.1 Global Suicide Rates (per 100,000) by Gender and Age, 1995

Age	Male	Female
5-14	0.9	0.5
15-24	14.2	12.0
25-34	18.9	12.6
35-44	24.9	11.6
45-54	27.6	12.4
55-64	33.3	16.4
65-74	41.0	22.1
75+	66.9	29.7

Source: World Health Organization Website (*www.who.int*)

Worldwide, older adults are the highest risk group for suicides. Although numbers are smaller, rates often exceed the much-publicized rates of younger age groups. The ratio of attempted to completed suicides is considered much lower among seniors than young adults as older suicides demonstrate greater lethality and determination compared to younger groups (Conwell, 2001; Klinger, 1999).

In the current climate of changing family and societal values, the industrialized world is seeing a decreasing number of births. In China, the 'one child policy', which came into effect in 1979, also meant that childbirth was severely curtailed. As such, in many countries, the number of older people is beginning to far outweigh that of the young. As a result of this global demographic shift, Haas and Hendin (1983) projected an estimated 14,000 suicide deaths in the U.S. in the 55 and over age group by the year 2020. Furthermore, epidemiological studies show that younger adults now have generally higher suicide rates than their grandparents did at the same age. As younger adults move into later life, their suicide rates will likely rise above those of current elderly people (Blazer, Bachar, & Manton, 1986; Manton, Blazer, & Woodbury, 1987). It can be expected, therefore, that suicide among the elderly will become a major public health concern in the coming decades.

1.3 Some risk factors

Suicide is a 'multidimensional malaise' (Shneidman, 1985). To understand suicide, one needs to consider a combination of social, cultural, physical, psychological, and biological factors. It is also important to view suicide from a developmental perspective. Until recently, there were few studies that specifically compared clinical correlates for suicide in elderly people with those of younger age groups. This is necessary, as it is clear that there are certain general characteristics to behaviour in later life: social isolation, loneliness, injuries to self-esteem, changes in body image, economic insecurity, loss and separation, stressful life events, physical illness, changes in personality and

coping style, and depression. These and other factors can and do contribute to the suicide of elderly people (Achté, 1988; Conwell, 1995).

i. Cumulative loss

From a developmental perspective, old age can be seen as a period of mounting losses. Elderly persons may progressively lose the important role they once played in their work place, their family, the community and in society in general. At the same time, their income, influence, status, and prestige often diminish upon retirement. Declining health, physical illnesses, weakening powers of perception and impaired functioning often add to their sense of loss. Additionally, the death of loved ones, be they spouses, close relatives or friends further heightens this sense of loss and highlights their own fragility as they approach their twilight years (Clark, 1999; Lester & Yang, 1992). The numerous losses which confront elderly people can sometimes lead to isolation and severe depression.

Conwell et al. (1990) identified several common stressors associated with late-life suicide, including financial problems, family discord, physical and psychiatric illness, isolation and lack of support, and perceived loss of status or of a valued role. Of these stressors, the two that appear to have an increasing effect with age are 'physical illness' and 'real or perceived loss'.

ii. Health and illness

Deteriorating physical health, which may result in declining or total loss of independent functioning, is believed to contribute to suicide risk in later life (Conwell, 1997). Serious illnesses, such as cancer, rheumatoid arthritis, diseases of the central nervous system and vision loss are often seen as risk factors (MacKenzie & Popkin, 1987; Whitlock, 1986).

Earlier, uncontrolled studies estimated physical illness to be a contributing factor in a significant portion of elderly suicide cases (Dorpat, Anderson, & Ripley, 1968). Harris and Barraclough (1994) concluded in their study that diseases such as head and neck cancers, spinal cord injury, and multiple sclerosis result in an increased risk of suicide. Recently, a case-controlled study also supported a link between physical illness and suicide in the elderly (Conwell et al., 2000).

iii. Psychiatric disorders

Recent controlled studies have shown that a combination of psychiatric and psychosocial factors may contribute to suicidal behaviour (Cheng, 1995; Foster, Gillespie, McClelland & Patterson, 1999; Vijayakumar & Rajkumar, 1999). These studies, having been conducted separately in Ireland, Taiwan and India also suggest that risk factors may be largely similar among western and eastern countries.

Affective disorders, in particular depression, have been found to be a predictive factor for self-injurious behaviour, especially among the older age groups (Conwell et al., 1996; Isometsä, 2000; Lawrence, Almeida, Hulse, Jabelensky, & D'arcy J. Holman, 2000; Mościcki, 1995).

Using the psychological autopsy method, researchers have established the distribution of psychiatric conditions in samples of adolescents, young adults and elders who have committed suicide; and in victims of ages across the entire life span in community-based populations. A review of these studies shows that affective disorders, substance abuse disorders and their co-morbidity are common in completed suicides of all ages, as well as a history of suicide attempts. Although methodological issues, group effects and time period effects limit the conclusions that can be drawn, age comparison made within and between studies further suggests that depressive illness is more common and substance abuse less prevalent in late-life suicide victims.

There may be fewer persons suffering from major depression in later life than at younger ages, but the proportion of completed suicides that had a major affective disorder increases with age. Studies have found that under-treatment for depression may contribute to suicide (Isacsson, Holmgren, Druid, & Bergman, 1999; Suominen, Isometsä, Henriksson, Ostamo, & Lönnqvist, 1998). Other studies have found an association between feelings of hopelessness and suicidal ideation in later life (Szanto, Reynolds III, Conwell, Begley, & Houck, 1998; Uncapher, Gallagher-Thompson, Osgood & Bongar, 1998). These findings suggest that in dealing with the elderly, diagnosis, treatment and follow-up consultations are vital measures to be taken in suicide prevention.

iv. Stressful life events

While not all studies have found even a majority of elderly suicidal people have an identifiable 'trigger' for their self-destructive behavior (Merrill & Owens, 1990), it is generally assumed that the circumstances under which an individual feels unable to live are relevant to the understanding of his decision to die. Luscomb, Clum, and Patsiokas (1980) addressed this issue in people who attempted suicide, finding that elderly psychiatric patients had experienced more stressful life events prior to their attempt than had non-suicidal patient controls. No such difference was evident between young 'attempters' and controls.

Gerontological studies suggest that stress in daily life may be related to depression in late life, and that exposure to stressful life events may increase depressive symptoms in older age groups (Colenda & Smith, 1993; Krause, 1986; Norris & Murrell, 1987). Life events that may adversely affect the elderly include the illness or death of a loved one, illness or death of a close friend or relative, being robbed or burgled, legal and financial problems, admission to nursing home, and hospitalization (Brown & Harris, 1978; Glass, Kasl, & Berkman, 1997).

v. Supportive social network

Another specific life circumstance that the literature suggests may predispose elders to suicide is social isolation. Sainsbury (1955) found a higher correlation between suicide and living alone in older than younger populations, while Barraclough (1971) found that suicide in his elderly population was more highly correlated with living alone than with any other social variables. However, living alone is not synonymous with social isolation. Clark (1991) found that while 46% of the victims aged 65 and over lived alone at death, 60% had weekly visits with others outside the home, and 98% had weekly contacts with friends and family. The San Diego Suicide Study also found that older suicides were less isolated than younger victims (Carney, Rich, Burke, & Howler, 1993). Nevertheless, studies repeatedly associate loneliness and isolation as motivation for late-life suicidal behavior (Frierson, 1991; Osgood,

1991). A more recent study by Stravynski and Boyer (2001) concluded that there was indeed a link between loneliness and serious consideration of suicide, although further controlled studies will need to be conducted to ascertain the role of other risk factors interacting with feelings of loneliness that produce suicidal thoughts in the subjects.

vi. Personality pattern

Apart from external triggers, the origins of suicidal desires and behavior may be traced back to an individual's established patterns of behaving, thinking, and feeling. The Five Factor Model of personality is the result of comprehensive research carried out over a period of years and describes five major dimensions of personality traits, namely: Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness (John, 1990; McCrae & Costa, 1997). These five factors are operationally defined by the revised NEO Personality Inventory (NEO-PI-R), which is used as a measure of personality (Costa & McCrae, 1992).

In depressed inpatients 50 years of age and older, extraversion has been found to be associated with attempted suicide while neuroticism and openness are more closely tied to suicidal ideation (Duberstein et al., 2000). Earlier studies have found that high scores on the neuroticism factor scale of the NEO-PI may be related to incidence of suicidal thoughts in young adults (Lester & Francis, 1993; Velting, 1999) and in completed elderly suicides (Duberstein, Conwell, & Caine, 1994). In another study, neuroticism was a significant predictor of suicide ideation in women, while conscientiousness was a significant predictor of suicide ideation in men (Velting, 1999).

Those who score high on the Conscientiousness scale are described as organized, motivated and persistent, which is characteristic of a lot of older persons (Duberstein et al., 1994). This perhaps explains why there are more completed than attempted suicides in later life, since the elderly are not as prone as the young to engage in impulsive acts.

Elderly people who commit suicide have been found to score significantly lower than normal in the personality category of Openness to Experience (Duberstein et al., 1994). This can be attributed to cognitive rigidity in the elderly age group, as older people have the tendency to be more closed to new experiences, adopt stricter routines, and have a narrower range of social and intellectual pursuits. It is possible that the low levels of openness observed in completed suicides reflect inadequate resources both for accessing and articulating feelings and for constructing meaning.

Further research is needed to correlate personality traits with patterns of behaviour in different age and gender groups. Recognition of these differences may result in more efficient prediction of attempted and completed suicides (Duberstein et al., 2000; Rudd, Joiner, & Rajab, 1996).

1.4 Psychological Autopsy

Much of what is known about suicide risk is derived from studies referred to as psychological autopsies (PAs). Coined by Edwin Shneidman, the name refers to the forensic, medico-legal investigation of the manner and cause of so-called equivocal deaths (Shneidman & Farberow, 1961). An equivocal death is a death in which it is not immediately clear whether a person committed suicide or not (e.g., drug-ingestion deaths, single-car accident deaths). The PA entails

reconstructing a detailed picture of the victim's symptoms, personality, lifestyle, and possible causes of the suicide, in the weeks and months before death. This information is gathered through psychological information from personal documents; police, medical, and Coroner records; and first-person accounts, either through depositions or interviews with family survivors, friends, co-workers, school associates, and physicians (Litman, 1989; Selkin, 1994). This procedure, originally used to assist the Coroner to determine the most likely cause of death in undetermined cases, has evolved into a systematic method for studying the many risk factors in suicide cases (Shneidman, 1977, 1994).

The PA is employed principally to review the specifics of the death and the particulars of the deceased for suicide risk factors. Shneidman (1981), for example, has identified 15 areas of inquiry in these studies, including demographics, the victim's family history, personality, recent life events, and so forth.

A thorough PA will also delve into factors that answer questions of 'foreseeability' and competency, such as the deceased's provision of false information or use of passive coercion or emotional blackmail against others (Jacobs & Klein-Benheim, 1995).

Compared with the other widely-used approaches to the study of suicidal behaviour, those being:

i) epidemiological studies of suicidal behaviour and risk factors;
ii) clinic-based follow-up studies;
iii) studies of those attempting suicide; and
iv) record linkage,

the PA is community-based, and can provide investigators with an inclusive, well-defined sample of all persons who die by suicide within a specific catchment area, region, or population (Pearson, Caine, Lindesay, Conwell, & Clark, 1999). The PA method has, over the years, also been found useful in determining liability in worker's compensation, product liability, medical malpractice, and criminal cases (Jacobs & Klein-Benheim, 1995).

Despite its strength as a forensic and research tool, the application of the PA to suicide among elderly persons has been slow in coming, in part because of the belief that older suicide victims are socially isolated from both formal and informal contacts, leading to the assumption that there may be fewer knowledgeable informants from whom to obtain data. In contrast to this belief, however, Younger, Clark, Oehmig-Lindroth, and Stein (1990) described ample numbers of informants available: In Cook County, Illinois, 70% of elderly suicide patients were married, 90% had one knowledgeable informant and 50% had two informants.

As the application of the PA method to later-life suicide is a relatively recent phenomenon, this technique is only now being standardized. Clark and Horton-Deutsch (1992) reviewed the history and evolution of the PA method and outlined standards for its application and evaluation. Among these criteria, the selection of appropriate comparison groups and the reason behind the selection are the most critical when considering which factors hold the greatest suicide risk potential. For example, demographic factors such as living alone, being widowed or divorced, or having illnesses (both physical and psychiatric) have been proposed as risk factors (Conwell, 1994; Li, 1995), yet all are common 'events' in later life. Examination of these factors in a carefully selected, demographically and socially comparable control sample will be critical for a well-designed PA study.

Touching on the limitations of the PA method, the main problem is that it is retrospective. Knowing the cause of death likely influences informants' reports and may shape how they create a 'narrative' of the event, as they attempt to come to terms with the suicide themselves (Cohler & Jenuwine, 1995). Moreover, the mood associated with bereavement at the time of the interview as well as the time lag between the death and the interviews are two factors thought to influence the quality of the information reported (Jacob & Klein, 1993). Brent (1989), however, did not find an association between time lag and family reporting of psychiatric symptoms in the adolescent suicide victims within a range of two to six months. Brent, Perper, Kolko, and Zelenak (1988) also did not find that having an affective disorder at the time of the interview had an impact on the information given during the interview.

Another limitation, of course, is that there are some questions to which only the deceased knew the answer. Important self-perceptions or cognitive distortions may never have been recorded or known to others. However, some studies have demonstrated that informants are able to respond to queries about the deceased's behavioural tendencies that reflect underlying personality dimensions (Duberstein, 1995; Duberstein, et al., 1994). Rigidity and lack of openness to new experiences are two such characteristics in elderly suicides.

A further issue arising from the use of the PA concerns its reliance on documentary evidence. It has been argued that experts should not base their opinions on police reports and other forms of documentary evidence. For instance, police reports are often incomplete as sources of information, perhaps because the police are primarily interested in determining whether a homicide was committed. Litman (1980), one of the pioneers of the PA technique, however, does not believe that basing a PA on documentary evidence is unusual or alarming. For example, police reports and other sources of information compiled shortly after a death often are more helpful than personal interviews conducted months after the fact, when witnesses have had a chance to forget - or conceivably alter or embellish - the facts (Jacob & Klein, 1993). Moreover, in evaluating a possible suicide, it is highly desirable to have a police report describing the scene of death (including the position of the body) and to have evidence gathered at the scene (e.g., weapons, pills, poisons, and notes) (Litman, 1980).

The PA is a very labour-intensive method. Because of the nature of the inquiry involved in PAs, only trained professionals, experienced in areas of mental health are qualified to be interviewers or researchers. Knowledge of psychiatric symptomatology, skills in maintaining a rapport and eliciting essential information from interviewee's memories, training in handling emotional reactions of the survivors and informants, and sensitivity in detecting subtle clues relevant to the inquiry are required. Informants should be approached in an empathic and cautious way.

Ethical issues are also central to the study design, and crucial when considering interviewing people in the midst of an emotional crisis. It is worth noting that nearly one-third of the informants in a PA study found the interview distressing (Cooper, 1999). This is hardly surprising, given the subject matter, but emphasizes the importance of the interviewer being a trained counsellor and sufficient funding being available to provide a further support session, if required. It should be made clear to the informant that a research study cannot meet their psychological needs. The counselling session is at best an assessment and informative procedure and at times seems inadequate to both interviewee and interviewer, though, when handled properly, a PA study may actually be of benefit to participants (Hawton, et al., 1998).

To sum up, the psychological autopsy, conducted by experienced professionals, can help identify crucial factors that help determine the proximate cause of equivocal deaths. It can also reconstruct the internal as well as external environment of the victim prior to his or her suicide. Risk factors can be identified and compared to aid in suicide prevention. However, the use of the PA is not

without controversy. For example, information from a PA will often be incomplete, being limited to only what the informant has observed. In addition, informants may be ignorant of various areas of the victim's life, such as undetected legal activities or they may have been insensitive to aspects of the victim's mental states, such as depression or anxiety (Shaffer, 1988). Despite such limitations, the PA is often the best method available to study the detailed characteristics of suicide victims, and, as such, will play an important role in research, assessment, treatment, and prevention of suicides.

1.5 The situation in Hong Kong

i. Rates and trends

Suicide rates in Hong Kong tend to increase with age, and the highest suicide risks occur among the oldest age groups (Hau, 1993; Ho, Hung, Lee, Chung, & Chung, 1995; Ho, 1996; Lo & Leung, 1985; McIntosh & Santos, 1982; Yip, 1996a). Suicide ranks seventh among the leading causes of death in Hong Kong. In 1994, 741 lives were lost through suicide, representing 2.5% of the total number of deaths (Yip & Louie, 1998).

In 1995, suicide rates for the age groups 5-14, 15-24, 25-59, 60-74 and 75 or above were 0.5, 9.2, 12.2, 23, and 50 per 100,000 respectively. The population average was 12. Male suicide rates were usually higher than female, except in the younger age groups. On average, the male/female ratio was 1.3 to 1 (Yip, 1997).

Suicide in Hong Kong has experienced a slight upward trend over the past two decades. Between 1981 and 1994, the crude suicide rate increased by 27% from 9.6 to 12.2 per 100,000. However, on an age-standardized basis, the increase over these 14 years was only 12.6% from 9.5 to 10.7, indicating that more than 50% of the upward trend can be explained by the change in age composition (Yip, 1996b). With an average standardized rate of 10.6 per 100,000 between the years 1981-1995, Hong Kong was placed in the middle range on the international scale of suicide rates (Chi, Yip, & Yu, 1997; Yip, Chi, & Yu, 1998).

ii. The elderly: A high risk group

Suicide rates among the elderly people of Hong Kong, however, are among the highest in the world. Between 1981 and 1994, the proportion of the population aged 60 and above increased from 11% to 14%. During the same period, elderly suicides were four to five times that of the general population. These higher suicide rates among the elderly have remained stable from 1981 to 1995, accounting for 33% of all suicide deaths and 1% of all deaths among people aged 60 and above. Each year, a disproportionate number of elderly people in Hong Kong commit suicide.

In the 15 years from 1981 to 1995, the crude elderly suicide rate was 31.1 per 100,000, with male and female rates at 35.7 and 27.1 per 100,000 respectively. The gender ratio (M/F) was 1.3 to 1. In 1994, the suicide rate for the general population was 12.2 per 100,000. In the same year, the suicide rate for people aged 75 and above was 53.0 per 100,000: fully 4.3 times higher than the general rate. Also, single males aged 60 and over had been found to have the highest suicide rate in Hong Kong: 80 per 100,000 (Yip et al., 1998).

In a local study examining socio-demographic aspects of elderly suicides between 1983 and 1986, it was found that physical illness (61.8%), interpersonal relationships (9.9%), and loneliness (5.5%) were the three major precipitants. In the same study, it was found that 58.7% of the suicide victims lived with their family while 19.2% lived alone (Kwan, 1988). Apparently, physical illness rather than the absence of family ties has a greater impact on elderly suicide victims in Hong Kong.

In another, more recent study conducted by Chi, Yip, Yu, and Halliday (1998), it was confirmed that the majority of elderly suicide victims suffered from chronic diseases, with only 3% of these cases free from any disease. Among them, over 80% were found to have severe or painful illnesses, whereas roughly 25% suffered from terminal illnesses. In most cases of terminal illness, the person suffered from some kind of cancer or heart disease. With regard to medical attention, about 40% of the cases had consulted a doctor about his or her physical illness within a month of committing suicide. Despite the severity of their illness, very few of them - only 5% - were totally dependent. From these figures, it seems that the majority of elderly suicide victims were quite self-reliant. They also did not see their doctors as often as expected considering the severity of their illness before their death. The phenomenon of the victims being apparently quite independent despite their illness may reflect one of two things: either adherence to the traditional values of self-reliance or the absence of appropriate assistance even when needed. Whether this was due to limited accessibility or other factors may need further exploration.

Another interesting observation from the study conducted by Chi et al. (1998) was that local elderly suicides were less likely to be driven by mental illness compared with the literature on elderly suicide. In this study, only 25% of elderly suicides had a history of receiving psychiatric treatment, and only 27% had consulted psychiatrists within a month of their death. These figures, however, cannot be used as sufficient evidence to say that psychiatric morbidity is not as significant a factor as other factors leading to a suicide. The fact that older Chinese people still see mental illness as a curse and consider seeking psychiatric treatment to be taboo can significantly diminish the elderly person's motivation to seek psychiatric help. Their psychiatric records, therefore, cannot be regarded as a reliable measure of psychiatric morbidity among the elderly suicide victims.

iii. Marital status

In terms of marital status, statistics for the years 1981-1995 indicated that elderly persons who had never married had a higher suicide rate than the other groups: never married, 43 per 100,000; married, 35 per 100,000; widowed, 11 per 100,000; divorced/separated, 22 per 100,000. Significant gender difference was noted. For example, the male never-married group had the highest suicide rate: 75 per 100,000 whereas only 19 per 100,000 were observed for their female counterparts. Also, the suicide rate among married females was higher than their male counterparts, being 42 and 31 respectively. Married females also had a higher rate than the never-married females. Widowed males had a higher rate than their female counterparts: 15 and 11 respectively. A similar differential was observed between the suicide rates of divorced males and females: 31 and 13 respectively (Yip, 1998).

iv. Economic status

By dividing the elderly into two groups - economically active and inactive - another

difference in the crude suicide rates can be observed. From 1981-1995, the rate for the former was 6 and for the latter, 38. The ratio was higher than that for the general population, which was 4 and 20 respectively (Yip, 1997). The loss of productivity and the associated loss of socio-economic status appear to raise the risk of suicide among the elderly.

v. Methods used

With regard to method, hanging, jumping from height or into the sea, and poisoning are most frequently employed in elderly suicides. In the past 20 years, there has been a trend towards jumping rather than hanging. Use of poison is also on the wane. In 1995, jumping and hanging together accounted for 88% of the cases (Yip, 1997). There was no obvious gender preference in the methods used by the elderly. Owing to inaccessibility, suicide deaths from firearms and explosives in Hong Kong are very rare. The recent dramatic rise of charcoal burning suicide in the community does not affect the elderly, as this 'latest' method is used more in the middle-aged and younger groups (Lee, Chan, Lee, & Yip, 2002).

vi. Seasonal variations

Interestingly, a significant seasonal effect on elderly suicide exists in Hong Kong. The peak season for suicides among the elderly is in the summer, with the months of May to August having more suicide deaths than average. The festive months of February, November, and December have markedly fewer suicides. One possible reason for this observed phenomenon is the increased family contact during such traditional Chinese festivals as the winter festival and Chinese New Year. This increased contact seems to bring more emotional support for the elderly (Yip, 1998).

vii. Motives

There is still much to be explored in this domain. In a local study, only 49 of the 279 (18%) elderly who committed suicide in 1992 left suicide notes. Among these, 84% were written by men. This gender difference could be explained by the fact that many female elderly in this age group were illiterate. The majority of death notes cited unbearable pain from such prolonged illnesses as arthritis and cancer. Also, some notes indicated explicitly that their suicide was to relieve their family of the burden of having to look after them (Chi et al., 1998; Ho, Yip, Chiu, & Halliday, 1998).

viii. General profile

Through an analysis of police records on elderly suicide cases in 1992, a general profile of the victims was produced. The deceased usually lived in the more crowded districts with fewer medical and social facilities. Most of the deaths occurred at home or nearby, and the suicidal elderly were usually alone before their death. The majority of elderly suicide victims suffered from chronic diseases. Very few of them, however, were totally dependent. About 40% of the cases had consulted medical practitioners, and 27% had consulted psychiatrists within a month of their death. Close to 70% of the cases had expressed their suicidal thoughts to their family members or others, and many of them had revealed numerous suicidal indications (Chi et al., 1998).

Chapter 2: Monitoring System

2.1 Introduction

In order to appreciate the need for a suicide monitoring and surveillance system in Hong Kong, it is important to understand how data are gathered and disseminated to the public.

The Hong Kong police force investigates all unnatural deaths. After a police investigation of these cases, including suicides, the files are sent to the Coroner's office. The Coroner will either set a date for a hearing of the cases he considers to be equivocal, or return a verdict of suicide if he is satisfied beyond all reasonable doubt that the deceased intended to kill him- or herself (Ho, et al., 1998). As the police investigation may take time, there will be a delay between the date of the suicide and the arrival of the investigative report at the Coroner's office. For example, for a death that took place in the last quarter of a certain year, the completed report may not reach the Coroner until the first quarter of the following year. By the time the Coroner makes a decision on whether to deem the death a suicide or set a date for hearing, it may already be the second or third quarter of the year after the death. The Coroner's office will then pass this information to the Immigration Department's Registry of Births and Deaths (for the issuance of the death certificate and other administrative matters). Eventually, the Census and Statistics Department (C&SD) obtains the data on all deaths (including suicides) from the Registry, and compiles statistics.

The study team has identified two possible problems in the process of compiling suicide data in Hong Kong:

i. Late registration:
   There are two different death data files available from the C&SD – known deaths and registered deaths. Most of the researchers use the known deaths files for analysis. However, a significant proportion of suicide deaths are not included with the cause of death in the known deaths files. For example, in 1997, the known deaths file indicated 645 deaths, but the registered deaths file recorded 784 cases. This represents an under-reporting of 18%. This time difference is mainly due to the reporting delay between the Coroner's office and the Births and Deaths Registry. The C&SD imposes a cut-off date in May of each year (in June since 1998) for collection of the data from the previous year from the Registry. Suicide deaths recorded after May of each year are therefore not included in the known deaths file under the relevant ICD classification (E950-E959). Even though the percentage of under-reported deaths is small relative to the total number of deaths in a year, the proportion of suicides among these under-reported deaths may be significant.
   We would like to stress how important it is to make use of the registered deaths files to obtain an accurate figure for the number of deaths in each calendar year and hence make studies of suicide behavior in Hong Kong more accurate. In this project, we were able to rectify the published suicide statistics in Hong Kong for the period from 1981-1997 based on the registered deaths files from 1981-1999. Table 2.1 gives the results of the suicide data based on known and registered deaths respectively. An underestimation in the region of 6%-18% can occur. The registered death data provides a more complete picture of suicide information, however, there seems to be a delay of about two years before the actual number of suicide deaths in each year can be calculated. This is far from satisfactory especially since the team recommends a more timely monitoring system.

Table 2.1 Suicide Deaths in Hong Kong from Registered Death Files and Known Death Files, 1981-1998

Year	1981	1982	1983	1984	1985	1986	1987	1988	1989
Registered Death	501	412	471	562	696	665	620	598	641
Known Death	497	405	460	555	684	641	601	569	609
Difference	4	7	11	7	12	24	19	29	32

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998
Registered Death	729	735	749	684	780	799	722	777	863
Known Death	679	689	727	638	741	718	646	645	819
Difference	50	46	22	46	39	81	76	132	44

ii. Undetermined cause of death (E980-E989):
From our study of the death files in sections E980-E989 in 1997, it appears that about 50% of the cases contained in these files could be classified as suicides. Though the number of E980-E989 deaths has not been large in recent years, it could affect the total number of suicide deaths as much as 10%. It is difficult to incorporate this figure into the estimation of the overall annual suicide rate as the number fluctuates from year to year and is dependent on the rulings of individual Coroners.

2.2 Data and method

i. Records based on Coroner's Court information:

The Coroner's Court has been very supportive in assisting with suicide research and a manual monitoring system has been installed with their assistance. Researchers can search the record book of the Coroner's Court for suicides that occurred in a particular year. This method, rather than reconstructing death statistics from registered death files, makes information on suicides available earlier. Also, more information can be collected from the Coroner's Court than the registered C&SD death files. For example, the 1998 and 1999 figures from the Census Department are not yet available from the registered deaths files, but the figures from the Coroner's Office (Figure 2.1, Tables 2.2a, 2.2b) show a decreasing trend in the elderly age group for the period 1997-2000.

Figure 2.1 Elderly Suicide Rate in Hong Kong, 1981-2000

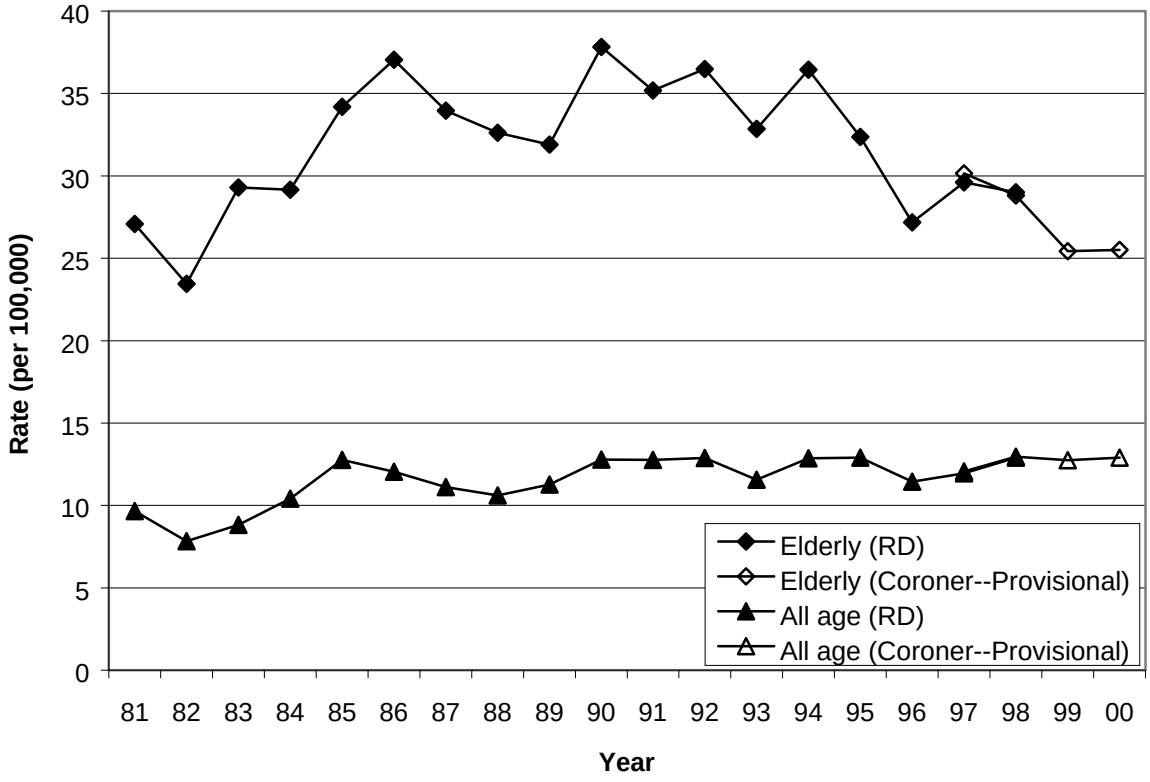

Table 2.2a Suicide Deaths by Age Group and Gender, 1981-2000

Year	Number															
	under 15			15-24			25-39			40-59			60 or over			All Ages
	M	F	P	M	F	P	M	F	P	M	F	P	M	F	P	
1981	3	3	6	43	26	69	91	52	143	84	52	136	74	70	144	498
1982	0	0	0	26	25	51	73	39	112	86	34	120	52	77	129	412
1983	1	3	4	28	25	53	68	37	105	103	39	142	85	82	167	471
1984	0	1	1	35	19	54	111	61	172	98	63	161	91	81	172	560
1985	1	2	3	46	36	82	120	90	210	118	73	191	108	102	210	696
1986	3	2	5	41	38	79	111	69	180	108	56	164	122	115	237	665
1987	0	0	0	35	21	56	116	82	198	85	56	141	119	106	225	620
1988	3	1	4	33	33	66	104	60	164	68	73	141	113	110	223	598
1989	0	0	0	35	29	64	117	89	206	89	58	147	123	101	224	641
1990	1	2	3	33	27	60	141	98	239	104	51	155	152	120	272	729
1991	4	3	7	34	28	62	132	91	223	119	63	182	146	115	261	735
1992	6	3	9	47	25	72	122	78	200	127	63	190	148	130	278	749
1993	2	4	6	38	29	67	113	86	199	95	59	154	136	122	258	684
1994	1	5	6	40	35	75	127	81	208	109	86	195	169	127	296	780
1995	5	5	10	58	26	84	146	81	227	137	66	203	152	119	271	795
1996	5	4	9	43	31	74	140	68	208	123	59	182	126	116	242	715
1997	5	1	6	55	26	81	128	65	193	142	76	218	158	120	278	776
1998	1	2	3	59	38	97	145	79	224	178	86	264	159	120	279	867
1999	5	5	10	33	22	55	165	92	257	198	93	291	147	108	255	868
2000	5	5	10	43	27	70	168	93	261	177	106	283	147	112	259	883
Total	*51*	*51*	*102*	*805*	*566*	*1371*	*2437*	*1491*	*3929*	*2348*	*1312*	*3660*	*2527*	*2153*	*4680*	*13742*

Table 2.2b Suicide Deaths Rates by Age Group and Gender, 1981-2000

Year	Rate															
	under 15			15-24			25-39			40-59			60 or over			All Ages
	M	F	P	M	F	P	M	F	P	M	F	P	M	F	P	
1981	0.45	0.49	0.47	7.0	4.61	5.86	14.1	9.72	12.1	15.3	11.1	13.4	31.7	23.5	27.1	9.6
1982	0.0	0.0	0.0	4.4	4.49	4.42	10.7	6.77	8.92	15.6	7.21	11.7	21.5	25.0	23.4	7.8
1983	0.15	0.48	0.31	4.8	4.6	4.71	9.47	6.0	7.84	18.6	8.25	13.8	33.7	25.8	29.3	8.8
1984	0.0	0.16	0.08	6.3	3.6	5.0	14.8	9.21	12.2	17.7	13.3	15.7	34.7	24.7	29.2	10.4
1985	0.15	0.33	0.23	8.5	7.0	7.79	15.4	12.8	14.2	21.2	15.4	18.5	39.3	30.0	34.2	12.8
1986	0.45	0.33	0.39	7.8	7.66	7.72	13.8	9.33	11.6	19.2	11.7	15.7	42.5	32.6	37.0	12.0
1987	0.0	0.0	0.0	6.9	4.39	5.68	13.9	10.6	12.3	14.8	11.4	13.2	39.8	29.2	34.0	11.1
1988	0.46	0.17	0.32	6.8	7.14	6.94	12.2	7.49	9.92	11.5	14.5	12.9	36.2	29.6	32.6	10.6
1989	0.0	0.0	0.0	7.4	6.44	6.92	13.5	10.8	12.2	14.6	11.2	13.1	38.1	26.6	31.9	11.3
1990	0.16	0.34	0.24	7.2	6.21	6.7	16.2	11.6	14.0	16.7	9.62	13.4	45.7	31.1	37.8	12.8
1991	0.64	0.52	0.58	7.6	6.55	7.11	15.0	10.5	12.8	18.4	11.5	15.2	42.1	28.9	35.0	12.8
1992	1.0	0.52	0.76	10.8	6.0	8.48	13.9	8.87	11.4	19.1	11.0	15.4	41.4	31.6	36.2	12.9
1993	0.33	0.69	0.5	8.8	7.0	7.91	12.8	9.52	11.1	13.8	9.91	12.0	36.8	28.7	32.4	11.6
1994	0.16	0.87	0.5	9.1	8.28	8.71	14.3	8.71	11.5	15.2	13.7	14.5	43.8	28.8	35.8	12.9
1995	0.81	0.87	0.84	13.1	6.06	9.64	16.6	8.53	12.4	18.5	10.0	14.5	37.9	26.1	31.6	12.9
1996	0.8	0.69	0.75	9.2	6.81	8.0	15.6	7.0	11.1	15.4	8.2	12.0	28.9	23.8	26.2	11.1
1997	0.82	0.18	0.51	11.7	5.6	8.68	14.5	6.7	10.4	17.2	10.0	13.8	35.4	24.3	29.5	12.0
1998	0.17	0.36	0.26	12.6	8.11	10.4	16.8	8.13	12.2	20.7	10.8	15.9	35.0	24.0	29.2	13.2
1999	0.84	0.9	0.87	7.1	4.7	5.9	19.5	9.46	14.1	22.2	11.1	16.8	31.8	21.3	26.3	13.1
2000	0.86	0.92	0.89	9.3	5.81	7.56	20.3	9.5	14.4	19.0	12.0	15.6	31.1	21.8	26.3	13.2
Average	*0.41*	*0.44*	*0.43*	*8.3*	*6.05*	*7.2*	*14.7*	*9.06*	*11.8*	*17.2*	*11.1*	*14.4*	*36.4*	*26.9*	*31.3*	*11.7*

Remarks:

a) Does not include 3 cases of unknown age and/or sex in 1981, 2 in 1984, 1 in 1988, 4 in 1995, 7 in 1996, 1 in 1997, and 4 in 1998

b) Figures in 1981 to 1997 are data from Registered Death Files from the Census and Statistics Department.

c) Figures in 1998 to 2000 are provisional data from the Coroner's Court

d) The rates since 1996 are compiled using the latest revised population estimate from the Census and Statistics Department

ii. Statistical modeling of the reporting delay:

Table 2.3 lists the estimated proportion of suicide cases not reported by a specific time using data from 1998-1999. It seems that a delay of more than 18 months is very unusual. Nearly ninety per cent of the cases will be reported within 12 months; this also supports the idea that C&SD's May cut-off date (before 1998) and June (after 1998) for known deaths files is not appropriate. The values in Table 2.3 may need to be updated if there are any significant changes made to the reporting system in Hong Kong.

Table 2.3 Proportion of Suicide Cases Not Reported by a Specific Time

Delay (x)	1	2	3	4	5	6	7	8	9
Pr (Delay>x)	1.0000	1.0000	0.9907	0.9117	0.7291	0.4732	0.2951	0.1686	0.0810
Delay (x)	10	11	12	13	14	15	16	17	18
Pr (Delay>x)	0.0428	0.0169	0.0118	0.0027	0.0025	0.0025	0.0016	0.0016	0.0000

2.3 Summary

In this Chapter we suggest the implementation of a monitoring system which can be used to monitor the suicide trend in a timely fashion. With the support of the Coroner's office, it should be possible to produce annual suicide rates in a correct and timely manner. This work needs to be done every year, and the Chief Magistrate has indicated his support for this proposal.

The newly established Centre for Suicide Research and Prevention at the University of Hong Kong has the requisite framework in place for continuing to monitor local suicide trends, but in order to maintain an ongoing monitoring system, extra government funding and continual support from the Coroner's office are required.

Chapter 3: International Comparisons

3.1 Introduction

This chapter provides an international comparison of suicidal behaviour across a number of countries. The World Health Organization has recently provided an updated report on suicide for its member states. This research team has also been provided with more detailed data from:

Australian Bureau of Statistics, Australia
New Zealand Census Department, New Zealand
Census Department, Singapore
Ministry of Health, Peoples' Republic of China
Office of National Statistics, England and Wales, UK
Department of Health and Census Department, HK Government, HK

3.2 Results

A more detailed analysis of the age and gender breakdown can be obtained for the countries mentioned above. For reference purposes, the following tables have been compiled from figures made available to us by the World Health Organization; the most up-to-date figures available at the time of preparing this report. Table 3.1 details the overall suicide rate for a selected number of countries; Hong Kong lies somewhere in the middle of the table. Table 3.2 gives age- and gender-specific suicide rates for the world. There are three major features relevant in the comparison of Hong Kong's suicide rates with those of other countries:

Table 3.1. Suicide Rates of Selected Countries in Ascending Order of Male Rates

Country	Year	Male	Female
Dominican Republic	1994	0.0	0.0
Egypt	1987	0.1	0.0
Iran	1991	0.3	0.1
Peru	1989	0.6	0.4
Bahamas	1995	2.2	0.0
Philippines	1993	2.5	1.7
Bahrain	1988	4.9	0.5
Brazil	1992	5.6	1.6
Thailand	1994	5.6	2.4
Argentina	1993	10.6	2.9
Zimbabwe	1990	10.6	5.2
United Kingdom	1997	11.0	3.2
India	1995	11.4	8.0
Netherlands	1995	13.1	6.5
China (mainland)	1994	14.3	17.9
Singapore	1997	14.3	8.0
Republic of Korea	1995	14.5	6.7
China (Hong Kong S.A.R.)	**1996**	**15.9**	**9.1**
Australia	1995	19.0	5.1
USA	1996	19.3	4.4
Sweden	1996	20.0	8.5
Canada	1995	21.5	5.4
Yugoslavia	1990	21.6	9.2
Germany	1997	22.1	8.1
New Zealand	1994	23.6	5.8
Japan	1996	24.3	11.5
Belgium	1992	26.7	11.0
Austria	1997	30.0	10.0
France	1995	30.4	10.8
Switzerland	1994	30.9	12.2
Croatia	1996	34.2	11.3
Finland	1996	38.7	10.7
Sri Lanka	1991	44.6	16.8
Hungary	1997	49.2	15.2
Latvia	1998	59.5	11.8
Estonia	1996	64.3	14.1
Russian Federation	1995	72.9	13.7
Lithuania	1998	73.7	13.7

Source: Department of Mental Health, World Health Organization (1999). *Figures And Facts About Suicide*, p. vi-vii.

Note: per 100,000; most recent year available, as of August 1999

Table 3.2. Global Suicide Rates (per 100,000) by Gender and Age, 1995

Age	Male	Female
5-14	0.9	0.5
15-24	14.2	12.0
25-34	18.9	12.6
35-44	24.9	11.6
45-54	27.6	12.4
55-64	33.3	16.4
65-74	41.0	22.1
75+	66.9	29.7

Source: World Health Organization Website (www.who.int)

i. The male to female ratio: Table 3.3 gives age- and gender-specific rates from selected eastern and western countries. In the west, the male to female ratios are around 3 or 4 to 1, for example, Australia (4.2: 1) and the United Kingdom (3.6 to 1). However, in Asian countries the ratio is much smaller - around 1 or 2 to 1; for example Japan (2.1:1), Singapore (1.5:1) and Hong Kong (1.2:1). This suggests that the female suicide rate in Hong Kong is relatively higher than that of western countries. On the other hand, Asian male suicide rate are less than their western counterparts. China is the only country in the world where the female suicide rate is higher than the male rate, especially in rural regions among the 25-34 age group. For elderly people, the gender ratio remains large in the west but quite small in Hong Kong.

Table 3.3 Suicide Rates (per 100,000) by Gender, Age and Countries

Country	Year	Gender	15-24	25-34	35-44	45-54	55-64	65-74	75 & +	All Ages
					Asian Countries					
China (Rural Area)	1994	M	16.7	21.9	23.1	30.1	48.6	101.5	142.6	**23.7**
		F	33.0	42.0	29.0	31.1	44.8	74.7	100.5	**30.5**
China (Urban Area)	1994	M	3.6	6.3	7.5	8.3	9.0	16.9	38.2	**6.5**
		F	6.4	7.1	7.1	7.3	8.6	15.9	32.8	**7.0**
Hong Kong	1994	M	9.5	13.7	12.1	14.2	19.4	39.2	62.7	**13.4**
		F	8.7	9.8	9.5	9.7	19.7	26.0	49.1	**11.3**
Japan	1994	M	12.0	19.8	24.1	35.6	38.9	29.7	55.1	**23.1**
		F	5.1	8.3	8.2	12.0	15.1	19.1	35.2	**10.9**
Korea	1994	M	11.0	15.7	16.5	20.3	22.4	28.6	46.1	**12.8**
		F	5.9	8.1	6.5	7.7	8.5	11.3	18.1	**6.1**
Singapore	1994	M	11.7	14.8	16.0	19.0	17.2	34.4	88.7	**14.0**
		F	10.2	8.4	10.2	9.0	13.9	20.3	56.3	**9.6**
					Western Countries					
Australia	1993	M	23.7	27.7	21.1	22.9	22.2	22.2	30.9	**18.7**
		F	3.7	5.4	6.5	7.3	5.0	5.8	6.7	**4.5**
Canada	1993	M	23.8	28.1	28.4	27.9	23.8	23.0	26.9	**21.0**
		F	4.7	5.8	7.9	8.7	6.8	5.5	6.4	**5.4**
Finland	1994	M	45.5	51.2	67.0	58.1	54.5	37.6	60.2	**43.6**
		F	7.8	10.7	18.5	23.6	15.0	11.3	9.3	**11.8**
Greece	1994	M	4.1	5.7	4.5	7.1	7.4	9.6	14.3	**5.5**
		F	0.4	1.2	1.3	1.4	2.7	2.9	3.0	**1.4**
Hungary	1994	M	20.2	46.4	76.6	91.8	83.9	92.7	178.5	**55.5**
		F	5.2	9.0	18.6	23.3	20.0	26.3	66.2	**16.8**
New Zealand	1993	M	39.4	29.3	22.2	20.7	15.8	24.8	25.0	**20.5**
		F	5.9	9.7	5.5	7.3	8.6	4.8	3.9	**5.4**
Norway	1993	M	21.9	25.1	27.4	28.2	20.5	28.1	36.6	**21.1**
		F	6.0	7.5	7.6	6.3	9.6	10.1	9.6	**6.5**
Poland	1994	M	17.9	27.9	39.5	45.6	32.7	37.0	35.4	**24.7**
		F	2.7	4.2	6.8	7.5	7.0	7.7	5.9	**4.5**
United Kingdom	1994	M	11.5	18.5	17.4	15.4	12.0	10.7	16.2	**11.9**
		F	2.2	3.8	4.0	4.6	4.5	4.3	5.7	**3.3**
USA	1992	M	21.9	24.0	23.7	22.4	24.1	29.9	52.3	**19.6**
		F	3.7	5.0	6.6	7.3	6.5	5.9	6.5	**4.6**

Source: World Health Organization Yearbook 1995, WHO

ii. The ratio of elderly suicide rates versus the overall suicide rate: the proportion of elderly suicides in the western countries is usually smaller than that of Hong Kong. For example, for the 65-74 age group, the rate in Australia is 1.2, while the rate in the U.K. is 0.9. However, for the same age group, the rates are 2.9 and 2.5 for Hong Kong and Singapore respectively. In China, the suicide rate among elderly people is even higher (4.3:1) for rural males. The absolute elderly suicide rate is highest in Hungary, with a rate of 92.7 per 100,000 for the age group 65-74, but the ratio to the overall suicide rate is only 1.3:1.

To compare and make sense of the suicide rates in Hong Kong in relation to the rest of the world, it is imperative to take into account the factors of gender and the overall suicide rates in the respective regions.

iii. Difference in methods used: Table 3.4 gives the detailed methods used in Australia, Hong Kong, Singapore and Taiwan for the period 1984-1994. Jumping in Australia and Taiwan is relatively uncommon, due to the comparative lack of tall buildings in those countries. However, in Singapore and Hong Kong, 60% of all suicides were a result of the person jumping. Over 80% of the population in Hong Kong and Singapore live in high-rise blocks, providing an effective and accessible suicide method. There is no difference between males and females in Hong Kong in the use of this method. In Hong Kong, the rapid rise in inhaling burning charcoal fumes as a suicide method seems to be unappealing to elderly people. In Australia, the use of firearms is more prevalent among rural elderly people, and poisoning is more frequently found among females. A significant reduction in the use of poison in Taiwan since 1990 is due to restrictions on the use of pesticides in rural areas (Yip, 1996a). The method used is thus very much determined by its availability and accessibility.

Table 3.4 Breakdown of Suicide Methods Used in Australia, Hong Kong, Singapore & Taiwan, 1984-1994

Method	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
						Australia					
Poisoning	37%	38%	40%	38%	38%	37%	38%	39%	37%	34%	37%
Hanging	17%	18%	18%	22%	24%	26%	26%	25%	27%	28%	28%
Drowning	4%	4%	4%	3%	3%	3%	2%	2%	3%	4%	3%
Firearms	31%	29%	27%	26%	23%	22%	22%	21%	21%	22%	19%
Jumping	4%	3%	4%	4%	4%	5%	5%	4%	4%	4%	5%
Others	7%	8%	7%	7%	8%	7%	7%	7%	8%	8%	9%
						Hong Kong					
Poisoning	8%	10%	10%	7%	7%	8%	6%	4%	8%	6%	5%
Hanging	41%	31%	32%	37%	44%	34%	29%	30%	31%	32%	28%
Drowning	6%	5%	4%	2%	3%	2%	3%	4%	3%	2%	3%
Firearms	1%	1%	0%	0%	0%	0%	0%	0%	1%	0%	0%
Jumping	40%	48%	49%	48%	43%	51%	57%	59%	54%	56%	59%
Others	4%	5%	5%	5%	3%	4%	5%	3%	3%	4%	4%
						Singapore					
Poisoning	7%	7%	8%	8%	3%	7%	7%	12%	8%	6%	7%
Hanging	23%	20%	28%	23%	23%	21%	22%	27%	25%	25%	26%
Drowning	2%	2%	2%	4%	2%	3%	1%	1%	1%	2%	1%
Firearms	0%	0%	1%	0%	0%	0%	1%	1%	0%	1%	1%
Jumping	66%	68%	60%	63%	68%	67%	66%	58%	63%	63%	60%
Others	2%	3%	1%	3%	3%	1%	2%	2%	2%	3%	4%
						Taiwan					
Poisoning	59%	60%	59%	55%	56%	52%	47%	39%	34%	35%	34%
Hanging	33%	33%	34%	38%	37%	40%	45%	52%	54%	52%	53%
Jumping	2%	1%	2%	1%	2%	1%	1%	2%	2%	3%	3%
Others[1]	5%	5%	5%	6%	5%	7%	7%	7%	10%	10%	10%

1. Others include drowning, firearms and explosives.

3.3 Summary

The suicide rate among the elderly in Hong Kong is high when compared to other countries around the world. However, it is encouraging to note that this rate has remained relatively stable for the past two decades. In 1998 and 1999, the rate decreased and it remained stable in the year 2000, despite an increase in the overall suicide rate. With an ageing population and a relatively high suicide rate among the elderly, the overall suicide rate in Hong Kong is expected to increase. With effective prevention programs in place, however, it should be possible to reduce (if not at least to maintain) the overall suicide rate.

Chapter 4: Prevalence Study

The object of this chapter is to report on a survey study conducted to ascertain estimates of the prevalence of suicidal ideation and behavior among elderly people in Hong Kong. The results of this study will help to identify the characteristics of high-risk groups. With the assistance of the Census and Statistics Department (C&SD), the study was conducted as a supplementary part of the General Household Survey (GHS), and a sub-sample of elderly persons identified in the GHS was selected for the study. The findings obtained from this study can be verified or tested in the results of the psychological autopsy study and vice versa.

4.1 Questionnaire

Preparation work on the questionnaire for the prevalence survey started in January 2000, acting on advice from members of the Steering Committee. The first draft became available in March, 2000 and was finalized in April, 2000 (see Appendix 1) after completion of a pilot study (see Appendix 2). The questionnaire is divided into the following 9 sections:

1. Personal Particulars
2. Memory Test
3. Health Status
4. Instrumental Activities of Daily Living (IADL)/ Physical Self Maintenance Scale (PSMS)
5. Health Care Utilization
6. Social Support Network
7. Life Events
8. Coping Methods
9. Depression

4.2 Target population and sampling framework

The target population was ethnic Chinese people living in Hong Kong, aged 60 and above, who were contactable by telephone and who lived in accessible areas. This essentially included most of all districts in Hong Kong Island, Kowloon and the New Territories. Areas not covered included the Outlying Islands and some remote sites in Yuen Long, Tuen Mun and Sai Kung, which were far off main transportation routes. Collective households (for example, homes for the aged) were also excluded from the sampling framework. A total of 2588 households were identified in the GHS as having at least one elderly person aged 60 or above. These households had been interviewed twice for a complete survey cycle of the GHS, once in October to November 1999 and a second time in a repeat interview carried out in January to February 2000. This list of households was provided as the master sampling frame for the prevalence study (conducted as a supplementary part of the GHS).

To elicit better response from the target respondents, those households confirmed as having at least one elderly person aged 60 or above on the GHS were asked in the repeat interview in January to February 2000 about their willingness to further participate in this prevalence study. Those who were strongly unwilling to participate were excluded, leaving a total of 2297 eligible households as the sampling frame. Out of this number, 1500 households were randomly selected for the prevalence study. When there was more than one elderly person aged 60 or above in a household, one elderly person was randomly selected. Among those 1500 selected households, 150 were also

earmarked as the control group of the psycho- autopsy study. These 150 cases were interviewed with the same questionnaire as the other 1350 cases, plus a section containing questions relating to the psycho-autopsy study.

4.3 Fieldwork

In total, 17 interviewers were recruited for the fieldwork. Training for the interviewers was held in April, 2000. The fieldwork started in April, 2000 - immediately after the training - and ended in August, 2000. The interviews were conducted based on C&SD standard procedures. The interviewers were managed by a research assistant from the research team together with a survey officer from C&SD, and were either college students or university graduates. Each of the 150 cases, both survey and control, was interviewed either by a clinical psychologist or a psychiatrist. Each interviewer was responsible for 1 to 2 regions and between 30 and 150 cases. A summary of the interviews is provided in Table 4.1. Upon conclusion of the survey, a total of 917 elderly persons (out of 1500 selected) were successfully enumerated, with 100 of them (out of 150 selected) also serving as the control group of the psycho-autopsy study. The response rate was about 73%.

Table 4.1. Response Rates

	Total
Success	917
Rejected[1]	250
Non-contact (No response)[2]	91
Not in Hong Kong	76
Moved	37
Age under 60	24
Failed Memory Test	22
No elderly person	21
In Home for the Aged	20
Language barriers	11
Dead	9
In Hospital	7
Deaf	6
Empty flat	6
Wrong address	3
Total	1500
Response rate	73%

[1]Some of the reasons for rejection include: complained about having been interviewed twice before; interview rejected by their family members; complained about not having received services from the government; interviewers did not have the correct name of the elderly person.

[2]At least 5 site visits and attempts to contact by telephone, but no response.

4.4 Results

i. Basic socio-economic profile

The cases were made up of 48.5% men and 51.5% women. The ages of the interviewees ranged from 60 to 98 years and the mean age was 71 years. Forty-eight percent of the total interviewed were aged 60 to 69 years, 37.1% aged 70 to 79 years and 14.9% aged 80 and above. Their length of stay in Hong Kong ranged from 1 to 86 years and the mean length was 48.3 years. The following tables show the percentage distribution of other demographic variables.

Table 4.2. Marital Status

Married (lived with spouse)	52.3%
Married (did not live with spouse)	8.1%
Widowed	32.7%
Single	4.0%
Divorced	2.2%
Separated	0.2%
Other	0.5%

Table 4.3. Living Arrangements

Spouse and child	38.0%
Child only	28.0%
Spouse only	15.8%
Alone	13.2%
Relatives or friends	2.5%
Not related	1.2%
Others	1.3%

Table 4.4. Had a Job in the Last 7 Days

Had a job in the last 7 days	9.5%
Had no job in the last 7 days	90.5%

Table 4.5. Educational Level

No formal education	37.6%
Primary or below	41.8%
Lower secondary	8.9%
Higher secondary	6.9%
Institute	2.2%
University or above	2.6%

Table 4.6. Religion and Spiritual Beliefs

No religion	35.6%
Ancestor worship	35.4%
Buddhism/Taoism	17.8%
Protestant	5.7%
Catholic	3.7%
Others	1.9%

Table 4.7. Importance of Religion or Spiritual Beliefs

Not Important	18.0%
Somewhat important	50.8%
Important	23.8%
Very important	7.5%

Table 4.8. CSSA Recipients

CSSA	13.6%
No CSSA	86.4%

Table 4.9. Self-described Economic Situation

Very sufficient	0.7%
Sufficient	22.7%
Barely sufficient	53.4%
Insufficient	19.9%
Very insufficient	3.3%

ii. Further analysis

A number of cross-tabulations were performed to examine the relationships between depression, suicide ideation and perception of life. The significance level for all results was set at 0.05 (i.e. $p < 0.05$).

Tables 4.10 and 4.11 show the contingency tables relating depression to suicidal wishes and the feeling that life is meaningless. The association between the two variables was significant (p-value < 0.001); in that 33.6% of elderly people who were depressed (n=113) felt that life was meaningless, while only 3.7% of those who were not depressed felt that way. Table 4.11 shows that suicidal desires were significantly related to depression (p-value < 0.001): among elderly people who were depressed (n=116), 25.9% of them had some sort of suicidal desires or had made suicide attempts while only 2.5% of non-depressed elderly people felt the same way.

Table 4.10 Depression vs. 'the feeling that Life is Meaningless'

			Depressed		Total
			Not depressed (GDS<8)	Depressed (GDS>=8)	
Life is meaningless	No	Count	764	75	839
		% within depressed	96.3%	66.4%	92.6%
	Yes	Count	29	38	67
		% within depressed	3.7%	33.6%	7.4%
Total		Count	793	113	906
		% within J2	87.5%	12.5%	100.0%
		% within depressed	100.0%	100.0%	100.0%

Table 4.11 Depression vs. 'Suicidal Wishes'

			Depressed		Total
			Not depressed (GDS<8)	Depressed (GDS>=8)	
Suicidal wishes	No suicidal wishes	Count	773	86	859
		% within depressed	97.5%	74.1%	94.5%
	Wishes or attempt	Count	20	30	50
		% within depressed	2.5%	25.9%	5.5%
Total		Count	793	116	909
		% within suicide wish	87.2%	12.8%	100.0%
		% within depressed	100.0%	100.0%	100.0%

Table 4.12a shows the results of the logistic regression on testing the significance of various risk factors versus suicide wish. Individual factors were tested one at a time. Factors that were found not to be significant in relation to having suicidal wishes included age, years in Hong Kong, living arrangement, job status, educational level, religion, receiving CSSA, memory or cognition performance, chronic pain, constipation, eating problem, hospitalization for a mental problem, life events - including a change of living arrangements, death or illness of family members, financial problems and passive coping skills.

Table 4.12a. Logistic Regression Relating Individual Factors to Suicidal Wishes

	Odd ratio	95% C.I.		p-value
Female	1.00			
Male	0.43	0.23	0.81	0.0084
Age	1.01	0.97	1.05	0.6825
Years in HK	1.01	0.99	1.02	0.5813
Marital status				0.3372
Married, with spouse	1.00			
Married, not with spouse	1.80	0.65	4.97	0.2600
Single	0.01	0.00	>1000	0.6133
Separated	0.01	0.00		0.9064
Divorced	2.67	0.58	12.36	0.2083
Widowed	1.94	1.03	3.65	0.0401
Other	6.01	0.64	56.42	0.1163
Living arrangement				0.3385
Alone	1.00			
Spouse only	0.81	0.34	1.93	0.6283
Spouse & children	0.41	0.18	0.94	0.0348
Children only	0.45	0.19	1.07	0.0693
Relatives/friends	0.45	0.05	3.64	0.4510
Not related	1.09	0.13	9.43	0.9370
Other	0.01	0.00	>1000	0.6423
Employed	0.39	0.09	1.65	0.2026
Educational level	0.97	0.82	1.13	0.6734
No religion	0.77	0.41	1.43	0.4041
CSSA	1.49	0.71	3.16	0.2952
Self-rated financially insufficient	2.37	1.32	4.27	0.0041
Self-rated health as unhealthy	2.90	1.63	5.16	0.0003
Memory (cognition)	0.89	0.74	1.07	0.2286
Number of diseases	1.28	1.03	1.60	0.0239
Chronic pain	1.40	0.75	2.61	0.2950
Incontinence	5.83	2.61	13.06	<0.0001
Long-term constipation	1.50	0.57	3.91	0.4105
Eating problem	1.32	0.66	2.64	0.4269
Vision problem	1.82	1.30	2.56	0.0005
Hearing problem	1.59	1.15	2.20	0.0049
IADL[1]	1.11	1.03	1.18	0.0043
PSMS[2]	1.26	1.08	1.48	0.0037
Freq. of seeing doctor	1.17	1.08	1.27	0.0003
Hospitalized for mental problem	0.00	0.00	>1000	0.8229
LSNS[3]	0.95	0.92	0.98	0.0050
Life event				
Change of living (negative)	0.90	0.62	1.30	0.5621
Member died or ill	0.68	0.42	1.08	0.1018
Relationship	1.61	1.01	2.56	0.0438
Financial problems	0.94	0.57	1.55	0.8023
Robbed	5.41	1.44	20.36	0.0124
Court case	11.89	1.94	72.84	0.0074
Passive coping	0.96	0.87	1.06	0.4341
Active coping	0.86	0.79	0.93	0.0001
Depressed	13.48	7.34	25.76	<0.0001

Note: if the ratio is larger than one, it implies a higher risk of having a desire to commit suicide; if it is smaller than one, then the risk is smaller

[1] Instrumental Activities of Daily Living

[2] Physical Self-Maintenance Scale

[3] Lubben's Social Network Scale

Table 4.12a also indicates that women had a higher risk of having suicide wishes or making suicide attempts. Marital status is not significant in itself, but being widowed seems to be marginally so (p=0.0401). Other factors that are significant in relation to having suicidal wishes include a self-rated poor financial state, self-rated poor physical health, having a number of diseases, vision problems, hearing problems, having problems with daily living activities, the lack of social support network, and the frequency of seeing a doctor. Life events that would increase the risk of having suicidal thoughts or making suicide attempts are relationship problems, being robbed and involvement in court cases. The single most significant health factor appears to be incontinence, and the single most significant psychological factor appears to be depression. Coping skills are significantly related to the risk. Specifically, those who used fewer active coping skills and those who are depressed are at higher risk.

To determine the significant multiple risk factors affecting suicidal wishes, the forward selection method was employed. Table 4.12b shows that when attempting to determine whether or not an elderly person harbors suicidal wishes, attention should be paid to factors such as the number of diseases they suffer from, their visual and hearing functionality, whether the elderly person was involved in a court case and how depressed the elderly person appears to be.

Table 4.12b. Results from a Logistic Regression Using Forward Selection

	Odd ratio	95% C.I.		p-value
Number of diseases	1.76	1.07	2.90	0.0260
Vision problem	3.34	1.24	9.04	0.0173
Hearing problem	2.74	1.13	6.64	0.0255
Court case	57.42	1.29	2557.90	0.0365
Depressed	7.23	1.52	34.38	0.0129

Table 4.13a shows the individual effects of various factors on the feeling that life is meaningless. Factors that were found not to be significant in relation to feeling that life is meaningless include gender, age, years in Hong Kong, marital status, living arrangements, job status, educational level, religion, receiving CSSA, chronic pain, life events including change of living state, death or illness of family members, financial problems and being robbed, and passive coping skills.

Factors significant in contributing to the interviewees' feelings that their life was meaningless include self-rated poor financial status, self-rated poor health, failing memory, having a number of diseases, suffering from incontinence, long-term constipation, eating problems, vision problems, hearing problems, problems with daily living activities, frequency of seeing doctor, being hospitalized for mental problems, and poor social support. Life events that were significant include relationship problems and being involved in court cases. As with the case of harboring suicidal wishes, those at risk used fewer coping skills, and the most significant psychological factor is depression.

It may be of interest to note that 'living with children only' produces a significant result (p=0.0347). This is in accordance with the traditional Chinese belief that the older generation, such as parents, prefers to live under the same roof as their children. As can be seen in Tables 4.12a and 4.13a, a decreasing ability to look after oneself as a result of declining or poor physical health, coupled with poor or a lack of social support are good predictors of poor psychological health.

Table 4.13a. Logistic Regression – Individual Factors vs. 'Life is Meaningless'

	Odd ratio	95% C.I.		p-value
Female	1.00			
Male	0.71	0.43	1.18	0.1830
Age	1.03	1.00	1.06	0.0771
Years in HK	0.99	0.98	1.01	0.4671
Marital status				0.5658
Married, with spouse	1.00			
Married, not with spouse	1.93	0.84	4.42	0.1190
Single	0.91	0.21	3.98	0.9005
Separated	0.03	0.00	>1000	0.8273
Divorced	1.77	0.39	8.01	0.4587
Widowed	1.49	0.85	2.61	0.1620
Other	3.98	0.43	36.82	0.2234
Living arrangement				0.5008
Alone	1.00			
Spouse only	0.52	0.23	1.21	0.1297
Spouse & children	0.55	0.28	1.08	0.0806
Children only	0.44	0.21	0.94	0.0347
Relatives/friends	0.00	0.00	>1000	0.6273
Not related	0.00	0.00	>1000	0.7434
Other	0.64	0.08	5.29	0.6757
Employed	0.76	0.30	1.94	0.5623
Educational level	1.00	0.87	1.13	0.9452
No Religion	0.87	0.51	1.48	0.6080
CSSA	1.69	0.89	3.20	0.1094
Self-rated financially insufficient	2.39	1.42	4.02	0.0011
Self-rated health as unhealthy	3.13	1.89	5.17	<0.0001
Memory (cognition)	0.78	0.67	0.91	0.0015
Number of diseases	1.31	1.08	1.59	0.0052
Chronic pain	1.51	0.88	2.59	0.1349
Incontinence	4.87	2.26	10.50	0.0001
Long-term constipation	2.24	1.05	4.76	0.0361
Eating problem	1.94	1.11	3.41	0.0202
Vision problem	1.80	1.33	2.42	0.0001
Hearing problem	1.45	1.09	1.93	0.0115
IADL	1.11	1.04	1.18	0.0015
PSMS	1.27	1.09	1.49	0.0021
Freq. of seeing doctor	1.11	1.02	1.20	0.0166
Hospitalized for mental problem	6.65	1.60	27.66	0.0091
LSNS	0.95	0.92	0.98	0.0005
Life event				
Change of living (negative)	0.96	0.70	1.32	0.8184
Member died or ill	1.15	0.82	1.61	0.4343
Relationship	1.56	1.03	2.38	0.0380
Financial problems	1.09	0.73	1.63	0.6740
Robbed	2.59	0.56	12.07	0.2256
Court case	6.42	1.15	35.72	0.0337
Passive coping	0.95	0.87	1.04	0.2807
Active coping	0.86	0.81	0.92	<0.0001
Depressed	13.35	7.97	23.87	<0.0001

Table 4.13b shows that based on the forward selection method, determining factors contributing to the feeling that life is meaningless are vision problems and depression.

Table 4.13b. Logistic Regression Using Forward Selection

	Odd ratio	95% C.I.		p-value
Vision problem	5.63	1.81	17.49	0.0028
Depressed	14.10	2.49	79.77	0.0028

Having identified depression as a significant psychological factor, logistic regression was applied to link the individual risk factors to depression. Tables 4.14a and 4.14b show the results of this logistic regression analysis.

Factors that are not significant include gender, age, and the number of years in Hong Kong, employment status, education status, and religion.

While marital status is not significant, being divorced produced a significant result (p=0.0095). Other significant risk factors include living arrangements, self-rated poor financial status, self-rated poor health, poor memory, having a number of diseases, suffering from chronic pain, vision problems, problems with daily living activities, and lack of social support. Recent life events such as the death or illness of a family member, being robbed and being involved in a court case did not produce significant results. However, relationship problems (p=0.0019) and financial problems (p=0.0021) were both found to be significant risk factors.

Living arrangements also contributed to depression in the interviewees. It should be noted that living with spouse and children appear to be more beneficial than living with children only or living with a spouse only.

Table 4.14a. Logistic Regression - Individual Factors vs. Depression

	Odd ratio	95% C.I.		p-value
Female	1.00			
Male	0.73	0.49	1.08	0.1187
Age	1.02	0.99	1.05	0.1389
Years in HK	0.99	0.98	1.01	0.2577
Marital status				0.0664
Married, with spouse	1.00			
Married, not with spouse	1.53	0.76	3.10	0.2357
Single	1.70	0.68	0.43	0.2605
Separated	0.05	0.00	>1000	0.7516
Divorced	3.76	1.38	10.23	0.0095
Widowed	1.49	0.96	2.30	0.0765
Other	5.85	0.95	35.87	0.0562
Living arrangement				0.0019
Alone	1.00			
Spouse only	0.38	0.19	0.73	0.0039
Spouse & children	0.36	0.21	0.61	0.0002
Children only	0.36	0.20	0.64	0.0005
Relatives/friends	1.07	0.39	2.96	0.8955
Not related	0.34	0.04	2.77	0.3116
Other	0.00	0.00	>1000	0.5649
Employed	0.57	0.26	1.26	0.1634
Educational level	0.95	0.85	1.06	0.3718
No Religion	0.96	0.64	1.44	0.8434
CSSA	2.31	1.44	3.72	0.0005
Self-rated financially insufficient	5.01	3.35	7.51	<0.0001
Self-rated health as unhealthy	3.52	2.37	5.24	<0.0001
Memory (cognition)	0.78	0.69	0.88	<0.0001
Number of diseases	1.28	1.10	1.50	0.0015
Chronic pain	2.84	1.90	4.25	<0.0001
Incontinence	2.36	1.12	4.96	0.0237
Long-term constipation	1.24	0.61	2.51	0.5453
Eating problem	1.53	0.96	2.43	0.0718
Vision problem	1.85	1.47	2.35	<0.0001
Hearing problem	1.22	0.96	1.53	0.0981
IADL	1.14	1.09	1.20	<0.0001
PSMS	1.36	1.17	1.57	<0.0001
Freq. of seeing doctor	1.11	1.04	1.19	0.0021
Hospitalized for mental problem	1.70	0.51	5.64	0.3875
LSNS	0.93	0.91	0.95	<0.0001
Life event				
Change of living (negative)	1.07	0.84	1.36	0.5737
Member died or ill	1.34	1.04	1.73	0.0256
Relationship	1.71	1.22	2.40	0.0019
Financial Problems	1.55	1.17	2.06	0.0021
Robbed	2.05	0.56	7.57	0.2800
Court case	1.36	0.16	11.70	0.7821
Passive coping	1.07	1.00	1.14	0.0656
Active coping	0.83	0.78	0.88	<0.0001

Table 4.14b. Logistic Regression Using Forward Selection

	Odd ratio	95% C.I.		p-value
Self-rated financial state				
sufficient	1			
insufficient	4.47	1.96	10.17	0.0004
times of seeing doctor in last 3 months	1.16	1.01	1.34	0.0310
relationship	2.84	1.37	5.82	0.0052
Passive coping	1.23	1.05	1.44	0.0103
Active coping	0.77	0.69	0.86	<0.0001

Coping is the cognitive or behavioral response to stress. The results show that active coping is a significant factor. This means that those who actively seek to manage or control the stressors experienced, such as ill health, decreasing ability to look after themselves, increasing dependency, lack of social support and so forth, will be able to lower the level of depression felt as a result of all the negative events in their lives. The failure to cope, on the other hand, results in feelings of hopelessness, helplessness and depression.

4.5 Summary

Depression is the most significant psychological factor on an elderly person developing suicidal wishes or feeling that their life is meaningless. The risk factors that contribute to the elderly persons' state of depression include poor health - in particular, those suffering from incontinence, vision problems, poor self-rated financial state, unsatisfactory living arrangements, a decreased ability or inability to look after themselves and lack of social support. An elderly person's ability to cope with stress, either in terms of their health, living arrangements, financial status, or recent negative life events, is an important determinant of his or her mental well-being. These areas should be addressed and taken into account when new mental health programs for the elderly in Hong Kong are designed and implemented.

Chapter 5: Psychological Autopsy Study

5.1 Introduction

The psychological autopsy project aims to retrospectively study the long-term factors and circumstances leading to the suicide of elderly people. This study aimed to look at a sample of 100 suicide cases, with an equal number of control cases, matched for sex and age. Consent from the Coroner was sought by the research team to study archival material on elderly suicides and extract relevant data for research purposes.

5.2 Methodology

i. Subjects

a. Suicide Group

The subjects of this study were people aged 60 and above who had committed suicide. Each case had a reliable informant (either a relative or caretaker who knew the subject well) who consented to participate in the study. Both the cases and consent from the informants were obtained from the police. The initial target was to collect 100 cases, but because of difficulties encountered, only 62 cases were finally included.

b. Control Group

A random sample of 100 elderly people (aged 60 and above) was recruited from the community, matched by age and sex to the suicide group. These subjects were a sub-sample of the 917 subjects who participated in an epidemiological study of the prevalence of suicidal ideas. Consent was obtained from the subjects themselves.

Table 5.1 shows the response of the control cases. The response rate was 76%, calculated by dividing the number of successful cases (100) by the sum of the number of successful cases, the number of refusals and the number of non-contact cases (132). Table 5.2 shows that the case and control groups were matched by sex and age. The p-value of the chi-square test, which tested the difference in the sex-age distributions of the control and suicide cases, was 0.169, which meant that the distributions were not significantly different.

Table 5.1. Response of the Control Cases

	Control
Success	100
Refused	21
Non-contact*	11
Not in Hong Kong	11
In Aged Home	3
Deaf	1
Moved	1
In Hospital	1
Dead	1
Total	150

* unable to contact the elderly in 5 visits.

Table 5.2. Age-sex Distribution of the Case and Control Groups

		Male	Female
	60-69	20.00%	21.10%
Control	70-79	16.80%	21.10%
	80+	7.40%	13.70%
	60-69	8.50%	13.60%
Case	70-79	27.10%	20.30%
	80+	13.60%	16.90%

p-value=0.169

ii. Measures

The following data were collected for both the Suicide and Control Groups (Appendix 3):

A. Demographic data – age, sex, living standard, marital status, occupation, income, education, religion.

B. The Structured Clinical Interview for DSM III R (SCID) (Spitzer, Gibbon, & Williams, 1994). This is a widely used interview used in psychiatric diagnoses. The SCID has been translated into Chinese and is now used extensively in research.

C. Instrumental Activities of Daily Living Scale (IADL). A functional assessment of an older person's abilities to perform simple everyday tasks. The range is 0 – 24, where a score of 0 means the person is the most capable.

D. Physical Self-Maintenance Scale. This scale is used to assess the physical activities of daily living (PSMS). The range is 0 –24 and a score of 0 means a person is highly independent.

E. Life events

F. Lubben's Social Network Scale (LSNS). A measure of a person's social support network, developed by J.E. Lubben. The scale ranges from 0 – 45 a score of 0 means a person has the least support.

G. Physical illness - any physical illness the subject suffers from.

H. Health care utilization - data on the use of outpatient and inpatient services.

I. NEO-PI – a personality inventory based on the Five Factor Model.

J. Dementia questionnaire- Subjects were screened for the presence of dementia

For the suicide group, details of the person who committed suicide were collected to identify the precipitating factors leading to the suicide, as well as to score the person on the Suicidal Intent Scale. For those who screened positive in the dementia questionnaire, they were administered the Retrospective Dementia Assessment interview. For the control group, subjects had to undergo a memory test - the Chinese version of the Short Portable Mental Status Questionnaire. This test has a score of 0 to 10. A score of 7 or below is indicative of cognitive impairment. Those with cognitive impairment were interviewed for assessment of a clinical diagnosis of dementia.

iii. Procedures

Interviews were conducted soon after obtaining consent from the informants of suicide cases or from the control subjects. The interviewers consisted of 2 psychiatrists, 1 clinical psychologist and a social worker, all of whom were trained in the use of the SCID and other measures and had extensive experience in the field of mental health. Each interview took an average of two hours. The Coroner's files were studied to obtain additional information. A final clinical diagnosis was made for each suicide case, after all the gathered information was synthesized.

In the control group, the elderly subjects were interviewed in their own homes by the interviewers after their consent was obtained. Information was obtained from the elderly subjects directly. For those who scored 7 or below on the Memory test, their relatives were also interviewed to ascertain if the elderly person in question suffered from problems of dementia.

iv. Data collection

An instrument for data collection was constructed, drawing on similar research conducted at the University of Rochester, New York State, USA. Local adaptations were made on some of the tests used. A pilot test was conducted and the package was found to be suitable for the intended purpose. The study was conducted between March 2000 and the end of June 2001. Before the commencement of data collection in March 2000, a briefing session was held with police officers in charge of suicide investigations on 25th February, 2000 at Shatin Hospital. The purpose, design and procedures of the study were explained to the officers. Questions were answered and their co-operation in inviting relatives of the deceased to participate was requested.

Referrals from the police, however, were received only intermittently. Just over 10 cases were completed in the 4 months following the meeting in February. A second briefing session with the police officers from all districts was held on 28th July, 2000, again at Shatin Hospital. The referral

situation was reviewed and the scope of services provided by the investigating team was explained to the police officers. It was clarified that the investigating team would not only try to obtain information from the victim's relatives, but was also ready to provide bereavement counseling and referrals to appropriate services to these relatives on the spot. Individual cases were explained to enhance the police officers' knowledge of the team's work. Mr. Peter Halliday, Assistant Commissioner of Police, was also invited to speak at the meeting in support of the investigating team's efforts. Referrals from the police increased for a short period immediately after the meeting.

Twenty cases were completed by the end of August. Between July and October, 2000, Mr. Peter Halliday sent two letters to the police officers in an attempt to boost the response rates. However, the rate of referral was still lower than expected. By the end of October 2000, only 30 cases had been completed. A meeting between Professor Helen Chiu and Dr. Li Shing-fu with the Police Coordinator was held on 1st November, 2000 to probe into these problems and discuss possible measures for improvement. Thereafter, the investigators approached the police coordinator regularly. However, the referral situation did not improve in spite of these efforts. Only 62 suicide case reports were collected at the time of this report.

The major difficulties in collecting the survey data lay in the recruitment of suicide cases. Confidentiality and privacy laws in Hong Kong meant that the research team could not approach the relatives of suicide cases directly. Prior consent had to be obtained by the police. However, referrals from police were not forthcoming. The field team, made up of two psychiatrists, one clinical psychologist and one social worker as interviewers, was readily available but under-utilized. Communication with the police officers concerned had been open and effective through sessions and close mutual consultation. The police coordinator was contacted by telephone on many occasions to facilitate the research. Many of the police officers were very helpful and enthusiastic, but they often encountered difficulties in persuading the relatives of the suicide victims to participate in the study during their period of mourning. This problem may be related to the attitudes of Hong Kong people regarding participation in such research. Furthermore, given the nature of the research, many relatives may not have wished to disclose information, as they may have believed that suicide is shameful and embarrassing; some relatives may have had feelings of guilt towards the deceased. In addition, there seemed to be some communication gap within the police force and it appeared that the frontline police might not have fully understood the purpose of the referral process.

v. Statistical methods

Logistic regression was applied to test the effect of the various factors. Both univariate and multiple logistic regression with stepwise selection method were employed to test for individual and multiple effects.

5.3 Results

i. Demographics

Table 5.3 illustrates the demographics of the suicide and control cases. Table 5.4 presents the psychiatric diagnoses.

Table 5.3. Demographics of the Suicide and Control Groups

	Suicide	Control
Sex		
Male	49.2%	43.0%
Female	50.8%	57.0%
Age	74.7 (7.6) years	72.1 (8.0) years
Years in HK	48.8 (18.6) years	48.3 (15.2) years
Job		
Had a job	17.7%	10.0%
Had no job	82.3%	90.0%
Marital status		
Married	53.2%	46%
Never married	6.5%	5%
Divorced/separated	4.8%	3%
Widowed	35.5%	46%
Living arrangements		
Living alone	16.1%	14.1%
Spouse only	16.1%	13.1%
Spouse and children	16.1%	16.2%
Children only	35.5%	50.5%
Relatives or friends	8.1%	4.0%
Non-relatives/friends	1.6%	1.0%
Others	8.1%	1.0%
Educational level		
No formal education	45.2%	35.1%
Primary or below	41.9%	41.2%
Secondary or above	12.9%	23.7%
Religion		
Yes	61.3%	31.3%
No	38.7%	68.7%
CSSA		
Yes	17.7%	12.8%
No	82.3%	87.2%
Perceived financial state		
Sufficient	96.7%	84.9%
Insufficient	3.3%	15.1%

Notes: Number in the bracket represents the standard deviation.

Table 5.4. Psychiatric Diagnosis of the Suicide and Control Groups

	Suicide	Control
Past Diagnosis		
No diagnosis	66.1%	97.0%
Major depression	24.2%	3.0%
Schizophrenia	3.2%	0.0%
Anxiety disorder	4.8%	0.0%
Delusional disorder	1.6%	0.0%
Current Diagnosis		
No diagnosis	12.9%	91.0%
Major depression	56.5%	3.0%
Adjustment disorder	14.5%	0.0%
Dysthymic disorder	11.3%	2.0%
Dementia	1.6%	2.0%
Schizophrenia	3.2%	0.0%
Anxiety disorder	1.6%	2.0%
Delusional disorder	1.6%	0.0%
Somatoform disorder	1.6%	0.0%
Organic delusional disorder	1.6%	0.0%
Alcohol dependence syndrome	3.2%	0.0%

N.B. Some subjects had more than 1 diagnosis

ii. Suicidal behavior

Among the suicide cases, 25.8% of the informants thought that the people committed suicide because of psychiatric problems, 67.7% because of health problems, 1.6% because of financial problems, 25.8% because of relationship problems with relatives, 3.2% because of relationship problems with non-family members, 3.2% because of the death of a spouse or another family member and 16.1% for other reasons. When asked to rank the most significant factors leading up to the suicide, 47.5% of the informants thought that a health problem was most important, followed by a psychiatric problem (24.6%), a relationship problem with relatives (11.5%), other reasons (11.5%), the death of a spouse or family member (3.3%), and financial problems (1.6%).

The most common methods of suicide used were jumping from a height and hanging, both of which accounted for 41.9% of suicide deaths. 4.8% of the deaths resulted from drowning, 6.4% through ingestion of a drug or other substance. Cutting one's wrists or stabbing other parts of the body accounted for 3.2%, and finally, carbon monoxide poisoning accounted for 1.6% of the suicide cases.

Twelve point nine percent of elderly suicide victims left a suicide note, 37.1% of the cases did not express any suicidal intent at all, 27.4% clearly expressed their ideas and 35.5% of the victims had made ambiguous statements as to their suicidal intentions before they committed suicide.

In 69.4% of the cases, the suicide act was the first one and resulted in death. In addition, 21.0% had attempted suicide once, 8.1% twice and 1.6% three times. Among those who had previously attempted suicide, 27.8% attempted it 1 – 7 days before the fatal act, 11.1% 1- 4 weeks beforehand, 16.7% 1 – 6 months before, 5.6% 6 – 12 months, 16.7% 1 – 2 years, 11.1% 2 – 5 years and 11.1% more than 5 years before the final, fatal act.

iii. Individual effects

Table 5.5 shows that factors such as marital status, educational level, involvement in a court case(s), religion, receiving CSSA, incontinence, vision and hearing problems were not significant in determining whether the person committed suicide or not.

The odds ratio for IADL and PSMS of the suicide group was 1.28 and 1.53 times that of the control group respectively. This means that the suicide cases were more disabled and more dependent than the control group. The suicide cases were less healthy where the odds ratio for the number of diseases was 2.18. Other points include:

1. Elderly people suffering from cancer were at higher risk than those who were not;
2. Suicide cases were more likely to suffer from both pain and constipation;
3. Suicide cases were more likely to have seen a doctor recently;
4. Suicide cases were more likely to have been hospitalized for a psychiatric disease;
5. More negative life events were experienced by suicide cases, including changes in living arrangements, death or illness in themselves or significant others and relationship problems;
6. Personality traits of the suicide and control cases were different: the suicide cases were more neurotic, less extraverted, less open to experience, less agreeable and less conscientious;
7. Suicide cases had better social support network than the control group;
8. Suicide cases were more likely to have a past history of suicide attempts;
9. Elderly people with a current or past psychiatric diagnosis were more likely to commit suicide;
10. Elderly people suffering from major depression - according to the SCID diagnosis - were also more likely to kill themselves.

iv. Multiple effects

Multiple logistic regression was used to investigate factors significant in predicting suicidal behavior. Because of the limited number of observations, the factors to be studied were obtained using simple logistic regression. Only the current diagnosis by SCID was deemed significant when factors identified by simple logistic regression were considered. Table 5.6 shows the results of the forward stepwise selection method. Significant factors in predicting suicide were the life events of death and illness, the personality trait of conscientiousness and a current psychiatric diagnosis by SCID. Table 5.7 shows the classification table. The R^2 of the logistic regression was 0.7765 and predicted probability was 91.7%.

Table 5.5. Simple Logistic Regression

	Odds ratio	95% CI		p-value
No. of diseases	2.18	1.56	3.05	<0.0001
Cancer	9.14	2.5	33.35	0.0008
IADL	1.28	1.15	1.43	<0.0001
PSMS	1.53	1.13	2.07	0.0058
Marital status				0.5942
Married	1			
Never married	1.12	0.28	4.47	0.8778
Divorced	1.39	0.26	7.34	0.6952
Widowed	0.67	0.34	1.31	0.2405
Educational level				0.2039
No formal education	1			
Primary or below	0.79	0.39	1.59	0.5093
Secondary or above	0.42	0.16	1.09	0.0745
Life events within 1 year				
Change of living arrangements	6.53	2.37	17.99	0.0003
Death/illness	15.13	4.95	46.26	<0.0001
Relationship	21.97	2.79	173.05	0.0033
Financial problems	820.99(*)			0.6696
Court case	0.0089(*)			0.7263
NEO-PI				
Neuroticism	1.17	1.09	1.25	<0.0001
Extraversion	0.87	0.8	0.94	0.0007
Openness to Experience	0.83	0.74	0.92	0.0009
Agreeableness	0.89	0.81	0.97	0.0104
Conscientiousness	0.79	0.71	0.88	<0.0001
Religion	0.72	0.37	1.40	0.3363
CSSA	1.47	0.61	3.59	0.3928
Pain	23.66	6.75	82.96	<0.0001
Incontinence	779.94(*)			0.672
Constipation	29.99	3.85	233.86	0.0012
Vision problem	0.89	0.42	1.88	0.7553
Hearing problem	0.53	0.21	1.34	0.181
Last seen a doctor				0.0002
Less than a month	9.31	2.99	28.93	0.0001
1 to less than 2 months	4.34	1.15	16.45	0.0307
2 to less than 3 months	1.32	0.21	8.23	0.7688
Not for last 3 months	1			
Psychiatric disease/drug abuse	0	0		0.6381
Hospitalized due to psychiatric disease	24.20	5.43	107.91	<0.0001
Suicide attempt	20.77	4.63	93.17	0.0001
At Least One Past Diagnosis	16.54	4.68	58.48	<0.0001
Major Depression Diagnosis	10.32	2.85	37.39	0.0004
At Least One Current Diagnosis	68.25	24.85	187.40	<0.0001
Current Major Depression Diagnosis	41.91	11.96	146.84	<0.0001

(*)-- the C.I. of the estimated odds ratio is not stable due to the small number of cases suffering from financial problems, court cases and incontinence.

Table 5.6. Significant Factors using Forward Stepwise Multiple Logistic Regression

	Odds ratio	95% CI		p-value
Life events				
Death/illness	14.39	2.17	113.44	0.0073
NEO-PI				
Conscientiousness	0.8	0.67	0.94	0.0076
At Least One Current Diagnosis	76.86	22.5	339.68	0.0001

Table 5.7. Classification Table Based on Forward Stepwise Logistic Regression

		Predicted		
		No suicide	Suicide	
Observed	No suicide	81	10	89.00%
	Suicide	5	49	90.70%
				91.70%

Cut-off = 0.15

5.4 Discussion

Across the world, the psychological autopsy has now become an important method in examining the factors associated with or leading to suicide. The use of a case-control study is necessary to address the issue of whether these factors are significantly more common in suicide victims than in the general population. However, a psychological autopsy study is extremely labour-intensive and requires a lot of experience and expertise on the part of the interviewers. In addition, the method is fraught with practical difficulties, especially in a society like Hong Kong where suicide is still regarded as a taboo subject and many relatives are unwilling to be interviewed. Nevertheless, the findings of this study give important insights into suicide risk factors among the elderly in Hong Kong.

i. Factors associated with suicide

a. Psychiatric disorders

One of the most significant findings of our study is the high prevalence of psychiatric problems among elderly people who committed suicide. Although previous studies into suicide among the elderly have found a high rate of mental illness, these were mostly studies carried out in Western countries. So far, there has been only one study specifically examining the issue of mental illness in Chinese adults who have committed suicide. This was a study conducted in Taiwan, and the results showed a high rate of mental illness (over 95%) among those who committed suicide (Cheng, 1995). Our study is the first to examine the suicide of elderly Chinese people using the psychological autopsy method. Eighty-seven percent of the elderly suicide subjects suffered from a psychiatric problem before committing suicide. But only 35% of the suicide sample cases had sought any treatment for their psychiatric problems before their death. This means that a significant proportion of the elderly suicide subjects had not received any help or treatment for their problems. This can be attributed to a low level of awareness of

psychiatric disorders or a reluctance to seek treatment because of the stigma attached to psychiatric illness. Among the psychiatric problems, major depression was the most common diagnosis. The rate of 56.5% of our sample suffering major depression is consistent with the findings of other studies into elderly suicide conducted in western countries.

There has been some debate on whether suicidal behaviour is elevated in patients with dementia (Chiu, Lam, Pang, Leung, & Wong, 1996). So far, there are only a few studies on this issue. A study on elderly people who attempt suicide in Hong Kong showed a low rate of dementia (Chiu et al., 1996). It is likely that the presence of severe cognitive impairment might interfere with suicidal intent and the ability to carry out the suicide act itself. Results of the present study further support the theory of a low rate of dementia in suicide subjects. However, it is possible that people with early dementia may still be suicide risks, especially if they suffer from depression as well.

Previous studies have found a relatively high rate of alcohol or substance abuse problems among suicide subjects. A study comparing the ages at which suicide subjects are diagnosed with psychiatric problems has found that substance abuse is a more serious problem in the younger age groups (Conwell et al., 1996). This is consistent with findings of a low rate of alcohol and other substance abuse problems across the general population of Hong Kong (Chen et al., 1993). As well, a previous study of elderly people attempting suicide confirms a low rate of alcohol abuse among them (Chiu et al., 1996).

A number of suicides might be prevented in the same way that many psychiatric problems, including depression, are treatable if detected early and given appropriate attention.

b. Physical health

Chronic physical illness is associated with suicide risk in many overseas studies. This is confirmed by our results: the suicide cases were less healthy physically - they had a greater number of chronic physical illnesses than the control subjects. In particular, cancer, chronic pain and constipation were more common. Additionally, the suicide cases were more physically disabled, more dependent in their daily activities, and their level of functioning was lower than that of the control group.

c. Personality traits

There have been very few studies looking into the effect of personality on the risk of suicide. A previous study found that elderly suicide subjects had lower openness to experience (OTE), higher neuroticism, as well as lower extraversion scores compared with control groups (Duberstein et al., 1994). The authors suggested that these people were at risk because their affective dampening, concrete ways of thinking and rigidly defined self-concept had decreased their ability to adapt to various age-related changes, specifically concerning their role and a decline in their health and function; and they were more at risk of having suicidal thoughts in times of stress. Other studies found that a low extraversion score increased the risks of suicidal behavior in younger adults (Beautrais et al., 1999) as well as in older people (Duberstein et al., 2000). Furthermore, high neuroticism scores were found to be associated with suicidal thoughts in the elderly (Duberstein et al., 2000).

In our study, we found that the suicide cases were more neurotic, less extraverted and less open to experience. In addition, they were less agreeable and less conscientious than the control group. It has been suggested that positive affects were related to extraversion, and negative affects to neuroticism and that all these traits were related to happiness (Costa & McCrae, 1980). Further studies (Costa & McCrae, 1984) found that the unhappiest individuals were those with low scores on extraversion and high scores on neuroticism. Individuals with high scores in agreeableness had greater levels of happiness and life satisfaction, perhaps because they were more generous, loving and altruistic. Conscientious people were also happier, perhaps because their diligence and organization led to them achieving their goals. As personality traits can influence an individual's coping style, mood state and life satisfaction, it is conceivable that certain personality traits might predispose a person to poor coping, negative thoughts and negative moods in the face of stress; in turn this might lead to suicidal behavior. The findings on the association of personality traits and suicide are intriguing and warrant further study.

d. Recent life events

There are very few studies looking into the relationship between recent life events and suicide. Some of these studies have found that recent life events played a significant role in precipitating the act of suicide. The results of this study showed that suicide cases experienced more negative life events in the year preceding their death. In particular, loss events in the form of bereavement or illness in themselves or their significant others were of great importance as a suicide risk factor.

e. Past history of attempted suicide

In general, suicide attempts are uncommon in the general elderly population as confirmed by findings of our study. Indeed, a past history of attempted suicide is found to be associated with an increased risk of completed suicide in this study. This is consistent with our previous study on elderly suicide attempters who had a fairly high rate of completed suicide on long-term follow up (Chiu et al., 1996).

f. Social support

Our findings of a better social support network in the suicide subjects may be an artefact of the study design. Only cases with a reliable informant were included in the suicide sample whereas in the control subjects, the subjects themselves were interviewed. This may have led to a bias toward including only those with a better social support in the suicide group.

g. Interaction between the various associated factors

Although a number of factors exerted significant effect on the risk of suicide during the univariate analysis discussed previously, only:

1. current psychiatric disorders,
2. negative life events in the form of death or illness, and
3. the personality trait of being less conscientious

were considered significant risk factors using multivariate analysis. Thus, these three factors were found to be the most important suicide risk factors in our study of the local elderly population.

ii. Clues for suicide prevention

a. Indication of suicidal thoughts

63% of the suicide subjects had expressed some form of suicidal intention to their relatives or friends before their death. Indeed, 35.5% made an unequivocal communication of their intent to kill themselves. This is consistent with our previous study on elderly suicides in Hong Kong, where 68% of the elderly had indicated suicidal intent (Chi et al., 1997). Recent overseas studies have also shown a similar rate (Waern, Beskow, Runeson, & Skoog, 1999). This is an important clue that could be helpful in suicide prevention. If relatives or other people in contact with elderly people are made more aware of and sensitive to the risk of suicide among elderly people who have made suicidal statements, early and timely interventions may be made, which in turn might prevent these tragedies from occurring.

b. Medical consultation

Seventy-five percent of suicide cases had consulted a doctor within 1 month of their suicide, a significantly higher rate than the control group (39%). This finding shows that elderly suicide subjects have a high rate of recent medical consultation and that this contact with health-care professionals can be an important venue for late life suicide prevention.

c. Reasons leading to the suicide

According to the informants' views, precipitating factors include: physical problems (67.7%), psychiatric problems (25.8%), and relationship problems (25.8%). In contrast, financial problems only account for 1.6%. It can be said then, that for those elderly people who are vulnerable to a suicide attempt because of personality factors, psychiatric problems or recent life events; the presence of precipitating factors such as distressing physical problems, an unstable mental state and problems in their relationships might lead to the act of suicide. Medical staff, caretakers and relatives should be made aware of these risk factors and be alert to the signals given by the elderly.

d. Methodological considerations and limitations

In this study, we used normal elderly subjects from the community as the control subjects instead of third-party informants. Ideally, one should use third-party informants as controls in order to 'compare apples with apples'. However, this method is subject to bias and other difficulties as discussed by Hawton et al. (1998).

For instance, elderly people in the control group may be unwilling to allow their relatives to be interviewed, resulting in a biased sample. Furthermore, difficulties of confidentiality may arise. In Hong Kong, our experience with previous studies showed that local Chinese elderly people are frequently reluctant to refer their relatives for an

interview. Thus, we interviewed an elderly control group to obtain information. This led to a good response rate among the control group in our study.

Secondly, it is possible that there is a systematic recall bias on the part of informants of suicide cases. This may be inevitable to some extent in this type of study (Cheng, Chen, Chen & Jenkins, 2000), however. This could be due to the fact that informants might not be aware of certain aspects of life events in the suicide subjects or that the informant may under- or over-report certain events because of their personal reaction to the suicide (Heikkinen, Aro & Lönnqvist, 1992).

Thirdly, it is possible that the low number of referrals from the police may have led to bias within the sample of suicide cases. As a result, caution must be exercised when interpreting some of the findings. At the time this report was published, not all the Coroners' files were available, so an accurate response rate cannot be calculated, nor could the characteristics of the respondents and non-respondents be analyzed to examine the differences.

Chapter 6: Recommendations

6.1 A surveillance and monitoring system:

The existing system of recording deaths fails to provide a timely or accurate estimate of the suicide rate in Hong Kong. We suggest that a monitoring system be established, with the assistance of the Coroner's Office. We also believe that this work should be on going, and Government support and funding will be necessary to make it viable. The newly established Centre for Suicide Research and Prevention at the University of Hong Kong (HKU) needs to be supported by the Government; since the members of the HKU research team, who are founding members of the Centre, have the expertise and experience to maintain the monitoring system once it has been set up. The data obtained will be made accessible to both local and international suicide researchers. With a formal research centre in HK, reciprocal arrangements could be made with international centres of suicide research so that there will be a continuous exchange of data, findings, and expertise.

6.2 Suicide archives:

Acquiring of detailed overseas suicide figures is bound to involve some cost. At the moment, one of the most cost-effective means of obtaining suicide data is from the World Health Organization (WHO), which has been systematically collecting suicide information from its member states for years. The International Association of Suicide Prevention (IASP) and other WHO-sponsored non-governmental organizations are also excellent organizations with which to share suicide information and data.

6.3 Prevention:

Five point five percent of elderly people surveyed in the prevalence study expressed a wish to commit suicide or had made a suicide attempt in the past year. These suicidal thoughts or attempts are highly correlated with both depression and physical illness. In the case of physical illness, about 75% of the elderly victims in the psychological autopsy study had consulted a medical practitioner within one month of his or her suicide and more than 90% within three months. It is necessary to explore how this particular phenomenon can be used in intervention. Similar observations have been made in studies from other countries (Appleby et al., 1999; Conwell, 2001; Isometsä, 2000; Pirkis and Burgess, 1998).

Furthermore, such factors as vision and hearing problems, problems in carrying out daily living activities and the lack of a social support network are significant factors relating to their wish to commit suicide. It is also relevant to note that living with children has a beneficial effect on the elderly.

i. A diagnostic tool:

In the psycho-autopsy study, the multiple logistic regression analysis identified current psychiatric illness, certain life events and personality traits, which were significant in the classification of both the suicide cases and the controls. The use of a cut-off figure of 0.15 produced an agreement of 92% with the prediction, which was very promising indeed. Basically, this indicates that a diagnostic tool can be developed to identify high-risk elderly

people, especially one that includes the identification of personality traits and recent stressful life events.

ii. Intervention at the primary care level needs to be strengthened:

As it appears that elderly people at risk of suicide have had access to health services not long before their suicidal act, both general practitioners and the primary health care sector offer excellent opportunities for intervention. In both the survey study and the psychological autopsy study, it was found that depression and hearing and/or vision impairment significantly predict elderly suicide wish. A study by Conwell et al. (1998) found similar results. At the same time, depression seems to be a major common factor among the suicide victims in the control group. As with other cultures, elderly Chinese people are more likely to express their affective discomfort and distress in physical terms, instead of reporting symptoms of depression or the fact that they have suicidal thoughts (Conwell, 2001; Chi et al., 1997).

We suggest further training for primary health care practitioners, which will help them identify and diagnose depression and suicidal ideas among the elderly. Also, the emphasis might be on depression rather than on suicide itself. If depression among the elderly can be detected and resolved, it is likely that the suicide rate among the elderly will drop as a result. In particular, it is essential that general practitioners be able to recognize depression, and refer those elderly with severe depression or suicidal risk to psychiatrists. These cases should be seen urgently, and psychogeriatric fast track clinics should be set up so that early and effective intervention can be provided. Psychogeriatric teams should be strengthened to provide support, from the secondary and tertiary levels, to the general practitioners, the department of Social Welfare and non-governmental organizations.

Some sort of `incentive' should be provided for the front-line health care workers to urge them to spend more time providing counseling to elderly people during medical consultations. Greater emphasis should also be placed on the recognition and effective treatment of depressive disorders and suicidal states in the elderly during medical training at the undergraduate and postgraduate levels. We understand the medical curriculum is already very full, however, with the use of problem-based learning, the existing teaching materials should be able to incorporate the subject of depression and suicide. In addition, continuing education is another useful source to better equip general medical practitioners on the detection and management of depression and suicide, in the elderly as well as other age groups.

iii. Community outreach:

A significant proportion of elderly people still slip through the net of the primary health care practitioners: those who are house-bound and physically unable to access health care; those who live alone in isolated areas; those who, for financial reasons, do not have telephones or for other reasons cannot be reached by the outside world; and those who choose not to access health care service. The 36 Support Teams for the Elderly of the Social Welfare Department are currently providing community outreach services to homebound elderly persons. Separately, Suicide Prevention Services (SPS) have launched an outreach program for elderly people who wish to commit suicide. SPS report that as a result of active intervention, the risk levels of these elderly people have effectively been lowered. It is noteworthy that 79.3% of their cases showed positive change after intervention: 52% improved within 1 month of referral and 76% of the cases showed positive changes within 3 months. Only one death has

been reported among their clients (Suicide Prevention Services, 2000). In one study carried out in Italy, telephone contact by trained workers was found to be effective in giving social and psychological support to the elderly (De Leo, Carollo, & Dello Buono, 1995). Another study showed that through proactive telephone intervention, positive results were found in depressed and isolated elderly people (Morrow-Howell, Becker-Kemppainen, & Judy, 1998). These studies suggest that similar outreach programs could conceivably work in Hong Kong. Social workers, other family members or volunteers could be trained to reach out to elderly people on a scheduled basis. Telephone calls are both time- and cost-effective, and enormously beneficial, as the person taking the call receives social contact with the outside world. Outreach programs are urgently needed to approach this particularly vulnerable group. However, whether outreach programs have to be structured and run by trained social workers have yet to be determined since these could be very expensive to run. Furthermore, we are proposing a change of attitude of the community at large - to be more alert to the needs of the elderly, and be ready to reach out and provide support to them.

Based on the SPS experience, it is not easy to expect a Chinese elderly person to express his or her personal feelings. Usually, they have very strong self-esteem and almost always choose to hold their emotions close to themselves. Therefore, trust, respect and a good relationship are first required before an elderly person will open up and freely express any distress they may experience. SPS volunteers visit every elderly client twice a month - or more frequently if necessary - and augment this contact through frequent follow-up telephone calls. Through this approach, volunteers provide a chance for high-risk elderly people to more openly express themselves and let out their emotions (Suicide Prevention Services, 2000).

iv. Education of family members:

Of the elderly suicide victims in the psychological autopsy study, about 27% had explicitly and 36% implicitly stated to their family members that they had plans to commit suicide. It is important for these family members not to ignore this signal and to seek immediate professional help. Also, a more integrated program should be put in place to respond to the needs of the family such that the lives of the family members will not be inordinately disrupted.

v. Education for the public:

It is important to educate the public at large as to the prevalence of psychiatric illnesses - especially depressive illnesses - among the elderly. This will allow those who come into frequent contact with the elderly - be they family members or others - to become aware of the signs and symptoms of depression and to alert the appropriate authority or family member(s). Early detection and treatment is by far the best preventive strategy. It is noteworthy that many suicide myths still exist among health care professionals: only education will equip them with the necessary skills to handle suicidal elderly people with confidence. We firmly believe that this will help prevent elderly suicides in Hong Kong.

vi. Healthy ageing:

More than 50% of the suicide deaths in the psychological autopsy study had a poor or very poor health condition. The majority suffered from hypertension, cardiovascular disease, cancer, arthritis, or bronchitis. About 61% had been hospitalized within three months of their death. The informants suggested that nearly 70% of the suicide deaths were primarily due to

health problems. Hence, it is important to promote public awareness as to the maintenance of good

physical and mental health throughout the course of one's life. We should work closely with the local media (TV, radio, magazine and newspaper) to continuously promote this message, since it is as imperative for both the young and the old to maintain a healthy lifestyle.

vii. Co-ordination among the various sectors:

An effective strategy of suicide prevention will only be possible if it is comprehensive and involves various sectors, including the Hospital Authority, the Department of Health, the Department of Social Welfare, non-governmental organizations, academics and policy makers. Co-ordination and cooperation between these sectors in the planning and delivery of suicide prevention services are crucial to the success of these interventions.

viii. Appropriate resource allocation:

Resource will be necessary for the various interventions, public education campaigns and medication costs, such as antidepressants. Evaluation must form an integral part of any suicide prevention program. The cost of evaluation needs to be built into any research proposal, and the effectiveness of any suicide prevention program needs to be evaluated. Resource allocation should be evidence based.

Conclusion:

Suicide among the elderly in Hong Kong ranks high in international comparison. Given that the population is ageing, the situation is likely to worsen. Is suicide in the elderly preventable? Our answer is a resounding **YES,** provided research, public education and training in suicide prevention all become available at the same time. Over the past two years, despite an increase in the overall population suicide rate, elderly suicides have in fact decreased. The exact reasons are yet to be determined. The Government of the Hong Kong SAR and various non-governmental organizations - the Suicide Prevention Services and others, for example - have been actively promoting healthy ageing and social support and services for the elderly; as well, researchers in academia provide the much-needed statistics and information, all of which could be linked to the recent reduction of the elderly suicide rate.

Further research is needed to better understand the problem and to guide the prevention programs, which will have to be evaluated for their effectiveness. Research-based programs for suicide identification and prevention for the elderly should be set up, specifically targeting general practitioners and health care workers. This research team believes that elderly suicides in Hong Kong are preventable, but it will take the persistent involvement of the whole community and the commitment of the Government and non-governmental organizations to make it possible.

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Appendix 1

香港老人精神健康研究

敬啟者：

香港政府十分關注老人的精神健康，希望透過研究，得以進一步了解影響老人精神健康的因素，從而提供適當的服務。

香港大學及香港中文大學已被政府委託進行上述研究。一隊由專業人士指導及受過專業訓練的社會工作者，希望以訪問形式與閣下面談，收集有關老人家生活狀況資料。在面談時，閣下可以提出任何有關老人方面的問題和意見，訪問隊內的專業人士樂意向閣下提供有關服務和輔導的資料。

如果閣下同意參加這個研究，請提供聯絡方法，本處將儘快與閣下聯絡、安排訪問。訪問所得的資料只作集体分析之用，個人資料絕對不會公開。若有查詢，請聯絡本研究助理先生／小姐(電話：　　)。閣下之參與及合作對這個研究十分重要，謹此致謝。

香港特別行政區政府
政府統計處
年　月　日

本人(姓名)_____，願意參與由香港大學及香港中文大學負責之老人精神健康研究，請安排有關之專業人士與本人會晤。

本人地址：_____

電話：(工作) _____(居所)_____(手提)_____

適合會面之時間: 上午／下午／晚上／另約

政府統計處
綜合住戶統計調查

填入數據後即成機密文件

香港老人精神健康研究

問卷編號：_____

訪問員姓名：_____
被訪者姓名：_____
電話：_____

地址：_____

1.		第一次	第二次	第三次	第四次	第五次
	聯絡方式：(上門/電話)					
	訪問日期: 時間：					
	訪問結果： 1 = 聯絡不成功 2 = 拒絕受訪 3 = 住戶資料不符 4 = 沒有合適訪問對象 5 = 成功訪問					

2. 最後結果：
☐ 1.成功訪問 ☐ 2.部分成功訪問 ☐ 3.多次聯絡不成功 ☐ 4.沒有訪問對象
☐ 5.非住戶 ☐ 6.居所空置 ☐ 7.對象長期不在 ☐ 8.居所已拆卸
☐ 9.長者拒絕受訪 ☐ 10.家人不准長者接受訪問
☐ 11.長者不能通過記憶測試

3. 面談地點： ☐ 1.受訪者的居所 ☐ 2. 其他地方 _____

4. 所需時間 _____分鐘 (完成時間 _____)

5. 完成日期：_____月_____日

A. 受訪者個人資料

引言 : 首先，我地想記錄一 D 你㓥個人資料用來做統計分析。

1. 性別: ☐ 1.男 ☐ 2.女
2. 出生年份: _____
3. 居港時間(係香港住了幾耐?): _____年 (未足一年記錄為 1)
4. 婚姻狀況: (結了婚未?)
   ☐ 1.獨身(從未結婚) ☐ 2.已婚(與配偶同住) ☐ 3.已婚(不與配偶同住)
   ☐ 4.正式分居 ☐ 5.離婚 ☐ 6.喪偶
   ☐ 7.其他_____
5. 居住安排 (同邊個住?)
   ☐ 1.獨居 ☐ 2.只與配偶同住 ☐ 3.與配偶及兒/孫同住
   ☐ 4.只與兒/孫同住 ☐ 5.與其他親戚或朋友同住
   ☐ 6.與不認識的人同住(如:傭人) ☐ 11.其他 _____
6. 你而家係唔係在職人士? (即過去 7 日內，以工作賺取酬勞或利潤，又或者係有一個職位)
   ☐ 1.是 (續問 6a) ☐ 2.否 (續問 6b)
   6a. 你現時的職業係_____
   6b. 你通常一星期內，會工作幾多小時呢? _____ 小時 (跳問 7)
   6c. 如果現時有人請你做工，你可吾可以隨時返工呢?
   ☐ 1. 可以 (跳問 6f) ☐ 2. 唔可以
   6d. 點解唔可以呢?
   ☐ 1. 生病 (跳問 6f) ☐ 2. 退休 ☐ 3. 料理家務 (跳問 7)
   ☐ 4.其他 (請註明:_____) (跳問 7)
   6e. 你退休/失業前的職業係_____
   6f. 你過去一個月有無搵工呢?
   ☐ 1. 有 (跳問 7) ☐ 2. 無
   6g. 點解唔搵工呢?
   ☐ 1. 相信無工作可以做 ☐ 2. 等緊返新工 ☐ 3. 期待返回原來的工作崗位
   ☐ 4. 其他 (請註明:_____)
7. 教育程度: (讀書讀到咩程度?)
   ☐ 1.從未接受正式教育 ☐ 2.小學或以下 ☐ 4.初中 ☐ 5.高中
   ☐ 6.專科 ☐ 11.大學或以上
8. 宗教信仰: (有無宗教信仰?)
   ☐ 1.天主教 ☐ 2.基督教 ☐ 3.佛/道教 ☐ 4.拜祖先
   ☐ 5.其他 _____ ☐ 0.沒有宗教信仰 (跳問第 10 題)
9. 若有信仰，宗教對你的重要性？
   ☐ 1.不重要 ☐ 2.有點重要 ☐ 3.重要 ☐ 4.非常重要
10. 你現在有無接受綜援？
   ☐ 1.有 ☐ 2.沒有
11. 你覺得自己的經濟情況如何？
   ☐ 1.非常足夠 ☐ 2.足夠 ☐ 3.普通 ☐ 4.不足夠 ☐ 5.非常不足夠

B. 記憶測試

以下有些問題不是每個人都能夠記得的，但希望你盡量回答。

	答對 1	答錯/無答案 0
1 今日星期幾？	☐	☐
2 今日幾多號？	☐	☐
3 而家特首係邊個？	☐	☐
4 最後一任港督係邊個？	☐	☐
5 用 20 不停減去 3 (即減完 3 再減 3)，答案分別是… [要全中才算答對：17, 14, 11, 8, 5, 2]	☐	☐
6A 你屋企電話號碼是？ [如沒有電話請問 6B]	☐	☐
6B 請講一次這裡的地址。 [如答案中包括正確的樓宇和單位號碼，便算答對；如答對，連第 7 題也答對。]	☐	☐
7 你住在哪區？ [被訪者只需答出香港、九龍、新界、某醫院、某區等有關住所資料便算答對。]	☐	☐
8 你幾多歲？ [請記錄年齡：___] [以自報出生年期或身份証作實際年齡比較] [如果實際年齡相差不超過五年便算答對。]	☐	☐
9 你出生日期是哪月哪日？ [只要被訪者答出某月某日便算答對。]	☐	☐
10 中國國父全名是甚麼？	☐	☐
	總分 _____	

[如分數低過 4 分，終止訪問。請向被訪者說出以下結束語]:
很多謝你接受今次的訪問，今次的訪問經已完畢，祝你身體健康，生活愉快！
[4 至 7 分，由被訪者回答以下問題，必要時向其家人核對。]
[7 分以上，必須由被訪者自行回答。]

C. 健康情況

1. 你覺得你而家㩒健康情況點樣？
   ☐ 1.極差 ☐ 2.差 ☐ 3.普通 ☐ 4.好 ☐ 5.極好
2. 你覺得你而家㩒生活情況點樣?
   ☐ 1.較以前好得多 ☐ 2.較以前好 ☐ 3.與從前差不多 ☐ 4.較以前差 ☐ 5.較以前差得多
3. 醫生有無話你有以下疾病？

	有 1	無 0
a. 高血壓	☐	☐
b. 心臟病	☐	☐
c. 中風	☐	☐
d. 柏金遜症	☐	☐
e. 糖尿病	☐	☐
f. 慢性支氣管炎/肺氣腫/哮喘	☐	☐

g.	慢性肝病	☐	☐
h.	腎病	☐	☐
i.	甲狀腺功能失調	☐	☐
j.	關節炎／痛	☐	☐
k.	癌症	☐	☐
l.	骨折、骨質疏鬆、老年人駝背等	☐	☐
m.	痴呆症	☐	☐
n.	其他疾病_____	☐	☐

4.	咁你有無以下問題？	有	無
		1	0
a.	長期身體痛症(困擾時間多過 6 個月)	☐	☐
b.	失禁	☐	☐
c.	長期便秘	☐	☐
d.	咀嚼食物有困難 (因無牙)	☐	☐

5. 連埋戴眼鏡，睇野清唔清楚？
   ☐ 1.睇得很好 ☐ 2.睇得普通 ☐ 3.睇得唔係幾好 ☐ 4.幾乎／完全睇唔到
6. 連埋用耳聾機，聽野清唔清楚？
   ☐ 1.聽得很好 ☐ 2.聽得普通 ☐ 3.聽得唔係幾好 ☐ 4.幾乎／完全聽唔到

D. 起居生活／自我照量表顧量表

I. (IADL)

以最近一星期內的生活情況為準，却進行以下呢 D 活動方面，你有無困難呢 ？ 可否自己處理呢？

1. 使用電話
   ☐ 0.應用電話自如, 能查閱, 接聽, 及打出電話
   ☐ 1.只能記得並打出幾個熟知的電話號碼
   ☐ 2.只能接聽, 不能打出電話
   ☐ 3.不使用電話
   ☐ 9.不適用（沒有電話／不准使用電話）
2. 購物
   ☐ 0.自己購買一切所需用品
   ☐ 1.自己購買少許所需用品
   ☐ 2.需人協助購買用品
   ☐ 3.不能外出購買用品
   ☐ 9.不適用（本身可以但由其他人代勞）
3. 食物準備
   ☐ 0.自行購物, 準備, 烹煮食物
   ☐ 1.若有材料, 能自行烹煮食物
   ☐ 2.只能翻熱食品, 但經常飯餐不繼
   ☐ 3.需別人代為準備食物
   ☐ 9.不適用（本身可以但由其他人代勞）
4. 做家務
   ☐ 0.自己做家務, 或間中需人幫助較粗勞工作

☐ 1.只能處理輕便家務, 但清潔未符標準
☐ 2.需別人幫助打理家務
☐ 3.不參與任何家務
☐ 9.不適用 (從不需要自己做，由家人或傭人負責)

5. 洗衫
☐ 0.自己清洗個人衣物，不用幫忙
☐ 1.清洗衣物次數不足, 亦不徹底
☐ 2.只能清洗小量及較輕便衣物(例如襪)
☐ 3.所有清洗需要別人幫忙
☐ 9.不適用(自己可以做，但由其他人代勞)

6. 交通工具
☐ 0.自己乘公共汽車, 或駕駛汽車
☐ 1.自己叫計程車, 或別人陪伴下乘公共汽車
☐ 2.需別人幫助叫車, 及陪伴上私家車
☐ 3.不出外
☐ 9.不適用(請註明: _____)

7. 食藥
☐ 0.能準時及定量服藥, 並能在藥物用清前, 叫醫生加添
☐ 1.能自行準時及定量服藥
☐ 2.能服下別人準備及按時給予的藥
☐ 3.不能自己服藥
☐ 9.不適用（不用服藥或由住院護士給藥）

8. 處理金錢
☐ 0.自己處理一切財務，並有長期預算
☐ 1.只能處理目前的財務, 但沒有長期預算
☐ 2.只能處理每日財務, 並需人協助處理銀行事務
☐ 3.完全不能處理財政
☐ 9.不適用（自己可以但由他人代勞）

II. (PSMS)
跟住我會問一凉生活上照顧自己剎情況，有凉瀝或者都好簡單，不過都要問冲，請你唔好介意。

9. 如廁
☐ 0.自己去廁所, 沒有失禁
☐ 1.需人提醒上廁, 並每星期有一次失禁
☐ 2.睡覺時, 每星期失禁多于一次
☐ 3.清醒時, 每星期失禁多于一次
☐ 4.完全失禁
☐ 9.不適用(請註明: _____)

10. 進食
☐ 0.自己進食, 不用幫忙
☐ 1.需要別人少許幫忙
☐ 2.需要別人中度幫忙

☐ 3.完全依賴別人幫忙
☐ 4.需要別人大量幫忙, 但本身又十分抗拒
☐ 9.不適用 (請註明: _____)

11. 穿衣
☐ 0.自己揀選衣服穿上
☐ 1.需要別人少許幫助穿／寬衣
☐ 2.需要別人中度幫助穿衣及揀選衣服
☐ 3.需要別人大量幫助, 但本身願意合作
☐ 4.完全需要別人幫助, 但本身不合作
☐ 9.不適用 (請註明: _____)

12. 梳洗
☐ 0.自己梳洗, 儀容整潔
☐ 1.自己梳洗, 大致保持儀容整潔
☐ 2.需要別人中度幫助梳洗
☐ 3.需要別人完全幫助梳洗, 但仍能保持儀容整潔
☐ 4.完全反抗別人協助梳洗, 不理儀容
☐ 9.不適用 (請註明: _____)

13. 洗澡
☐ 0.自己洗澡 (不用別人協助)
☐ 1.大致自己洗澡, 只需別人少許幫助
☐ 2.只能洗手及面, 不能清洗身體
☐ 3.不能自行洗澡, 但願意接受別人幫助
☐ 4.不能自行洗澡, 亦抗拒別人幫忙
☐ 9.不適用 (請註明: _____)

14. 活動能力
☐ 0.能到其他地方 (街上) 走動
☐ 1.只能在家內或附近走動
☐ 2.能在下列工具協助下走動 (請✓一項)
  ☐ a.人
  ☐ b.扶手
  ☐ c.枴杖
  ☐ d.步行架
  ☐ e.輪椅
☐ 3.能自己坐在輪椅或凳上, 但需人協助才可活動
☐ 4.一半時間躺床
☐ 9.不適用 (請註明: _____)

E. 醫療服務使用狀況

1. 你對上苑次見醫生刦幾耐之前呢？
☐ 1.少過一個月 ☐ 2.一個月至少過兩個月 ☐ 3. 兩個月至少過三個月
☐ 8.過往三個月沒有見醫生(跳問 Q.3)

2. 你過往三個月看了幾多次醫生？ _____

3. 過往一年，你有無入過醫院呢? (最少要在醫院留院一晚或以上)? 如有曾留院幾多次？ _____ (若答無填 0 及跳問題 Q.5)
   a. 幾多次是身體問題？ _____
   b. 幾多次是精神問題？ _____
4. 過往 3 個月，你有無在醫院留醫? (最少要在醫院留院一晚或以上)? 如有曾留醫幾多次？ _____(若答無填 0 及跳問題 Q.5)
   a. 幾多次是身體問題？ _____
   b. 幾多次是精神問題？ _____
5. 你有無精神或藥物濫用問題？ ☐ 1.有 ☐ 2.沒有(跳向 **Part F.)** ☐ 9.不知道
   若有，是什麼問題或病 _____
6. 你有無因精神問題見精神科醫生或入院？
   ☐ 1.有 ☐ 2.沒有 ☐ 9.不知道

F. 社會網絡量度表

1. 你通常一個月內會同幾多位唔同住剗家人和親戚聯絡或者見面呢? (打電話都計)
   ☐ 0.沒有任何人 ☐ 1.一個 ☐ 2.二個 ☐ 3.三個至四個
   ☐ 4.五個至八個 ☐ 5.九個或以上
2. 最常同你聯絡的那位家人或親戚, 請問你多久與他聯絡一次?
   ☐ 0.少過一個月一次 ☐ 1.一個月一次 ☐ 2.一個月數次
   ☐ 3.一個星期一次 ☐ 4.一個星期數次 ☐ 5.每一天
3. 你有幾多位較親近的家人和親戚呢? 親近即是指你覺得可以同佢地傾自己的心事或向佢地尋求幫助?
   ☐ 0.沒有任何人 ☐ 1.一個 ☐ 2.二個
   ☐ 3.三個至四個 ☐ 4.五個至八個 ☐ 5.九個或以上
4. 你有多少位好朋友? 即是指你覺得可以同佢地傾自己的心事或向佢地尋求幫助？
   ☐ 0.沒有任何人 ☐ 1.一個 ☐ 2.二個
   ☐ 3.三個至四個 ☐ 4.五個至八個 ☐ 5.九個或以上
5. 有多少好朋友你係最少一個月內見面或聯絡一次?
   ☐ 0.沒有任何人 ☐ 1.一個 ☐ 2.二個
   ☐ 3.三個至四個 ☐ 4.五個至八個 ☐ 5.九個或以上
6. 你與那一位跟你接觸最多的朋友見面或聯絡的次數大概是?
   ☐ 0.少過一個月次 ☐ 1.一個月一次 ☐ 2.一個月數次
   ☐ 3.一個星期一次 ☐ 4.一個星期數次 ☐ 5.每一天

7. 當你有重要的事情要決定, 有無人同你商量?
   ☐ 0.沒有 ☐ 1.很少 ☐ 2.有時有
   ☐ 3.時常有 ☐ 4.經常有 ☐ 5.每次都有
8. 當你認識的人有重要的事情要決定時, 他們有無同你商量?
   ☐ 0.沒有 ☐ 1.很少 ☐ 2.有時有
   ☐ 3.時常有 ☐ 4.經常有 ☐ 5.每次都有

9. 有無人依賴你為他們做些事, 如買東西、煮飯、修理東西、清潔、看小孩?

☐ 0.沒有 ☐ 1.很少 ☐ 2.有時有

☐ 3.時常有 ☐ 4.經常有 ☐ 5.每次都有

G. 生活事件量表

過往三年你有沒有遇過以下的生活事件？ 如果有，係幾耐之前剎事呢？（請用以下編碼記錄）

編碼：			
0.沒有	1.一星期或以內	2.多過一星期至三個月	3. 多過三個月至半年
4.多過半年至一年	5. 多過一年至兩年	6.多過兩年至三年	9.不知道

	編碼
1. 子女搬開住	
2. 家庭加添成員(包括子女結婚、孫兒出世等)	
3. 與近親或好友分離(但不是去世)	
4. 居住情況有變(如遷家、移民等)	
5. 入住院舍	
6. 配偶過身	
7. 子女過身	
8. 好朋友過身	
9. 其他家人過身	
10. 自己重病或重傷	
11. 家人重病	
12. 離婚或分居	
13. 婚姻或感情問題	
14. 配偶不忠	
15. 與家人不和 (唔開心的事)	
16. 與同事或朋友不和	
17. 退休	
18. 失業/被解僱	
19. 生意失敗	
20. 經濟出現嚴重問題	
21. 打劫或 “爆格”	
22. 法律訴訟 (惹官非)	

23. 除以上事件，有無其他事對你心情好有影響，不論好壞？

☐ 1.有 ☐ 0. 沒有

若有，請說明是什麼及發生時間

_____

24. 你覺得以上的事件，邊 D 對你影響最深？

_____

H. 應付問題的方法和感受

引言 : 而家我會讀出一凉句子，形容一凉人應付問題剗方法同感受，想知道一下你本人多唔多咁樣諗，又或者多唔多咁做。

	從來沒有 1.	有時有 2.	很多時有 3.
1. 透過工作上學習或一些其他活動來解決問題	☐	☐	☐
2. 同人傾，講心事	☐	☐	☐
3. 盡量看到事物好的一面	☐	☐	☐
4. 改變自己的想法或重新發現生活中什麼是重要	☐	☐	☐
5. 唔好將問題看得太嚴重	☐	☐	☐
6. 堅持自己的立場，繼續努力	☐	☐	☐
7. 搵出幾種不同的解決方法	☐	☐	☐
8. 向親戚朋友尋求建議/意見	☐	☐	☐
9. 改變原來的一些做法或自己的一些問題	☐	☐	☐
10. 借鑒他人處理類似困難情景的辦法	☐	☐	☐
11. 搵出業餘愛好，積極參加文體活動	☐	☐	☐
12. 盡量克制自己的失望、悔恨、悲傷和憤怒(唔開心)感情	☐	☐	☐
13. 試圖休息或休假，暫時把問題(煩惱)拋開	☐	☐	☐
14. 透過吸煙、喝酒、服藥或吃東西來解除煩惱	☐	☐	☐
15. 認為時間會改變現狀，唯一要做的便是等	☐	☐	☐
16. 試圖忘記整個事情	☐	☐	☐
17. 依靠別人解決問題	☐	☐	☐
18. 接受現實，因為沒有其他辦法	☐	☐	☐
19. 幻想可能會發生某種奇蹟改變現狀	☐	☐	☐
20. 自己安慰自己	☐	☐	☐

I. 老年抑鬱及困擾

係最近兩星期內 , 你是否曾有以下感受或想法呢?

	是 1	不是 0
1. 你基本上對自己的生活感到滿意嗎？	☐	☐
2. 你係唔係已放棄了很多以往的活動和嗜好？	☐	☐
3. 你係唔係覺得生活空虛？	☐	☐

	是 1	不是 0
4. 你係唔係常常感到煩悶？	☐	☐
5. 你係唔係很多時感到心情愉快呢？	☐	☐
6. 你係唔係會怕將會有唔好的事情發生係你身上呢？	☐	☐
7. 你係唔係大部份時間感到快樂呢？	☐	☐
8. 你係唔係常常感到無助？ (即是沒有人能幫自己)	☐	☐
9. 你係唔係寧願留在家裏，而不愛出外做些有新意的事情？	☐	☐

(譬如 : 和家人到一新開張酒樓吃晚飯)

10. 你係唔係覺得你比大多數人的記憶無咁好? ☐ ☐
11. 你認為現在仍然生存是一件好事嗎？ ☐ ☐
12. 你會唔會覺得自己現在一無是處呢？ ☐ ☐
13. 你係唔係感到精力充足？ ☐ ☐
14. 你會唔會覺得自己的處境無望？ ☐ ☐
15. 你覺得大部份人的境況比自己好嗎？ ☐ ☐

引言： 以下我會問一些有關心理感受㗎問題，請你以現時或最近(即過去一個月內)的情況作答。咁 D 問題可能會令你感到不開心，請你唔好介意。

編碼：（除另外註明，請用以下兩種編碼）
0: 無/正常 1: 有/不正常 8: 沒答 9: 不適用
0: 無 1: 有．輕度 2: 有．嚴重 8: 沒答 9: 不適用

1. 你對自己的前途如何看法（怎樣想的）？（你覺得將來你的境況會如何？你對未來抱有什麼希望？）
   1.1 不悲觀，但也不抱希望（過一天算一天）（進一步探問）。 ☐0 ☐1 ☐8 ☐9
   如果悲觀，則問：為什麼悲觀呢？
   你真的感到毫無希望（絕望）了嗎？
   如果答話含糊，則問：你是否對將來的一些事情不願去考慮？
   1.2 若悲觀或覺得前途暗淡，或根本看不到前途，或對未來無法承受。 ☐0 ☐1 ☐8 ☐9
   1.3 一般的無望和絕望感。 ☐0 ☐1 ☐8 ☐9
   1.4 明顯是由環境造成的悲觀。 ☐0 ☐1 ☐8 ☐9

2. 你是否覺得生命沒有意義，不值得活下去？ ☐0 ☐1 ☐2 ☐8 ☐9

3. 你是否曾想過生不如死（因為生命對你已成為負擔？）你是否曾想過要一死了之？（你是否曾想過由自己來採取某種行動？）（自殺？） ☐0 ☐1 ☐8 ☐9

4. 什麼時候有過這種想法的？最近有無這種想法？（在近一月內嗎？）（有過幾次？）

	從無	有時有	沒答	不適用
4.1 在最近一個月裏。	☐0	☐1	☐8	☐9
4.2 在最近一年裏。	☐0	☐1	☐8	☐9
4.3 在最近一個月至少有兩次曾有想死的念頭。	☐0	☐1	☐2	☐8 ☐9

編碼：（除另外註明，請用以下兩種編碼）
0: 無/正常 1: 有/不正常 8: 沒答 9: 不適用
0: 無 1: 有．輕度 2: 有．嚴重 8: 沒答 9: 不適用

5. 開始 :
   人於不愉快的時候，不免會有一涼消極㗎想法，有涼人會停留於思想㗎階段，唔會採取實際㗎行動，但有涼人就會採取某些較衝動㗎實際行動或會去計

劃一凉行動。

請問你有沒有試過為想死真的採取過什麼行動？什麼時候？
是什麼行動？（或計劃做什麼？）你為什麼會想去死呢？

5.1 為自殺已採取過一些行動或計劃進行一些行動。 ☐ 0 ☐ 1 ☐ 8 ☐ 9(請註明:_____)

	沒有	最近一個月內	一個月以前
5.2 如有，何時？	☐ 0	☐ 1	☐ 2

5.3 已放棄自殺，但因覺得生命是一個負擔，曾想過自己死去。 ☐ 0 ☐ 1 ☐ 8 ☐ 9(請註明:_____)

6. 如果你曾有自殺念頭，由於甚麼原因而放棄此想法？你曾做過些甚麼令你放棄此想法？

（請詳細記錄被訪者的描述）

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

多謝你接受我們的訪問，祝你身體健康，生活愉快.

---------(全卷完)----------

Appendix 2

Pilot study

The pilot study for the survey was conducted over a two-day period in March, 2000 by a trained interviewer. The interviews were conducted at St. James' Settlement, a Multi-service Centre for the Elderly in Wan Chai. Four males and six females were interviewed, with ages ranging from 62 to 89 years.

Each interview lasted between 20 and 55 minutes. The interviews generally went smoothly except for the following issues, which were identified and properly dealt with by the interviewer: -

- Problem: The interviewees got distracted easily and would go off on a tangent.
  Solution: The interviewer paid attention to such behaviour and would bring the interviewee back on track in an appropriate manner.

- Problem: The interviewees had difficulty in selecting the appropriate options for 'Housework' and 'Toileting' concerning the IADL and PSMS questions.
  Solution: Options for 'Housework' were rephrased in Cantonese and the options for 'Toileting' were explained to the interviewees by the project supervisors.

- Problem: In the section titled 'Medical Utilization', the option '2-3 months ago' was missing from the question asking when the interviewee last saw a doctor.
  Solution: The missing option was added.

- Problem: The interviewer encountered more problems in completing Section H because the interviewees had difficulties understanding the questions being asked, as they were presented in a technical language.
  Solution: To make the questions more understandable, the questionnaire was rephrased in Cantonese.

Apart from the above, the interviewer had no problems in conducting the rest of the questionnaire. In the interests of completeness regarding the IADL measure in Section D, a further question concerning washing clothes was added, after advice from team members.

With regard to Section I, concerning suicidal ideation, an agreement with the Centre's staff was reached, whereby any client identified as having suicidal thoughts would be referred to the Centre's workers, providing that the client would accept the referral arrangement. As it turned out, one interviewee was identified as having suicidal thoughts in the pilot test. The interviewer asked the client if assistance was required and whether he or she would accept a referral arrangement. The client did not reject the proposal and thus the interviewer referred the client to a counsellor at the Centre. It was suggested that a similar practice should be employed during the main survey, whereby the interviewers would refer any suicidal interviewee(s) to professional service providers upon the interviewee's agreement.

Subsequently, Suicide Prevention Services (生 命 熱 線) and the Family Services Centre of the Social Work Department agreed to accept referrals from our interviewers during the main survey.
In accordance with the findings of the pilot study, and after thorough discussion with the research members, the questionnaire was finalized.

Appendix 3*

香港中文大學醫學院精神科
香港大學社會工作及社會行政學系
填入數據後即成機密文件

香港老人自殺研究

問卷編號: _____

訪問員姓名：_____

被訪者姓名：_____

電話：_____

地址：_____

1. 面談地點： ☐ 1.受訪者的居所 ☐ 2. 其他地方 _____
2. 開始時間：_____
3. 完成時間 : _____
4. 所需時間 _____分鐘
5. 完成日期：_____月_____日

* 因版權關係，在研究中所採用的「性格問卷」並沒有被載錄於此。如欲查看，請與研究 人員聯絡，詳見封面資料。

A. 資料提供者背景

資料提供人的背景

1. 年齡 _____
2. 性別 ☐1.男 ☐2. 女
3. 教育程度: (讀書讀到咩程度?)
   ☐ 1.從未接受正式教育 ☐ 2.小學或以下 ☐ 4.初中 ☐ 5.高中
   ☐ 6.專科 ☐ 11.大學或以上
4. 與死者的關係
   ☐1.夫婦 ☐7.親生父母
   ☐2.兒女 ☐8.養父母
   ☐3.兄弟姊妹 ☐9.朋友
   ☐4.同父異母／同母異父的兄弟姊妹 ☐10.起居照顧員
   ☐5.其他親戚 ☐11.其他
   ☐6.同居/重要人士
5. 認識死者多久？(以年計算) _____
   (少於 6 個月= 00；6 - 18 個月=01 等)
6. 是否與(死者姓名)同住？
   ☐1.是 ☐2.否
7. 最後一次與(死者姓名) 談話的時間？
   ☐1. 少於一日前 ☐5. 2-6 個月前
   ☐2. 1-6 日前 ☐6. 7-12 個月前
   ☐3. 1-2 星期前 ☐7. 多于一年前
   ☐4. 3-4 星期前 ☐8. _____ 小時前
8. 通常每月見(死者姓名) 幾次？_____
   (99 代表不知道，每天=28)
9. 每月與(死者姓名)的稔熟深淺？
   ☐1. 非常稔熟 ☐4. 不十分稔熟
   ☐2. 頗稔熟 ☐5. 完全不認識
   ☐3. 一般
10. 你／妳有沒有想過(死者姓名)會因自殺而死？
    ☐1. 絕對有
    ☐2. 有時
    ☐3. 或有可能
    ☐4. 不可能

若答 1, 2 或 3 者，此部分問題完。

若答 4, 請問：

11. 你/妳認為(死者姓名)的死是由於？
    ☐1. 自然死亡
    ☐2. 意外
    ☐3. 謀殺
    ☐4. 其他 _____
    ☐5. 不知道

B. 自殺死者個人資料

1. 性別: ☐ 1.男 ☐ 2.女
2. 出生年份: _____
3. 居港時間 (係香港住了幾耐?): _____年 (未足一年記錄為 1)
4. 婚姻狀況: (結了婚未?)
   ☐ 1.獨身(從未結婚) ☐ 2.已婚(與配偶同住) ☐ 3.已婚(不與配偶同住)
   ☐ 4.正式分居 ☐ 5.離婚 ☐ 6.喪偶
5. 居住安排 (同邊個住?)
   ☐ 1.獨居 ☐ 2.只與配偶同住 ☐ 3.與配偶及兒孫同住
   ☐ 4.只與兒孫同住 ☐ 5.與其他親戚或朋友同住
   ☐ 6.與不認識的人同住(如:佣人) ☐ 11.其他 _____

6. 職業狀況: (仲有無做工?)
☐ 1.全職工作 ☐ 2.半職工作 ☐ 3.退休
☐ 4.失業 ☐ 5.家庭主婦 ☐ 6.其他 (如:從未工作)
6a. 現有的職業 _____
6b. 退休前職業 _____

7. 教育程度: (讀書讀到咩程度?)
☐ 1.從未接受教育 ☐ 2.小學或以下 ☐ 3.初中 ☐ 4.高中
☐ 5.預科 ☐ 6.學徒訓練計劃 ☐ 7.商科／工業學院
☐ 8.大專 ☐ 9.護士／教育學院 ☐ 10.大學 ☐ 11.研究院

8. 宗教信仰: (有無宗教信仰?)
☐ 1.天主教 ☐ 2.基督教 ☐ 3.佛教 ☐ 4.拜祖先 ☐ 5.其他 _____
☐ 6.沒有宗教信仰

9. 若有信仰，宗教對他／她的重要性？
☐ 1.不重要 ☐ 2.有點重要 ☐ 3.重要 ☐ 4.非常重要

10. 他／她有沒有正在接受綜援？
☐ 1.有 ☐ 2.沒有

11. 若他／她沒有接受綜援，你覺得他／她的經濟情況如何？
☐ 1.非常足夠 ☐ 2.足夠 ☐ 3.普通 ☐ 4.不足夠 ☐ 5.非常不足夠

C 自殺行為剖象

現在問一下(自殺死者姓名)自殺時及之前的情況。請儘你所能回想他/她在自殺前那數天發生的重要事情。

1. 你覺得(死者姓名)為何自殺？(可選多于一項)
☐1. 精神問題
☐2. 健康問題
☐3. 經濟問題
☐4. 與家人關係問題
☐5. 與其他人關係問題
☐6. 喪偶或其他家人去世
☐7. 喪偶或其他家人去世
☐8. 其他_____

2. 那些因素最重要？(按重要性排次序)
_____
_____
_____

3. 你覺是什麼直接因素引致他/她在當日自殺？
_____
_____
_____

4. 方法#1 (最先的方法)
☐1. 割腕
☐2. 戮/割其他地方
☐3. 服食藥物
☐4. 服食非藥物
☐5. 跳樓
☐6. 吊頸
☐7. 吞槍
☐8. 跳海
☐9. 吸入煤氣/石油氣/一氧化碳
☐10. 窒息
☐11. 其他 _____

5. 方法#2
☐1. 割腕
☐2. 戮/割其他地方
☐7. 吞槍
☐8. 跳海

☐3. 服食藥物
☐4. 服食非藥物
☐5. 跳樓
☐6. 吊頸
☐9. 吸入煤氣/石油氣/一氧化碳
☐10. 窒息
☐11. 其他 _____
☐12. 不適用

6. (死者姓名)自殺前有沒有喝酒？
☐1. 有 ☐2. 沒有 ☐3.不知道

7. (死者姓名)在那裏自殺？有沒有其他人在場？
(SIS - 1) **孤立**
☐0. 有其他人在場
☐1. 有其他人在可見及可聽到的範圍附近
☐2. 沒有其他人在可見及可聽到的範圍附近

8. (死者姓名)自殺前有沒有任何行動，來掩飾他/她的自殺行為？(例如自殺前將門上鎖)
誰人發現死者？怎樣發現？
(SIS-2) **時間性**
☐0. 其他人是可以干預的
☐1. 其他人是不可能干預的
☐2. 其他人是非常不可能干預的

9. (SIS-3) **預防性(防止他人發現自殺行為)**
☐0. 沒有預防
☐1. 消極預防(例如獨自在房內但沒有上鎖)
☐2. 積極預防(例如獨自在房內並將房門上鎖)

10. (SIS-4) **嘗試求救**
☐0. 自殺時曾通知可能會趕來阻止自殺的人
☐1. 聯絡但沒有特意知會可能前來阻止自殺的人
☐2. 完全沒有通知/聯絡其他人

11. (死者姓名)有沒有為自己準備身後事？(例如立下遺書，或將有紀念價值的物件送予別人)
(SIS-5) **最後行動**
☐0. 沒有
☐1. 曾考慮過並作某些安排
☐2. 一切已安排妥當

做了什麼特別行為去安排身後事？
_____
_____
_____

12. (死者姓名) 的自殺行動是否有計劃地進行？
(SIS-6) **積極準備**
☐0. 沒有準備
☐1. 略有準備
☐2. 準備週詳

13. (死者姓名)有沒有在信中或日記中提及自殺計劃？
(SIS-7) **提及自殺的便條、日記**
☐0. 沒有
☐1. 曾在日記、字條或信中提及自殺，但後來被撕掉或擦去
☐2. 有字條、日記或信件留下

14. 除書信、日記外，(死者姓名)有沒有向別人透露或暗示他/她的自殺計劃？使人事後醒覺死者的說話是有玄機。
(SIS-8) 自殺前(死者姓名)表露自殺傾向的情況
☐0. 沒有
☐1. 不清楚表露
☐2. 清楚表露

15. 若有，(死者姓名)曾向誰表露自殺的念頭？
☐1. 家人 ☐4. 一同居住的人
☐2. 朋友 ☐5. 其他
☐3. 同事 ☐9. 不適用

16. SIS 總得分 _____

17. 一生中自殺的次數？(不包括今次) _____-

18. 最近一次自殺的發生時間？(不包括今次)
☐ 1. 1 – 7 日前 ☐ 5. 1 – 2 年前
☐ 2. 1 – 4 星期前 ☐ 6. 2 – 5 年前
☐ 3. 1 – 6 個月前 ☐ 7. 多於 5 年前
☐ 4. 6 – 12 個月前 ☐ 0. 不適用

19. 自殺的方式？(不包括今次)
☐1. 割腕 ☐7. 吞槍
☐2. 戮/割其他地方 ☐8. 跳海
☐3. 服食藥物 ☐9. 吸入煤氣/石油氣/炭
☐4. 服食非藥物 ☐10. 窒息
☐5. 跳樓 ☐11. 其他 _____
☐6. 吊頸 ☐ 0. 不適用

20. 第一次自殺的發生時間？(若今次是第一次自殺，請填號碼 8)
☐ 1. 1 – 7 日前 ☐ 5. 1 – 2 年前
☐ 2. 1 – 4 星期前 ☐ 6. 2 – 5 年前
☐ 3. 1 – 6 個月前 ☐ 7. 多於 5 年前
☐ 4. 6 – 12 個月前 ☐ 8. 今次是第一次自殺

21. 第一次自殺所用的方法？(若今次是第一次自殺，請填號碼 12)
☐1. 割腕 ☐7. 吞槍
☐2. 戮/割其他地方 ☐8. 跳海
☐3. 服食藥物 ☐9. 吸入煤氣/石油氣/炭
☐4. 服食非藥物 ☐10. 窒息
☐5. 跳樓 ☐11. 其他 _____
☐6. 吊頸 ☐ 12. 今次是第一次自殺

D. 痴呆症病歷

現在問及(死者姓名)生前的記性問題。

1. 記憶力(Memory)
a) (死者姓名) 生前是否記性有問題？(可選多于一項)

1. 忘記放置物件的位置	☐有	☐沒有	☐ 不適用
2. 忘記關掉煮食爐	☐有	☐沒有	☐ 不適用
3. 在熟識的地方迷失方向	☐有	☐沒有	☐ 不適用
4. 記不起他 / 她應該知道的事情	☐有	☐沒有	☐ 不適用

若有以上的情況發生
b) 可否給我一些例子？_____

c) 是否有顯著的退化或惡化？ ☐有 ☐沒有 ☐ 不適用
d) 有沒有影響他 / 她的社交生活及事？ ☐有 ☐沒有 ☐ 不適用
e) 這情況已維持多久？(以月計算)_____

2. 失語症(Aphasia)
a) (死者姓名)的語言能力有沒有問題？
1. 忘記熟人或地方名字 ☐有 ☐沒有 ☐ 不適用
2. 理解他人的說話有困難 ☐有 ☐沒有 ☐ 不適用
3. 表達自己有困難 ☐有 ☐沒有 ☐ 不適用
4. 書寫有困難 ☐有 ☐沒有 ☐ 不適用

若有以上的情況發生
b) 可否給我一些例子？ ☐有 ☐沒有 ☐ 不適用
c) 是否有顯著的退化或惡化？ ☐有 ☐沒有 ☐ 不適用
d) 有沒有影響他 / 她的社交生活及事？ ☐有 ☐沒有 ☐ 不適用
e) 這情況已維持多久？(以月計算)_____

3. 動作協調困難(Apraxia)
a) (死者姓名)是否有困難做一些慣性動作？(縱使他 / 她的身體協調、知覺、感應等一切正常)如鎖門、剃鬚、穿衣、煮食？ ☐有 ☐沒有 ☐ 不適用

若有以上的情況發生
b) 可否給我一些例子？_____
c) 是否有顯著的退化或惡化？ ☐有 ☐沒有 ☐ 不適用
d) 有沒有影響他 / 她的社交生活及事？ ☐有 ☐沒有 ☐ 不適用
e) 這情況已維持多久？(以月計算)_____

4. 覺識能力消失(Agnosia)
a) (死者姓名)是否有困難認得熟人或地方？(縱使他 / 她的感覺知覺正常。感覺知覺指視力、聽力等)
☐有 ☐沒有 ☐ 不適用

若有以上的情況發生
b) 可否給我一些例子？_____
c) 是否有顯著的退化或惡化？ ☐有 ☐沒有 ☐ 不適用
d) 有沒有影響他 / 她的社交生活及事？ ☐有 ☐沒有 ☐ 不適用
e) 這情況已維持多久？(以月計算)_____

5. 執行功能/其他(Executive function / Other)
a) (死者姓名)是否好像已喪失在其他方面的能力？
1. 難於適應新環境，遵從新指示？ ☐有 ☐沒有 ☐ 不適用
2. 容易被事件弄得頭昏腦脹？ ☐有 ☐沒有 ☐ 不適用
3. 對自身環境及事情的判斷有問題？ ☐有 ☐沒有 ☐ 不適用
4. 並不理解現實世界？ ☐有 ☐沒有 ☐ 不適用
5. 在社交場合表現失儀？ ☐有 ☐沒有 ☐ 不適用
6. 理財不善？ ☐有 ☐沒有 ☐ 不適用
7. 性格大變？ ☐有 ☐沒有 ☐ 不適用

若有以上的情況發生
b) 可否給我一些例子？_____
c) 是否有顯著的退化或惡化？ ☐有 ☐沒有 ☐ 不適用
d) 有沒有影響他 / 她的社交生活及事？ ☐有 ☐沒有 ☐ 不適用
e) 這情況已維持多久？(以月計算)_____

E. 健康情況

1. (死者姓名)去世前的健康情況？ ☐極好 ☐好 ☐普通 ☐差 ☐極差

2. 醫生有無話他/她有沒有以下的疾病？

	沒有 0	有 1
a. 高血壓	☐	☐
b. 心臟病	☐	☐
c. 中風	☐	☐
d. 金遜症	☐	☐
e. 糖尿病	☐	☐
f. 慢性支氣管炎／ 肺氣腫／哮喘	☐	☐
g. 慢性肺病	☐	☐
h. 慢性肝病	☐	☐
i. 腎病	☐	☐
j. 甲狀腺功能失調	☐	☐
k. 關節炎／痛	☐	☐
l. 癌症	☐	☐
m. 骨折／骨質疏鬆／老年人駝背等	☐	☐
n. 其他疾病_____	☐	☐

3. 咁他/她有無以下問題？

	沒有 0	有 1
a. 長期身體痛症	☐	☐
b. 失禁	☐	☐
c. 長期便秘	☐	☐

d. 連埋戴眼鏡，(死者姓名)睇野清唔清楚？
☐ 1.睇得很好 ☐ 2.睇得普通 ☐ 3.睇得唔係幾好 ☐ 4.幾乎／完全睇唔到

e. 連埋用耳聾機，(死者姓名)聽野清唔清楚？
☐ 1.聽得很好 ☐ 2.聽得普通 ☐ 3.聽得唔係幾好 ☐ 4.幾乎／完全聽唔到

F. 起居生活量表

III. (IADL)
以最近一星期內的生活情況為準，喺進行以下呢 D 活動方面，他／她有無困難呢？ 可否自己處理呢？

1. 使用電話
☐ 0.應用電話自如, 能查閱, 接聽, 及打出電話
☐ 1.只能記得並打出幾個熟知的電話號碼
☐ 2.只能接聽, 不能打出電話
☐ 3.不使用電話
☐ 9.不適用（沒有電話／不准使用電話）

2. 購物
☐ 0.自己購買一切所需用品
☐ 1.自己購買少許所需用品
☐ 2.需人協助購買用品
☐ 3.不能外出購買用品
☐ 9.不適用（本身可以但由其他人代勞）

3. 食物準備
☐ 0.自行購物, 準備, 烹煮食物
☐ 1.若有材料, 能自行烹煮食物
☐ 2.只能翻熱食品, 但經常飯餐不繼
☐ 3.需別人代為準備食物
☐ 9.不適用（本身可以但由其他人代勞）

4. 做家務
   - ☐ 0.自己做家務, 或間中需人幫助較粗勞工作
   - ☐ 1.只能處理輕便家務, 但清潔未符標準
   - ☐ 2.需別人幫助打理家務
   - ☐ 3.不參與任何家務
   - ☐ 9.不適用 (從不需要自己做，由家人或傭人負責)
5. 洗衫
   - ☐ 0.自己清洗個人衣物，不用幫忙
   - ☐ 1.清洗衣物次數不足, 亦不徹底
   - ☐ 2.只能清洗小量及較輕便衣物(例如襪)
   - ☐ 3.所有清洗需要別人幫忙
   - ☐ 9.不適用(自己可以做，但由其他人代勞)
6. 交通工具
   - ☐ 0.自己乘公共汽車, 或駕駛汽車
   - ☐ 1.自己叫計程車, 或別人陪伴下乘公共汽車
   - ☐ 2.需別人幫助叫車, 及陪伴上私家車
   - ☐ 3.不出外
   - ☐ 9.不適用(請註明: _____)
7. 食藥
   - ☐ 0.能準時及定量服藥, 並能在藥物用清前, 叫醫生加添
   - ☐ 1.能自行準時及定量服藥
   - ☐ 2.能服下別人準備及按時給予的藥
   - ☐ 3.不能自己服藥
   - ☐ 9.不適用（不用服藥或由住院護士給藥）
8. 處理金錢
   - ☐ 0.自己處理一切財務，並有長期預算
   - ☐ 1.只能處理目前的財務, 但沒有長期預算
   - ☐ 2.只能處理每日財務, 並需人協助處理銀行事務
   - ☐ 3.完全不能處理財政
   - ☐ 9.不適用（自己可以但由他人代勞）

IV. (PSMS)

跟住我會問一 D 生活上他／她照顧自己嘅情況，有 D 嘢或者都好簡單，不過都要問吓，請你唔好介意。

9. 如廁
   - ☐ 0.自己去廁所, 沒有失禁
   - ☐ 1.需人提醒上廁, 並每星期有一次失禁
   - ☐ 2.睡覺時, 每星期失禁多于一次
   - ☐ 3.清醒時, 每星期失禁多于一次
   - ☐ 4.完全失禁
   - ☐ 9.不適用(請註明: _____)
10. 進食
    - ☐ 0.自己進食, 不用幫忙
    - ☐ 1.需要別人少許幫忙
    - ☐ 2.需要別人中度幫忙
    - ☐ 3.完全依賴別人幫忙
    - ☐ 4.需要別人大量幫忙, 但本身又十分抗拒
    - ☐ 9.不適用 (請註明: _____)
11. 穿衣
    - ☐ 0.自己揀選衣服穿上
    - ☐ 1.需要別人少許幫助穿／寬衣
    - ☐ 2.需要別人中度幫助穿衣及揀選衣服
    - ☐ 3.需要別人大量幫助, 但本身願意合作
    - ☐ 4.完全需要別人幫助, 但本身不合作

☐ 9.不適用 (請註明: _____)

12. 梳洗
☐ 0.自己梳洗, 儀容整潔
☐ 1.自己梳洗, 大致保持儀容整潔
☐ 2.需要別人中度幫助梳洗
☐ 3.需要別人完全幫助梳洗, 但仍能保持儀容整潔
☐ 4.完全反抗別人協助梳洗, 不理儀容
☐ 9.不適用 (請註明: _____)

13. 洗澡
☐ 0.自己洗澡 (不用別人協助)
☐ 1.大致自己洗澡, 只需別人少許幫助
☐ 2.只能洗手及面, 不能清洗身體
☐ 3.不能自行洗澡, 但願意接受別人幫助
☐ 4.不能自行洗澡, 亦抗拒別人幫忙
☐ 9.不適用 (請註明: _____)

14. 活動能力
☐ 0.能到其他地方 (街上) 走動
☐ 1.只能在家內或附近走動
☐ 2.能在下列工具協助下走動 (請✓一項)
☐ a.人
☐ b.扶手
☐ c.枴杖
☐ d.步行架
☐ e.輪椅
☐ 3.能自己坐在輪椅或凳上, 但需人協助才可活動
☐ 4.一半時間躺床
☐ 9.不適用 (請註明: _____)

G. 醫療服務使用狀況

7. 他／她對上個次見醫生嘅幾耐之前呢？
☐ 1.少過一個月 ☐ 2.一個月至少過兩個月 ☐ 3. 兩個月至少過三個月
☐ 8.過往三個月沒有見醫生(跳問 Q.3)

8. 他／她過往三個月看了幾多次醫生？ _____

9. 過往一年，他／她有無入過醫院呢? (最少要在醫院留院一晚或以上)? 如有曾留院幾多次？ _____
(若答無填 0 及跳問題 Q.5)
a. 幾多次是身體問題？ _____
b. 幾多次是精神問題？ _____

10. 過往 3 個月，他／她有無在醫院留醫? (最少要在醫院留院一晚或以上)? 如有曾留醫幾多次？
_____(若答無填 0 及跳問題 Q.5)
a. 幾多次是身體問題？ _____
b. 幾多次是精神問題？ _____

11. 他／她有無精神或藥物濫用問題？ ☐ 1.有 ☐ 2.沒有(跳向 **Part G.**) ☐ 9.不知道
若有，是什麼問題或病 _____

12. 他／她有無因精神問題見精神科醫生或入院？
☐ 1.有 ☐ 2.沒有 ☐ 9.不知道

13. 請列出精神科醫生的姓名或診所名稱、地址及電話：

H. 社會網絡量度表

1. (死者姓名)通常一個月內會同幾多位唔同住嘅家人和親戚聯絡或者見面呢? (打電話都計)
☐ 0.沒有任何人 ☐ 1.一個 ☐ 2.二個 ☐ 3.三個至四個
☐ 4.五個至八個 ☐ 5.九個或以上

2. 最常同(死者姓名)聯絡的那位人或親戚, 請問多久與他聯絡一次?

☐ 0.少過一個月次　☐ 1.一個月一次　☐ 2.一個月數次
☐ 3.一個星期一次　☐ 4.一個星期數次　☐ 5.每一天

3. 有多少家人和親戚(死者姓名)覺得與他們親近? 親近即是指你覺得(死者姓名)可以同佢地傾(死者姓名)的心事或(死者姓名)向佢地尋求幫助?
☐ 0.沒有任何人　☐ 1.一個　☐ 2.二個
☐ 3.三個至四個　☐ 4.五個至八個　☐ 5.九個或以上

4. (死者姓名)有多少好朋友? 即是指你覺得(死者姓名)可以同佢地傾(死者姓名)的心事或(死者姓名)向佢地尋求幫助？
☐ 0.沒有任何人　☐ 1.一個　☐ 2.二個
☐ 3.三個至四個　☐ 4.五個至八個　☐ 5.九個或以上

5. 有多少好朋友最少一個月內見面或聯絡(死者姓名)一次?
☐ 0.沒有任何人　☐ 1.一個　☐ 2.二個
☐ 3.三個至四個　☐ 4.五個至八個　☐ 5.九個或以上

6. (死者姓名)與那一位跟他/她接觸最多的朋友見面或聯絡的次數大概是?
☐ 0.少過一個月次　☐ 1.一個月一次　☐ 2.一個月數次
☐ 3.一個星期一次　☐ 4.一個星期數次　☐ 5.每一天

7. 當(死者姓名)有重要的事情要決定, 有無人跟他/她商量?
☐ 0.沒有　☐ 1.很少　☐ 2.有時有
☐ 3.時常有　☐ 4.經常有　☐ 5.每次都有

8. 當認識(死者姓名)的人有重要的事情要決定時, 他們有無同(死者姓名)商量?
☐ 0.沒有　☐ 1.很少　☐ 2.有時有
☐ 3.時常有　☐ 4.經常有　☐ 5.每次都有

9. 有無人依賴(死者姓名)為他/她們做些事, 如買東西、煮飯、修理東西、清潔、看小孩?
☐ 0.沒有　☐ 1.很少　☐ 2.有時有
☐ 3.時常有　☐ 4.經常有　☐ 5.每次都有

I. 生活事件量表

過往三年(死者姓名)有沒有遇過以下的生活事件？　如果有，係幾耐之前嘅事呢？（請用以下編碼記錄）

編碼：			
0.沒有	1.≦1 星期之內	2. 2 至 12 個星期	3. 3 至 26 個星期
4. 27 至 52 個星期	5.多於 52 星期至 2 年	6. 2 年以上	9.不知道

		編碼
25.	子女搬開住	
26.	家庭加添成員(包括子女結婚、孫兒出世等)	
27.	與近親或好友分離(但不是去世)	
28.	居住情況有變(如遷家、移民等)	
29.	入住院舍	
30.	配偶過身	
31.	子女過身	
32.	好朋友過身	
33.	其他家人過身	
34.	(死者姓名)重病或重傷	
35.	家人重病	
36.	離婚或分居	
37.	婚姻或感情問題	
38.	配偶不忠	
39.	與家人不和 (唔開心的事)	
40.	與同事或朋友不和	
41.	退休	
42.	失業/被解僱	
43.	生意失敗	

44. 經濟出現嚴重問題 ☐
45. 打劫或 “爆格” ☐
46. 法律訴訟 (惹官非) ☐

47. 除以上事件，有無其他事對(死者姓名)心情好有影響，不論好壞？
☐ 1.有 ☐ 0. 沒有
若有，請說明是什麼及發生時間

_____

48. 你覺得以上的事件，邊 D 對(死者姓名)影響最深？

_____

I. 精神病及徵狀診斷

A. (死者姓名)去世前一個月，有沒有以下的精神病徵狀？

	有	沒有	不知道
心情抑悶	☐	☐	☐
缺乏生趣	☐	☐	☐
體重驟增或驟降	☐	☐	☐
失眠	☐	☐	☐
行動激速或遲緩	☐	☐	☐
經常疲憊不堪、沒有力氣	☐	☐	☐
感到自己沒有用及極度內疚	☐	☐	☐
很難集中精神、舉棋不定	☐	☐	☐
擁有厭世思想及嘗試自殺	☐	☐	☐

B. 精神病類別及病歷：

DSM-III-R diagnosis with SCID

Lifetime diagnosis _____

_____

_____

Current Axis I diagnosis 1 _____

_____

Axis I diagnosis2 _____

_____

---------(全巻完)----------