His involuntary movements, which appeared minimal during the evaluation, were exacerbated when the patient was observed indirectly. He had normal intelligence (IQ 74), had never used illegal substances, and denied any psychiatric or criminal family history.

The patient adequately modulated affect, and endorsed guilt and shame for the offense he had committed. The diagnoses of Tourette's disorder and OCD increased the manifestations of acts that were not necessarily subjugated to volition, making commission of the sexual offense more impulsive and disorganized (committed in the presence of others). This modus operandi is distinct from that of sexual aggressors, whose practices involve premeditation and dissimulation, absence of guilt, and high odds of recidivism. The judge accepted the expert's report, considered the patient not guilty by reason of insanity, and ordered regular outpatient treatment in the community. Identifying the clinical repercussions of Tourette's disorder, as well as understanding its forensic psychiatric implications, can improve referral and treatment and prevent double stigmatization.

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Prevention of suicide in older adults

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''People who don't cherish their elderly have forgotten whence they came and whither they go.'' (Ramsey Clark)

It is common for older adults to recall the point in their life when their thoughts naturally shifted from exclusive concerns about the future and what lies ahead to also contemplating the past and what was. This transformation does not take place in a day, but over the course of months and years. There is little published information to pinpoint when it occurs, but empirical data would suggest it happens in the seventh decade of life.[1] An individual commences the process of objectively and subjectively confronting the ''beginning of the end'' with mixed emotions, as they assess and take stock. What has one achieved or accomplished that is of significance? What opportunities remain in the decades ahead? How closely does one's real life match the life imagined decades ago? What goals are still left to attain? And, perhaps, the most daunting question of all: how will it all end?

In approaching older adulthood, one may assess their satisfaction with the past, and level of confidence – emotionally, physically, financially, and socially – in what the future entails. Unfortunately, for some older adults, this is an arduous process, and the satisfaction and confidence on which they are meant to draw is insufficient, or even nonexistent. They feel ill-equipped to confront what lies ahead, and faced with the perception of a tormented demise, some older adults take deliberate measures to bring their life to a premature end. Older adults (age 65 and up) comprise nearly 12% of the American population, but account for 18% of suicides, making suicide among the elderly one of the most uncontrolled public health issues in the United States.[2] Suicide rates are the highest in individuals aged 70 years or older among both men and women in almost all regions of the world.[3] These statistics alone are alarming enough to warrant attention by health care practitioners, but as dire as the problem may seem, its actual dimension is probably even worse. Published studies fail to account for the overlooked phenomenon of ''silent suicide,'' including death from intentional medication non-compliance, self-starvation or dehydration, or ''accidents'' that were not necessarily accidental.[4] Forensic pathologists and other investigators may be left with insufficient evidence to determine the intent of a deceased person. The stigma of suicide, the reputation of the deceased individual, and financial considerations such as life insurance payouts are among the reasons these deaths are misclassified. The elderly also have an inordinate rate of completed suicide by means of firearms, hanging, and drowning.[5] The incidence of double suicide, where spouses or partners choose to take their lives together, is also high among this demographic group.

As older adults are unlikely to seek treatment for mental health issues, the first line in defending against suicidality among the elderly is family, friends, and primary care providers.[5] They must be concerned when older adults make statements conveying hopelessness or worthlessness. They must draw suspicion when learning

that an elderly person is losing interest in things or activities they once found enjoyable, cutting back on social interaction, self-care, and grooming, ignoring their medication regimen, stockpiling medication, skipping meals, giving their possessions away, giving money away without regard to their personal financial needs, showing lack of concern for personal safety, becoming preoccupied with death, or making fatalistic remarks like "You would be better off if I wasn't here," or "This is the last time…". There must be added concern if an older adult loses a spouse, partner, or significant other. Family and friends should alert health care providers if any of these characteristics of suicidal ideation come to light.

Health care providers should make greater use of screening tools, such as the Patient Health Questionnaire (PHQ-9) and other instruments. Knowing the population of older adults in many countries will steadily increase in absolute and relative numbers in the decades to come, it may be an appropriate time to devise a rating scale specific to this demographic group that takes predisposing, precipitating, and protective factors into account to assess for depression and the potential for suicide. It may be appropriate for primary care providers to administer rating scales for patients over age 65 during all office visits, regardless of the reason for consultation.

The moral obligation to ensure optimal health, comfort, and security for older adults is a value shared by most of humanity. To that end, it reflects poorly on Western societies that so many older adults are ill-equipped to confront the latter years of their life, and resort to suicide. Ageist views need to be counteracted as a major obstacle to suicide prevention. It is imperative that we improve.

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