**Talking Points and data briefing on older adult suicide**

**Take-home points:**

* More attention needs to be placed on suicide prevention among older adults, particularly older men.
* Health care provides good opportunities to identify and intervene with older patients who are potentially suicidal.
* Older adult services and programs can integrate suicide prevention into their ongoing activities.

**Why focus on this population?**

For many years, most of the suicide prevention emphasis has been on youth and young adults. However, the data tells us that middle-aged and older adults die by suicide at higher rates and in larger numbers than youth.Prevention efforts may have been effective among youth; now we need to turn our attention to working-aged and older adults. As the population ages, suicide may continue to increase unless intervention and prevention programs are implemented.

In addition, the End of Life Option Act, which became effective in June 2016, has raised many questions about suicide. These questions provide opportunities to discuss suicide in an open manner and to assist people in getting help for underlying depression, pain, and other problems. Note that this Act applies only to individuals who are terminally ill and allows them to request aid in dying in certain, clearly defined, situations. For more information on this legislation, see <http://coalitionccc.org/tools-resources/end-of-life-option-act/>

**What do we mean by “older”?**

Different agencies use varying definitions for this population. Some regard it as 65+ (the traditional retirement age and older); the California Area Agencies on Aging use 60 and older.

**Older adult suicide risk**

For many years, the highest rates (although not numbers) increased with age across the lifespan so that people in their 80s had higher rates of suicide death than those in their 70s, which were higher than in their 60s, and so on. However, in the past decade, the rate and number of suicides among adults aged 35-64 – increased by almost one third (28%) from 1999 to 2010. The greatest increases were observed among American Indian/Alaska Natives and whites. Within age groups, the largest increases were among people in their 50s. Among over 65, there was a slight decline in the same period. [[1]](#footnote-1)

Some risk factors increase with age, including social isolation as older people lose family members and friends to death and as their mobility becomes more limited; pain and health problems; substance abuse; fear of prolonged illness; and disabilities. Medical fragility means that a suicide attempt is more likely to be lethal or to have more drastic health consequences for the individual.

Symptoms of depression can often be mistaken for “normal” signs of aging in an older population by providers and by patients themselves and their families. Depression also manifests differently in older adults, showing up not as dysphoria (sadness) but as loss of appetite, changes in sleep, and disinterest in activities once enjoyed. Other health issues such as incontinence may lead to increased social isolation.

Older adults also may have access to lethal means, including firearms and medications. And they tend to plan their deaths in advance, rather than act impulsively.

**Older adult suicide prevention**

Many older adults see their primary care providers on a more frequent basis than when they were younger. They may also have improved insurance coverage as they become eligible at age 65 for Medicare, which offers full parity for outpatient mental health treatment. Frequent health care contact provides more opportunity for screening, assessment and treatment. The US Preventive Services Task Force has recommended screening for depression in the general adult population.[[2]](#footnote-2) Health care can also address other underlying issues that may increase an older person’s risk.

Home visiting programs, day programs, and warm lines such as the Friendship Line [415-752-3778; 800-971.0016] all provide opportunities to “check in” on older adults, assess their state of mind, and offer early intervention.

Every county has services and programs designed to serve older adults already in place, but service providers may need additional training or support to include suicide risk and prevention.

Among adults who are in the workforce, prevention efforts through employers may be effective, including educating co-workers and managers about signs of mental illness and suicide[[3]](#footnote-3), offering Employee Assistance Programs (EAPs), and handling layoffs and terminations carefully.

Family members can learn to pay attention to the signs of depression since they often manifest as observable behavior changes. And health providers can be trained to assess for depression more often in older adults. Many older adults participate in their faith communities, which can also offer support, outreach, and comfort.

**Data**

National data for 2014 indicates that California ranks 21st among the states for suicide rates (17.7/100,000) among ages 65+. This compares to a rate of 7.6/100,000 and a ranking of 47th for suicide among youth ages 15-24.[[4]](#footnote-4)

Although people ages 65+ were 13.75% of the US population in 2012, they accounted for 16.37% of all suicides. [[5]](#footnote-5)

83.6% of all suicides among people aged 65+ were male, with white men at the highest risk (32.24/100,000). Firearms were the most common means (72.1%) used to complete suicides.

Older adults use telephones more frequently than do young adults, including calling warm lines and crisis lines. In 2013, a consortium of California crisis centers showed that 23% of calls were from adults aged 55-64, with another 6% from adults aged 65 and older. [[6]](#footnote-6) The Friendship Line has contact with approximately 8,000 older adults each month.

1. Centers for Disease Control. “Suicide among adults aged 35-64 years—United States, 1999-2010.” MMWR, May 3, 2013 [↑](#footnote-ref-1)
2. Siu AL and the US Preventive Services Task Force. Screening for Depression in Adults: US Preventive Services Task Force Recommendation Statement. JAMA, January 26, 2016 [↑](#footnote-ref-2)
3. For instance, MHA California’s Wellness Works program <http://www.wellnessworksmentalhealth.org/> and the Carson J Spencer Foundation’s Working Minds program. [↑](#footnote-ref-3)
4. [www.suicidology.org/resources/facts-statistics](http://www.suicidology.org/resources/facts-statistics) [↑](#footnote-ref-4)
5. American Association of Suicidology fact sheet. Suicide in the Elderly (2012). [↑](#footnote-ref-5)
6. Common Metrics report, July 2013 [↑](#footnote-ref-6)