

The Challenge of Suicide in Older Adults

Introduction

Older adults experience a high rate of suicide. **According to data from the Centers for Disease Control and Prevention’s Web-based Inquiry Statistics and Query Reporting System, in 2014, 7,693 adults aged 65 and older died from suicide; the age-adjusted rate of suicide per 100,000 was 16.73 for this age group. In comparison, the rate of suicide for all ages was 12.93. In that same year, adults aged 85 and older experienced the highest suicide rate of any age group.** The rate of suicide for adults aged 85 and older was 19.34. It is particularly significant to note that white males aged 85 and older, specifically, experienced a suicide rate of 54.39.

Older adults compose a growing proportion of the population. The Institute of Medicine (2012) details that the projected number of adults aged 65 and older will increase from 40.3 million to 72.1 million between 2010 and 2030, based on U.S. Census Bureau data. **Suicide in older adults is thus an important public health issue and the prevention of suicide in the elderly should become a major public policy concern.**

A Wide Range of Contributing Factors

Depression, one of the main contributors to suicide and strongest risk factors for late-life suicide, is prevalent in older adults. According to the Institute of Medicine (2012), approximately 14 to 20% of the older adult population experiences mental health and substance use conditions, and depressive disorders and dementia-related behavioral and psychiatric symptoms are the most prevalent of these conditions. **Frequently, however, depression in older adults is not diagnosed and/or is untreated.**

Older adults often display symptoms of depression that are different from those presented by individuals in other age groups. Some of these symptoms may also be mistaken for normal signs of aging, thus complicating the diagnostic process. Furthermore, generational biases toward mental illness may impede older adults from seeking help, especially in traditional mental health settings. Primary care physicians end up bearing the brunt of the responsibility for detecting and treating depression in this demographic, and yet these physicians are often untrained and/or unprepared to do so.

Research indicates that over 70% of older adults have visited their primary care physician within the month of their suicide and a third within the week of their suicide; most of these individuals had not sought mental health services.

Older adults experience a higher suicide completion rate compared to other age groups. Frailty and method of attempt might contribute to this occurrence. **According to the American Association of Suicidology (2014), firearms are the most common means used (72.1%) for completing suicide among older adults.**

In addition to mental illness, particularly depression, and access to lethal means (e.g., firearm possession), other risk factors for elder suicide include:

- Suicidal ideation; suicidal behavior; prior suicide attempts;
- Feelings of hopelessness;
- Physical illness;
- Pain;
- Functional impairment (e.g., loss of vision, hearing, and/or mobility);
- Cognitive impairment, which can impact impulsivity;
- Lack of social support; social isolation;
- Personal stressors (e.g., loss of a loved one, divorce, retirement,

financial difficulty, and loss of a driver's license); and

- Substance misuse or abuse

Because of the complex and overlapping nature of many of the aforementioned contributing factors to elder suicide, it is often a combination of these conditions that leads to suicide in older adults.

Interventions for the Prevention of Elder Suicide

Fortunately, suicide in older adults is preventable. Early detection of risk factors is key; thus, education on such factors for the public in general and primary care physicians and family members, specifically, is critical. Warning signs include:

- Mental health problems and depressive symptoms;
- Diagnosis of medical conditions that limit functioning and/or life expectancy;
- Lack of interest in enjoyable activities or future plans;
- Feelings of loss of independence and/or sense of purpose;
- Daring or risk-taking behaviors;
- Sudden personality changes;
- Verbal threats; and
- Giving away of prized possessions

Relatedly, depression and suicidal ideation screenings, especially in primary care

settings, are necessary. However, screening alone does not inevitably lead to improved geriatric mental health outcomes. Health care providers must be trained on how to provide the best possible mental health treatment, referrals, and follow-up care once depressive symptoms and/or suicidal behaviors/risks are detected. Geriatric depression is readily treatable. It is important to consider that research shows that older adults have a preference for psychotherapy over medication. **Effectively treating geriatric mental illness, specifically depression, can significantly reduce the risk of suicide in this age group.**

Enhancing protective factors, such as improving independent functioning and access to social support, can also help to prevent suicide in older adults. Treating pain, sleeping problems, and/or other physical ailments that can decrease quality of life is similarly beneficial. **Essentially, mitigating or eliminating the contributing factors to elder suicide is perhaps the most important intervention to immediately minimize the occurrence of suicide in older adults.**

Since older adults often experience different life stressors/circumstances and present different symptoms of mental illness when compared to other age groups, **it is imperative to provide age-appropriate**

suicide prevention services and mental health programs. For example, older adults tend to not reach out to traditional suicide prevention centers/hotlines. In order to innovatively target at-risk older adults, Dr. Patrick Arbore developed the Institute on Aging's Center for Elderly Suicide Prevention's [Friendship Line](#) in 1973. *"The Friendship Line is both a crisis intervention center and a "warm" line for routine, even daily, phone calls that provide emotional support, medication reminders and well-being check-ins. The line has never gone unanswered since 1973 and in 2012, Institute on Aging's staff and volunteers made 36,000 outgoing calls."* Another example of a suicide prevention service that is tailored to older adults is a primary care-based intervention, developed in Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT). The PROSPECT intervention involves case management in the primary care setting to help physicians successfully treat and manage, in a long-term capacity, late-life depression. [Analysis of PROSPECT](#) has supported that *"an intervention consisting of guideline treatment managed by a master's-level clinician is both feasible and effective in significantly reducing suicidal ideation in geriatric patients suffering depression in primary care. The intervention was also effective in reducing depressive symptoms in patients with major depression and, when*

suicidal ideation was present, minor depression. Together, these findings indicate that efforts to improve the quality of depression treatment for geriatric primary care patients can focus on patients with suicidal ideation or major depression with the expectation that appropriate management will reduce depressive symptoms, suicidal ideation, and the risk of suicide in late life.”

A Growing Urgency

It is expected that as the number of older adults continues to increase, so too will the number of older adults experiencing mental health issues. The Institute of Medicine (2012) predicts that by 2030, the number of older adults with mental health and substance use conditions will increase by 80%. **Rising numbers of older adults and older adults with mental illness will likely result in a surge in elder suicide, especially if access to care remains stagnant.**

The current health care system is not adequately meeting the needs of many older adults. Policymakers and/or advocates should work to improve the detection and treatment of geriatric mental health problems, with relevance to elder suicide, through: increasing education for the general public and health care providers regarding elder suicide risk factors and warning signs; requiring appropriate

provider guidelines for pertinent training, detection, and management concerning suicide in older adults; funding and creating more, age-specific geriatric mental health services and elder suicide prevention interventions; encouraging depression and suicide screenings in clinical as well as non-clinical settings (e.g., senior day care facilities, senior companion centers, etc.); supporting proper reimbursement regulations for mental health providers; and disseminating significant information on health insurance and assistance with getting access to necessary geriatric services.

Furthermore, as a society, we should work to reduce the current, prevalent ageist mentality. Ageism contributes to feelings of loneliness, hopelessness, and isolation among older adults. **Encouraging positive sentiments toward aging and older adults should allow for more opportunities for connectedness, greater well-being, and supportive policies.**

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