We in the field of suicide prevention have worked hard to educate health care providers, policymakers, and the public about the increasing suicide rate in the United States and the need for resources and research to address this tragic situation. But what is less widely known is the disparity in the suicide rate by age. The age-adjusted suicide rate in the United States in 2014 was 12.93/100,000. That same year, the suicide rate among people 85 years of age and older was 19.34/100,000. The suicide rate among white men 85 and older was a staggering 54.39/100,000 (Centers for Disease Control and Prevention, 2014).

Although younger people attempt suicide at higher rates than older adults, older adults are more likely to die by suicide than younger people. Suicide attempts by younger people—especially adolescents—tend to be impulsive. Older adults often plan their deaths more carefully. They typically use methods that are more lethal, such as firearms. Younger people often choose methods that are less lethal or provide more time for discovery and medical treatment, such as poison. Elderly people are also more physically vulnerable. They may be unable to withstand the bodily insult that a younger adult may survive. Older people, many of whom are retired and live alone, are also less likely to be discovered and treated after an attempt than younger people, who may be living with their family or whose absence at work may cause more immediate concern.

We also know that older adults do not utilize mental health services at levels appropriate for their needs. About 70 percent of adults aged 55 and older with mood and anxiety disorders do not use mental health services (Byers, Arean, & Yaffe, 2012). We have made progress by integrating mental health services and collaborative care models into primary care. But we need to move beyond primary care to serve our most vulnerable older adults. I am fortunate to be involved with several projects that provide models for such care.

PROTECT, a collaboration between the Weill Cornell Medical Center and the New York City Department for the Aging, trained staff from the Elderly Crime Victims Resource Center to implement depression screening. They identified a very high rate of depression (34 percent) and suicidal ideation (16 percent) among their clients (Sirey et al., 2015). To address this need, we embedded a mental health care practitioner into elder abuse services, who offered brief psychotherapy in addition to acute crisis elder abuse services. Victims of abuse who received the combined services had reduced depression, reduced incidents of abuse, and greater empowerment. This demonstrated a practical method of providing mental health services to older adults whose life experiences render them especially vulnerable to suicide risk.

Another particularly vulnerable population are people in their mid- to upper-80s who live alone in a community setting, such as a private home or apartment. These older adults are often living with multiple medical conditions, disabilities that require nutritional support, chronic pain, and social isolation. Research showed that more than 12 percent of older adults participating in the Westchester County, New York home meal delivery program had clinically significant depression and more than 13 percent screened positive for suicidal ideation (Sirey et al., 2008). To respond to this need, we developed the Open Door intervention, which encouraged at-risk older adults to access mental health care by educating them about depression and treatment options, helping them identify and address barriers to accessing mental health care, and following up on referrals with both face-to-face and telephone contacts. When the Open Door intervention was implemented with those at-risk older adults, 91 percent initiated mental health services. These findings support the usefulness of interventions that improve engagement in mental health for vulnerable older adults (Sirey, 2015).
To prevent suicide among older adults, we need to develop, implement, and evaluate interventions that tackle the converging risk factors at work in this population, including social isolation, diminished functioning, chronic illness, physical disability, and untreated depression. We also need to learn to identify and help older adults in collaboration with the service providers that reach them wherever they are—in their homes and apartments, in senior residential communities, and through senior centers, agencies, and organizations that serve older adults.

References


Sirey, J. A. (2015, October). Reducing depression and suicide risk in vulnerable older adults by improving links to mental health treatment. In M. Bruce (Chair), *Suicide Risk, Prevention, and Response in Vulnerable Older Adults*. Symposium conducted at the IASR/AFSP International Summit on Suicide Research, New York, NY.


For more information, we recommend *Reaching Older Adults* [2], a SPARK Talk by Jo Anne Sirey.

Links within this resource

