Focus on Older Adults

Comprising 13 percent of the U.S. population, individuals age 65 and older accounted for nearly 18 percent of all suicide deaths in 2002. Within this older adult group, Caucasian men ages 85 and older have the highest rates of suicide (more than five times the national U.S. rate of 51.1 per 100,000).[1] In California, adults over the age of 85 have the highest suicide rate of all age groups in the state, at a rate of 22.5 per 100,000.[2] This fact becomes more concerning as older adults are becoming a larger proportion of the state's growing population, particularly as the baby boomers approach age 65. In 2000, the population of Californians over the age of 65 was over 3.6 million; in 2010 it is projected to be over 4.4 million; and in 2020, it may exceed 6.3 million. Today, approximately 18.4% of the San Diego population is aged 55 or older.[3]

What does available San Diego data tell us about older adults?

Suicide is the second leading cause of non-natural death for older adults ages 65 and up (preceded only by falls).[4] The suicide rate among older adults has been generally higher in San Diego County than in either the state of California or the United States overall since 1979.[5] From 1998 to 2007, there were a total of 656 suicides (a mean rate of 20.3 suicides per 100,000 people) among older adults ages 65 and up.[6] Gender was a major factor in suicide among older adults: the male suicide rate was more than three times higher (a rate of 37.8) than the rate among females (a rate of 7.2) in San Diego County, and increased dramatically in older age groups (rate of 38.5 for adults over 85).[7] The suicide rate among older adults was highest in the North Coastal region, the lowest rate was in the South region. [8] Firearms were by far the leading method of competed suicide among older adult men, accounting for 72%. Among older women, however, only 31% were attributed to firearms, with 39% due to drugs/poisons. [9]

The role of mind altering substances among older adults who completed suicide is evidenced in the high rate of positive

Older Adults Quick Facts:

- Approximately 18.4% of the San Diego population identified as older adult.
- Suicide rate: 20.3 per 100,000 people.
- Suicide rates were highest in the North Coastal region and lowest in South region.
- Older adult males are more likely to commit suicide than females.

[1] Office of Minority Health. *Suicide and Suicide Prevention 101 (2008).* Web. 11 Dec. 2010. <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=136>.

[2] California Department of Mental Health. *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. Web. 30 Sept. 2010. http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf

[3] U.S. Census Bureau, Census 2010. Web 20 Dec. 2010. <http://factfinder.census.gov/servlet/DatasetMainPageServlet>.

[4] Community Health Improvement Partners. *Suicide in San Diego County: 1998-2007*. Web. 1 Dec. 2010. <http://www.sdchip.org/media/53352/suicidedatareport_1998-2007.pdf>

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Ibid.

toxicology results for alcohol and/or drugs of abuse among suicide victims (37.7% of male and 58.1% of female suicide victims age 65 and older).[10]

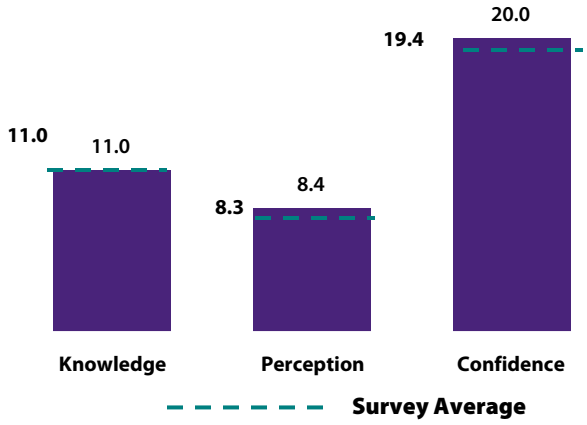
Among older adults (65 and up), those who were divorced, widowed, or single had a higher risk of suicide than those who were married.[11] Older adults reported a higher suicide rate than youth, and lower self harm rates, suggesting that older adults were more likely to complete a suicide attempt than their younger counterparts. In 2008, 78 older adults ages 65+ (a rate of 21.9 adults per 100,000 population for all patients) were hospitalized with a self-inflicted injury and 54 adults ages 65+ (a rate of 15.2 adults per 100,000 population for all patients) were discharged from the emergency room with a self-inflicted injury.[12, 13]

What do stakeholders know and say about older adults?

Community service providers who serve older adults were asked key questions regarding their knowledge of risk factors, perceptions of suicide, and confidence in their ability to address suicide. On average, these providers exhibited scores similar to the general service provider population for knowledge of risk factors and perceptions regarding suicide scores; but above the average in their confidence to address suicide for their target population score (see Exhibit 3.3).

Service provider stakeholders interviewed for this project noted that older adults are at a very high risk for suicide and perceive the risk is higher for low-income individuals who lack access to care.[14] Stakeholders and focus group participants alike noted that a major contributor to suicidal thoughts among the older population is isolation: "Many seniors are depressed because they're left alone in their houses. They don't get to go out and socialize with others." (API focus group participant). Service providers noted that Medicare and MediCal continues to reduce reimbursement rates for mental health professionals. Consequently, fewer providers are available. The lack of providers who assist seniors without Medicare also creates a bottleneck in the system of care. One provider noted that some of her clients with private insurance had difficulty finding referrals through 211.

Exhibit 3.3:
Older Adult Service Providers Knowledge, Perception & Confidence Services



[10] Ibid.

[11] Ibid.

[12] County of San Diego, HHSA, Public Health Services, Community Health Statistics Unit. *San Diego County Profile by Region.* Web. 29 Nov. 2010. < http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/CHS-CommunityProfile_County_2010.pdf>.

[13] Ibid.

[14] According to the California Strategic Plan on Suicide Prevention, lack of availability of quality mental heath care can contribute to higher suicide rates. In addition, depression rates are higher among isolated older adults, such as those receiving in-home care of living in institutions. There is limited data as to whether income plays a role in suicide risk.

Stakeholders also noted that primary medical care providers are an excellent entry point because of the chronic medical conditions of the older adult population that places them in regular contact with providers. However, one stakeholder observed that the physical health providers are more taxed in their work and less likely to ask about mental health problems. As a result, these providers may be disinclined to ask about suicide and mental health issues because an affirmative response takes more time than they have. Other providers who could be trained as early identifiers for suicide risk among older adults includes Meals on Wheels, senior centers, nutrition sites, and the faith community.

"Several times a week, I consult with a senior who has had serious intent or has attempted suicide"
- Senior center clinician

What does the target population say about themselves?

Generally, the older adults who participated in the focus group were not familiar with prevention services for seniors who were depressed or suicidal. They noted that seniors who are living alone may not notice their increasing depression, and unless they are visited by a friend or participating in regular activities, the identification of their depression often does not happen. This is particularly true for seniors who lose their spouses. Participants noted that the loss of a spouse may cause a deep depression and older adults may not know that they can ask for help. One participant knew that he was getting depressed and turned to the VA. "I was feeling so bad that one day I had to pull off the road because I was crying so hard." The doctor at the VA recommended the bereavement group. "In the group, I could talk about my feelings; everyone did. The Chaplain and social workers were there to help us." This group helped him move past his depression and to even get a job. As he said, "this probably saved my life. Working kept me busy and from feeling isolated."

Most focus group participants said that they did not know where to turn for information services and were not familiar with the Access and Crisis line. While several were aware of 211, they did not view this as a viable resource for people who were in crisis. They wanted a number that would offer immediate suicide counseling and prevention. The participants, who were recruited through a senior center, said that they relied on the senior center for support and information. When seniors did know of a service, they noted that limited financial resources would prohibit them from accessing it unless Medicare covers the cost.

Finally, medication management was an issue. Assistance with taking medication regularly was noted as important for those who are depressed. Some people may have trouble remembering to take their medication, particularly those who take more medication as they age. Senior housing or treatment facilities can assist with this issue.

In the end, one of the most important activities that could be done for the older adult population is to show caring and kindness through calling and visiting programs. One man shared a story about a friend who had been delivering food and support to other people and then he completed suicide. "He was supporting other people, but no one was supporting him. No one noticed that he was in need." He and others repeated that the best intervention is to "Call people and let them know that you will listen. It is a little thing that can make a big difference." Knowing that someone cares was a repeated theme for effective suicide prevention for seniors. For that reason, seniors were more likely than other groups interviewed for this assessment to recommend volunteer prevention intervention models which could create networks of people to provide support to seniors who were alone and/or in poor health.

What barriers were identified by stakeholders and focus group participants?

The major barriers reported by seniors include:

- Not recognizing the signs of depression in themselves (and others).

- Lack of knowledge about available services.
- Lack of finances to pay for mental health services.
- Changes in MediCal and Medicaid reimbursements for mental health services.
- Transportation/proximity of services.

What opportunities for improvement were identified by stakeholders and focus group participants?

Opportunities for successfully engaging the older adults in suicide prevention included:

- Greater education and outreach to provide seniors, particularly isolated seniors and those living alone, with information and referral.
- Encourage seniors to be involved in senior centers, church, and other groups so they are not isolated and depressed.
- Support groups in convenient locations so seniors can meet regularly. These should be facilitated by experts who can handle emotional issues that may arise.
- Restart the County's training program on suicide prevention for providers and include 211 responders. Stakeholders recommended including key providers that interact with the older adult population, such as Meals-on-Wheels drivers on the signs of depression and give them materials to distribute. The Union of Pan Asian Communities PEI funded Positive Solution Program partners with resources like Meals on Wheels to reach isolated seniors.
- Identify people who need a home visitor.
- Train service providers in how to better work with the older adult populations. Maximize the "geriatric mental health certificate" program, which trains professionals in aging who need mental health training and mental health providers in aging issues.

"I am amazed at how many health care providers think that depression is a normal part of aging so they don't do anything about it… ignore depression in older adults because they think "of course she wants to die, she's old and sick" so help is not accessed"

-Senior health provider