

AN EPIDEMIOLOGY PUBLICATION OF THE OREGON DEPARTMENT OF HUMAN SERVICES

ELDER SUICIDE IN OREGON

IT MAY NOT be a big surprise to regular readers of these pages to hear that suicide is a leading cause of death in Oregon; to be precise—as we epidemiologists strive to be—even when it comes to macabre subjects, suicide was the ninth leading cause of death in Oregon for 2002. However, you might not know that the age group with the highest suicide rates (by far) is the elderly—elderly men, in particular. This issue of the *CD Summary* reviews what is known about suicide in the elderly in Oregon, including associated circumstances, risk factors and prevention approaches.

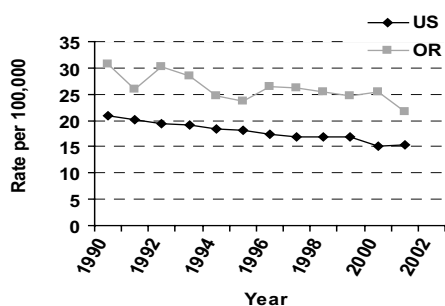
ELDERLY SUICIDE IN OREGON AND THE US

Between 1999 and 2002 there were an average of 106 suicide deaths per year among Oregonians ≤ 65 years of age, for an average annual rate of 24 per 100,000. This rate ranks 6th in the nation and is 56% higher than the national rate of 15.4 per 100,000. Oregon's elder suicide rate has been higher than the national rate for more than a decade. Death rates in the elderly due to suicide both nationally and in Oregon have declined slowly since 1990 (figure).

AGE, SEX AND RACE

Suicide rates increase dramatically after the age of 64. For example, in 2003, the suicide rate was 38 per 100,000 among males aged 65–74 and increased to 109 per 100,000 by age 85.

Suicide Rates Among Individuals Aged ≥ 65 , US vs. Oregon, 1990–2002



Source: CDC WISQARS

Earlier in life males have suicide rates three and four times higher than females, but elder males have rates ten times those of elder females. Ninety-nine percent of those deaths occur among whites.

MECHANISMS OF DEATH

In 2003, firearms were the lethal means to 80% of suicide deaths among elderly Oregonians. Other mechanisms included suffocation, poisoning, and multiple mechanisms.

CIRCUMSTANTIAL INFORMATION

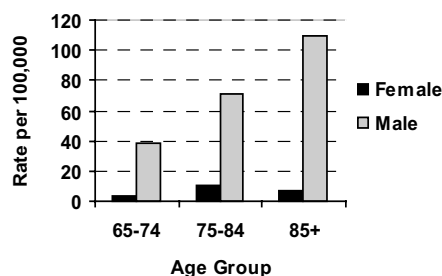
In 2003, 50% of males and 61% of females who died by suicide were reported in medical examiner records to have been currently suffering from depressed mood. Twenty percent of males and 54% of females were reported to have been in treatment at the time for depression.

Seventy-six percent of males and 72% of females were reported to have some physical health problem:

- 58% had declining health;
- 37% had a loss of autonomy or independence;
- 35% had visited a physician in the last 30 days; and
- 25% suffered from chronic pain.

Social isolation and failed or lack of marital or co-habiting partnerships are thought to be important risk factors. The table (*verso*) illustrates the marital status of male and female elders who died by suicide in 2003.

Suicide Rates by Age Group and Sex Oregon, 2003 (n=122)



Source: Oregon Violent Death Reporting System

Acute crises are not thought to be the underlying cause of many suicides in the elderly, but they are thought to be precipitating events. When they occur among those at risk for suicide, they can alert clinicians, family and friends of the need to take immediate action to prevent a suicide. Fifty-three percent of males and 18% of females who died by suicide had experienced a precipitating crisis, such as the loss of a spouse or friend who was the last of a dwindling peer group, or financial crisis related to costs of medical care or ability to maintain independent living, the diagnosis of a new serious illness, a move to new living situation, or a need to transition to supervised care in the last two weeks prior to their death.

Although deaths of friends and spouses may be common late in life, the recent death of a spouse occurred only among 5% of older males and 12% of older females who committed suicide in 2003. Death of a family member or a friend similarly occurred in only a minority of cases—in 9% of older males and 12% of older females who committed suicide.

Alcohol or other substance abuse plays a large role in suicides among younger people. In the elderly, however, it is found to be a factor in far fewer cases than might be expected. Although alcohol use and dependence are probably under-reported, alcohol intoxication was suspected at the death scene in only 11% of cases, and only 8% tested positive for blood alcohol. Alcohol dependence was reported in only 3% of suicides. There were no reports of other substance abuse among elderly Oregonians who died by suicide in 2003.

CONCLUSION

Multiple losses, declining health and social isolation may come with age, and for many, financial problems are an additional new stressor. And age-associated mortality reduces protective social networks. As the baby boom generation ages, the elderly will make up an increas-



If you need this material in an alternate format, call us at 503/731-4024.

If you would prefer to have your *CD Summary* delivered by e-mail, zap your request to cd.summary@state.or.us. Please include your full name and mailing address (not just your e-mail address), so that we can effectively purge you from our print mailing list, thus saving trees, taxpayer dollars, postal worker injuries, etc.

Suicide Rates by Marital Status Oregon, 2003

Marital status	Males	Females
Married	55%	35%
Divorced	13.8%	23.5%
Widowed	22%	41%
Single, never married	7.4%	0%
Living alone, isolated	26%	41%

ing proportion of Oregon's population, the number of patients at risk for suicide will rise commensurately.

Active screening for depression in the elderly can be an important factor in reducing suicides. Because many elderly people have health problems requiring primary care, visits to primary care providers are a logical time to screen for suicide risk. Unfortunately, there is a tendency by many to overlook depression as merely a natural reaction to declining health and diminishing independence. Although not all elderly patients who are depressed experience suicidal thoughts, it is important to screen patients for depression and possible suicidal thoughts or past self-harming behavior. An affirmative screen should be taken seriously, and lead to a thorough evaluation. Follow-up to an affirmative screen includes exploring the patient's access to firearms, harmful medications and other means of suicide.

Healthcare providers are encouraged to assess their skills and increase their confidence in assessment and treatment of depression and suicidality. The article referenced below provides some templates for questions and an approach to this issue. Careful assessment and prompt response can alleviate depression and save lives.

REFERENCES

1. Oregon Vital Statistics, Oregon Violent Death Reporting System, Centers for Disease Control and Prevention WISQUARS.
2. Hamilton, NG. Suicide prevention in primary care; careful questioning, prompt treatment can save lives. *Postgrad Med* 2000; 108: 81-7.

Flu Update

IN THE WAKE of the influenza vaccine shortage this season, professional groups have met to better define priority groups for receipt of sparse vaccine supplies.

The February meeting of the CDC's Advisory Committee on Immunization Practices (ACIP) featured two major thrusts—instituting several changes to the general recommendations regarding the use of influenza vaccine and a tiered approach to priorities for vaccine recipients in the event of future shortages. The final recommendations will be included in recommendations to be published in late April 2005.

The first group of possible changes includes: addition of conditions compromising respiratory function into the list of high risk conditions; language more strongly emphasizing the use of the live, attenuated influenza vaccine (FluMist®) for healthy people aged 5-49; and clarification that ranking of vaccine priority

groups applies only to the inactivated vaccine; language noting evidence that vaccination of healthcare personnel prevents deaths among nursing home patients and, consequently, stronger emphasis on vaccination of healthcare workers.

The proposal, as presented, is as follows:

Group 1A: ≥65 years of age with co-morbid conditions; long-term-care facility residents.

Group 1B: 2-64 years of age with co-morbid conditions; ≥65 years of age without co-morbid conditions; 6-23 months of age; pregnant women.

Group 1C: Healthcare personnel; close contacts of children ≤6 months of age.

Group 2: Contacts of high-risk children and adults; healthy persons aged 50-64 years.

Group 3: Ages 2-49 years without high-risk conditions.

The finalized recommendations will be explicated in upcoming issues of the *CD Summary*.

The FDA advisory committee also met this month and recommended that the influenza vaccine for the 2005-2006 season contain antigenic components of: A/New Caledonia/20/99 (H1N1)-like virus; A/California/7/2004 (H3N2)-like virus; and B/Shanghai/361/2002-like virus. The only change over this year's vaccine is the substitution of immunologic antigens of an A/California/7/2004 (H3N2)-like virus for that of A/Fujian/411/2002 (H3N2)-like.