Oregon Older Adult Suicide *Prevention Plan*

A Call to Action

For more information or to receive this plan in an alternate format, please contact:

Oregon Department of Human Services
Office of Disease Prevention and Epidemiology
Injury and Violence Prevention Program
800 NE Oregon Street, Suite 772
Portland, Oregon 97232

For more information contact: Lisa Millet, IVPP Manager
971-673-1111 or Lisa.M.Millet@state.or.us

Website: http://oregon.gov/DHS/ph/ipe/esp/index.shtml

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Compiled and Written by the Injury and Violence Prevention Program (IVPP)
Oregon Department of Human Services (DHS)
Office of Disease Prevention and Epidemiology (ODPE)
800 NE Oregon Street, Suite 772
Portland, Oregon 97232

Editors

Janice Alexander, PhD, DHS, IVPP, Injury Epidemiologist
Mel Kohn, MD, MPH, State Epidemiologist and DHS, ODPE Office Administrator
Lisa Millet, MSH, DHS, Injury and Violence Prevention Program Manager
Sandra Moreland, PhD, DHS, Office of Mental Health and Addiction Services (OMHAS)
David Pollock, MD, OMHAS

Oregon Older Adult Suicide Prevention Advisory Work Group

Members of the workgroup assisted in the writing and development of the plan and engaged community partners in providing input at community forums.

Mariana Bornholdt & Marilyn Hinds
Governor's Committee on Senior Services

Lynda Crandall, RN, GNP
DHS, Seniors & People with Disabilities

Jeanne Dalton, RN, ANP, PMHNP
DHS, OMHAS, Oregon State Hospital

Judy Strand, LCSW
Metropolitan Family Service

Dianne Devilliers, LCSW
Coos County Mental Health

Mark Kaplan, PhD
Portland State University

Tim Malone, LCSW
Deschutes County Mental Health

Sandra Moreland, PhD
DHS, OMHAS

Consultants: Mercedes Dekker, MPH, and Ann Glaze and Rachel Ozretich of AGA Consulting

Data for this plan were compiled from a number of published and unpublished sources. Many of these are available at the DHS website: www.healthoregon.org

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Oregon Older Adult Suicide Prevention Plan

Executive Summary

Suicide among older adults is a serious public health problem with over 5,000 older Americans dying by suicide annually. In 1999, the United States Surgeon General issued a National Call to Action to prevent suicide. Adults aged 65 and older are identified in this document as a priority for prevention.

National data from 2003 show that Oregon had the fourth highest suicide rate among older adults in the US. The problem is particularly acute among older males: in 2003 the rate among Oregon males (54.89 per 100,000) is nearly nine times higher than that among Oregon females (6.19 per 100,000).

Both nationally and in Oregon suicide rates are highest among older adults compared with any other age group. Currently about one in five suicides in Oregon occur among older adults,[a] with an annual average of approximately 100 deaths. While Oregon has launched efforts to reduce suicides among youth, from 1999-2003 the suicide rates among adults aged 65 and older were three times higher than rates for those aged 10-24 (average rates of 27.12 vs. 8.49).

In the next three decades the aging of the "baby boomers" will cause the number of older adults in Oregon to double and the proportion of the population in this age group is expected to increase to 24%, which represents a 78% increase. As Oregon's population ages, the problem of suicide among older adults is likely to grow concomitantly, unless something is done to prevent these deaths.

Suicide can be understood as the result of the interplay of a complex set of factors that exist in individuals, relationships, communities and institutions, and society.[1] Although a wide range of factors contribute to the problem of older adult suicide, they fall into two main groups. The first group of factors is related to the provision of medical and behavioral health care to older adults, and includes such factors as: the prevalence of mood disorders in the older adult population, financial and logistical barriers to medical and behavioral care, lack of linkage between medical care and behavioral care services, and failure by clinicians to identify and treat mood disorders among older adults. The second group of factors is related to community attitudes and practices that affect suicidal behavior and engagement with clinical care, and includes such factors as: social isolation, lack of awareness about the problem of suicide, social stigma and misconceptions about suicide and behavioral health care, low rates of care-seeking by older males, the "ageist" belief that depression is an inevitable consequence of aging, and lack of community-based suicide prevention programs for older adults. Progress in addressing both of these groups of factors would be enhanced by improvements in public health surveillance of

[a] Deaths that occur under Oregon's Death with Dignity Act by law are not classified as suicides, and are not addressed in this State Plan.

older adult suicides and suicidal behavior, research on new medical, behavioral health and community-based techniques to address this problem, and evaluation of existing efforts. Although many suicides are preventable, suicide prevention requires the implementation of a multifaceted approach. Just as there is no single cause of suicide, there is no single prevention activity that alone will reduce suicide. To be successful, prevention efforts must address factors at the individual, relationship, institutional, community and societal levels.

In 2003, with funding from the Centers for Disease Control and Prevention, the Injury and Violence Prevention Program within Oregon State Public Health convened a multidisciplinary workgroup to write a plan that could help coordinate and focus efforts to prevent suicide among older adults in Oregon. The workgroup used as its framework the National Strategy for Suicide Prevention,[2] Elder Specific Goals and Objectives developed by international consensus in 2002.[3] The Centers for Disease Control and Prevention funded Oregon Violent Death Reporting System and Injury Surveillance Programs, that provided data on suicidal behavior among older adults. The workgroup reviewed data available from deaths, hospitalization, adult risk surveys and research literature,[4] interviewed national and local experts, older adults, and medical and social service professionals, and then developed draft prevention concepts. The workgroup partnered with local hosts to conduct six community forums throughout the state to collect public input. Staff then took the information gathered through this process and the recommendations of the workgroup and wrote this plan.

This plan identifies three primary strategies to prevent suicide in older adults:

1. Clinically based suicide prevention.
2. Community-based suicide prevention.
3. Public health surveillance, program evaluation, and research.

For each of these strategies a list of objectives is included. Under each objective a variety of ideas for action are listed. While these lists of ideas for action are not exhaustive, the lists are included in order to help make the objectives more concrete for readers.

While this plan represents the hard work of many contributors, a plan itself will not save lives. The challenge for the future is to take this plan and use it to galvanize and guide action in Oregon to prevent older adult suicide.

Oregon Older Adult Suicide Prevention Plan

Introduction

Suicide among older adults is a serious public health problem with over 5,000 older Americans dying by suicide annually. In 1999, the United States Surgeon General issued a National Call to Action to prevent suicide. Adults aged 65 and older are identified in this document as a priority for prevention.

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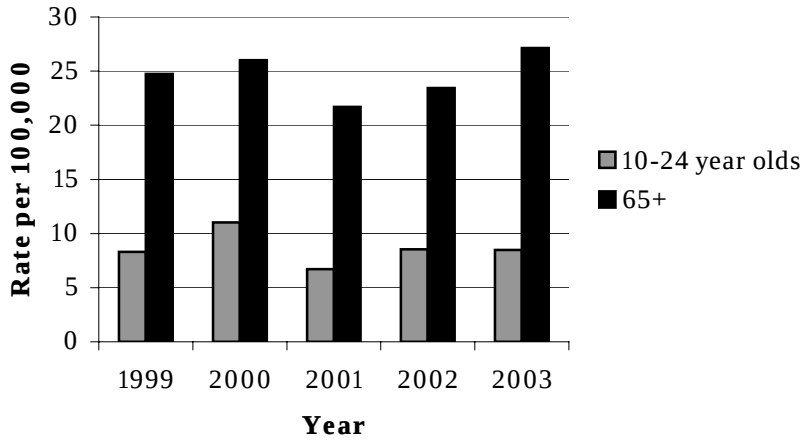
Both nationally and in Oregon suicide rates are highest among older adults compared with any other age group. Currently about one in five suicides in Oregon occur among older adults,[b] with an annual average of approximately 100 deaths. While Oregon has launched efforts to reduce suicides among youth, from 1999-2003 the suicide rates among adults aged 65 and older were three times higher than rates for those aged 10-24 (average rates of 27.12 vs. 8.49).

Figure 1. Rates of suicide deaths per 100,000 among youth aged 10-24 and adults aged 65+, Oregon, 1999-2003



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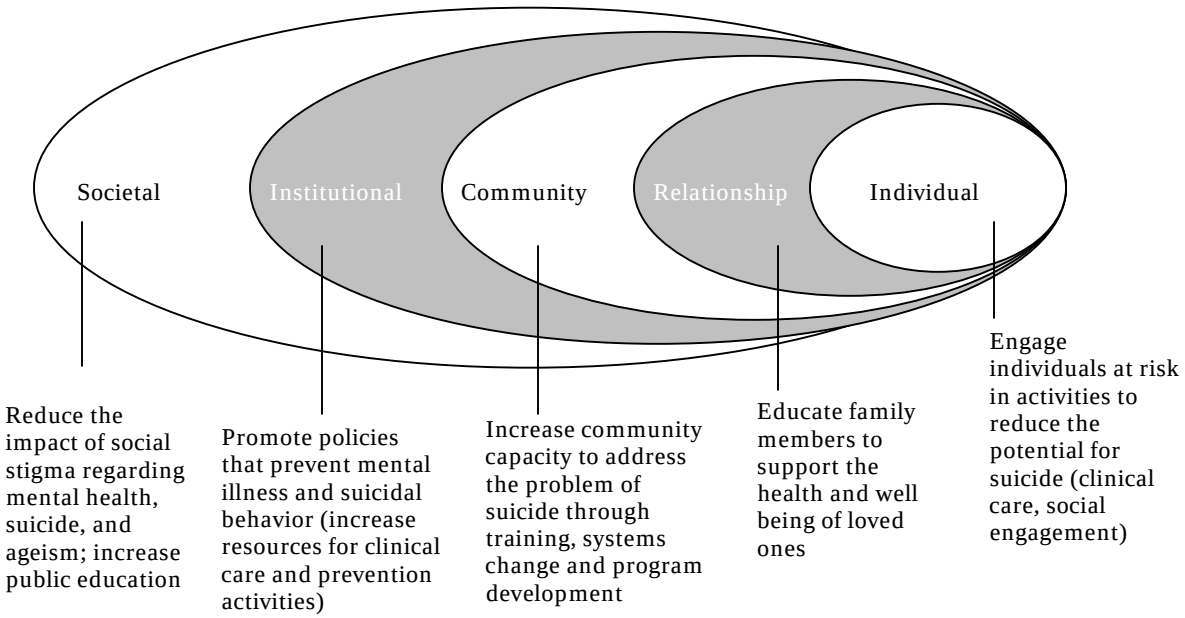
Although a wide range of factors contribute to the problem of older adult suicide, they can be grouped into two main groups. The first group of factors is related to the provision of medical and behavioral health care to older adults, and includes such factors as: the prevalence of mood disorders in the older adult population, financial and logistical barriers to medical and behavioral care, lack of linkage between medical care and behavioral care services, and failure by clinicians to identify and treat mood disorders among older adults. The second group of factors is related to community attitudes and practices that affect suicidal thinking and engagement with clinical care, and includes such factors as: social isolation, lack of awareness about the problem of suicide, social stigma and misconceptions about suicide and behavioral health care, low rates of care-seeking by older males, the "ageist" belief that depression is an inevitable consequence of aging, and lack of community-based suicide prevention programs for older adults. Progress in addressing both of these groups of factors would be greatly enhanced by improvements in public health surveillance of older adult suicides and suicidal behavior, research on new medical, behavioral health and community-based techniques to address this problem, and evaluation of existing efforts.

An Ecological Model for Prevention [5]

Suicide can be understood to result from the interplay of a complex set of factors that exist in individuals, relationships, communities and institutions, and society (figure 2). Prevention activities should be implemented on each level.

Figure 2. Ecological model for understanding suicide[6]



Individual Level

Research has identified a number of individual risk and protective factors for suicide among older adults. Risk factors include such factors as:[8, 9, 10]

- Depression
- Hopelessness
- Withdrawal
- Induced helplessness
- Institutionalization
- Organic mental deterioration
- Recent change in organization or complexity of behavior
- Decreased self-regard
- Access to lethal means
- Poor physical health
- Alcoholism or other substance abuse
- Expectation of death from some cause
- Changes in sleep patterns: severe nightmares
- Life lacks pleasure or purpose, a sense that life is meaningless

The success of recent suicide prevention efforts that increase social support and other positive variables underscores the usefulness of addressing individual-level protective factors as well.[7]

Individual protective factors include factors such as:[8]

- Effective coping skills
- Engagement in evidence based treatment for behavioral health problems
- Life satisfaction, existential & spiritual well-being, &/or belief that one can resolve problems & survive difficult periods

On the individual level, suicidal behaviors[c] among older adults are different than behaviors among youth. Older people who initiate self-harming behavior are more likely to die as a result than younger people. Suicide among older people is often long-considered and planned rather than impulsive, and frequently involves highly lethal methods, such as firearms.[9]

Relationship Level

Relationships with peers, intimate partners, and family members can affect the risk for suicide. For older adults, social isolation, family discord, and the loss of relationships through death and divorce are important relationship-level risk factors. Bereavement is particularly important in the first year after a death. In addition, the attitudes and actions of peers, partners, and family members can influence the help-seeking behavior of those at risk for suicide.

Community and Institutional Level

Communities and their institutions provide a broader context of risk and protection. Educational systems, faith institutions, workplaces, healthcare systems, and social service systems all have characteristics that influence social connectedness, the availability and accessibility of health, behavioral health and social services, a sense of spiritual connection, and perceptions of safety in a community, which in turn affect the risk for suicide.

Gaps in our medical care system are particularly problematic with regard to limiting our ability to provide clinical suicide prevention services. Some of these gaps include:

- The nation needs 9,000 physicians qualified in geriatrics care to meet present needs,
- There are only five departments of geriatrics in the nation's 145 medical colleges,

[c] Suicidal behavior includes thoughts about suicide, talking about suicide, and attempts to harm oneself.

- Only one percent of professionals in nursing, pharmacy and other allied health fields have training in geriatrics care,
- Only 720 of the nation's 200,000 pharmacists have geriatric certifications even though most prescription and over the counter drug consumers are over the age of 65,
- Geriatricians comprise only 0.5 percent of all medical educators in the U.S.,
- Reimbursement rates for Medicare continue to decline and physicians are reducing care or not providing care for Medicare patients.[10]

Societal Level

Societal factors also influence the rate of suicide. Cultural norms that accept depression and suicide as inevitable for older adults, and social stigma regarding behavioral health problems and suicide are examples of societal level factors that contribute to suicide death rates.

On the societal level, ageism prevents appropriate identification and treatment of depression among older adults.[11] Contrary to popular belief, poor health, depression, and suicidal thoughts are not the inevitable consequences of aging. Negative stereotypes, attitudes and assumptions about older adults are a result of ageism in our society. Ageism can be defined as any prejudice or discrimination against or in favor of an age group.[12] Ageism affects our willingness as a society to address the needs of older adults, including the need to address the factors related to suicide.

Prevention Approaches

Because of the complexity of suicide, there is no single program or strategy that will prevent these deaths. No one component of service delivery has been shown to be effective when implemented as a stand-alone strategy. To be most powerful, multiple prevention strategies should be implemented in a coordinated way on the individual, family, community and societal levels.

Some prevention practices should be implemented universally for the entire population, others known as selected interventions should be implemented with populations considered to be at heightened risk for suicide, and indicated interventions are approaches for use with those individuals who have already demonstrated self-harming behavior (see Appendix B).

The research to determine evidence-based practice for suicide prevention is in its infancy. Therefore this plan contains a few evidence-based strategies, and a great deal more of what are termed "best practices" or "promising strategies." The World Health Organization's *World Report on Violence and Health* and the Department of U.S. Department of Health and Human Service's *National Strategy for Suicide Prevention: Goals and Objectives for Action* call on states and communities to invest in evidence-based practice and to implement and test what are thought to be best practice and promising strategies. All of these prevention activities should be evaluated and monitored carefully.

How This Plan Was Developed

In 2003, with funding from the Centers for Disease Control and Prevention, the Injury Prevention and Epidemiology Section within Oregon State Public Health convened a multidisciplinary workgroup to write a plan that could help coordinate and focus efforts to

prevent suicide among older adults in Oregon. The Centers for Disease Control and Prevention funded Oregon Violent Death Reporting System and Injury Surveillance Programs, that provided data on suicidal behavior among older adults. The workgroup used as its framework the National Strategy for Suicide Prevention,[13] Elder Specific Goals and Objectives developed by international consensus in 2002.[14] The workgroup reviewed data available from deaths, hospitalization, adult risk surveys and research literature,[15] interviewed national and local experts, older adults, and medical and social service professionals, and then developed draft prevention concepts. The workgroup partnered with local hosts to conduct six community forums around the state to collect public input on prevention concepts. Staff then took the information gathered through this process and the recommendations of the workgroup and wrote this plan.

Contents of This Plan

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Strategy One: Clinically-based suicide prevention

Rationale and Implementation Considerations:

- Nationally, more than two-thirds of older adults who died by suicide had seen a primary care physician within the previous month.[16] In Oregon, 93% of older adults who died by suicide in 2004 had a chronic illness.[17] Screening, assessment, treatment and referral in the primary care setting can provide important opportunities to prevent suicide in older adults.
- When suicidal adults are seen in primary care, depression and suicidal thought often are not identified. It has been estimated that 15% of adults over age 65 suffer from persistent and serious symptoms of depression but only 3% are given the clinical diagnosis of depression.[18] Between 63% and 90% of depressed older adults go untreated or receive inadequate treatment. Several studies have shown that many physicians are not adequately trained about the importance of screening older adults for depression and suicidality.[19]
- While this plan is focused on preventing suicide, treating depression also has other health benefits. Depression is associated with increasing mortality from a number of other diseases, such as cancer and heart disease. Depressed adults often have more difficulty attending to self-management of chronic diseases, such as diabetes, which can have a devastating impact on health. Even mild depression, if it goes on long enough, can weaken the immune system of older adults.[20]
- Even when health care providers recognize depression and suicidality in patients they may be less willing to treat an older adult patient.[21] In one study, 75% of physicians were found to believe that depression in older persons is a "normal facet of old age."[22]
- Although integration of primary medical care with behavioral health care has been shown to improve patient outcomes,[23] there is substantial variability in implementation of this approach across Oregon.
- Key informant interviews indicated that there are currently not enough behavioral health resources to meet the demand for services among older adults. This is occurring just as the leading edge of the baby boom generation is approaching the age of 60. In 1995 older adults comprised 14 percent of Oregon's population. By 2025 that percentage is expected to increase to 24 percent.[24] Training primary care providers in behavioral health, and integrating primary medical care and behavioral health care can help address this gap in resources.
- Cultural differences between urban and rural areas, and between different racial and ethnic groups require culturally and linguistically competent approaches to care in order to be successful.
- Affordability is a barrier to seeking services, particularly for older adults who are more likely to be on a fixed income. Health insurance coverage often is not adequate to cover the necessary behavioral health care.
- Distance to services and travel requirements create barriers to care throughout Oregon's rural areas, particularly for specialty care.
- When primary care providers make a referral for behavioral health care the referrals are often unsuccessful because fewer older adults use behavioral health services than people of other ages. Older adults may be more likely to associate a stigma with behavioral

health services, see their problems as being physical rather than psychological, and be unaware of the existence of outpatient therapy.[25]

Objective 1.0: Increase the confidence and competence of primary care providers and other clinicians to identify, assess, and treat older adult suicidal behavior and depression.
Ideas for Action:

- Disseminate screening and assessment tools for depression, suicidality, and substance abuse, particularly to primary care providers.
- Train primary care providers to use screening tools.
- Train primary care providers in culturally competent care.
- Increase the proportion of educational programs in undergraduate, graduate, and continuing education in relevant professions (medicine, nursing, allied health, psychology, social work, etc.) that include training in the identification, assessment and management of suicide risk in older adults.
- Increase the number of recertification or licensing programs in relevant professions that require competency in late life depression assessment and management and in prevention of suicide in later life.
- Implement evidence-based models of primary care/behavioral health integration.
- Improve cross system referrals to assure the continuity of care for older adults at risk for suicidal behavior.

Objective 1.1: Improve the availability of medical and behavioral health care providers trained in geriatrics.
Ideas for Action:

- Develop policies and programs to help recruit physicians, nurses, and physician's assistants into geriatric specialties.

Objective 1.2: Reduce financial barriers to medical and behavioral care for older adults.
Ideas for Action:

- Increase financial resources for primary care and behavioral health services.
- Ensure parity of behavioral health with physical health care coverage.

Objective 1.2: Institute clinical outreach programs to older adults.
Ideas for Action:

- Enhance telehealth links for rural areas.
- Strengthen and expand services in rural areas through close cooperation and coordination among agencies, including those that serve members of Tribes.
- Enlist Parish Nurses and Home Visiting Nurses to screen older adults and help connect them with clinical resources.
- Increase the proportion of counties with primary care and/or social service outreach programs for at-risk populations that incorporate behavioral health services.

Strategy Two: Community-based suicide prevention

Rationale and Implementation Considerations:

- Programs that reduce certain risk factors such as depression, social isolation, loss of spouse or partner, access to lethal means,[26] alcoholism, and poor physical health and

increase protective factors such as social support, coping skills, and outreach can reduce suicide deaths.[27, 28]

- Implementing evidence-based practice should be the first priority. However, since the field of suicide prevention is in its infancy, implementing and evaluating the benefits of "best practice" and "promising" strategies should be done.
- Programs should be sensitive and culturally competent in order to best address the needs of older adults. Older adults should be involved in all levels of program planning.[29]
- Among older adults, social stigma and shame often prevent open discussion about mental illness and suicide.[30] Families conceal suicidal behavior and mental illness to avoid shame or embarrassment, or to avoid the societal perception that they are to blame. Many professionals have difficulty talking with older adults about health-related risk factors for suicide or suicidal ideation, or aren't sure how to address shame and stigma among their patients and staff. Because stigma affects both professionals and their patients or clients and families, attempts to reduce prejudice and stigma must involve all elements of the community.[31]
- The media can help enhance public awareness. Media guidelines for appropriate reporting of suicide can (a) help reduce the stigma of suicidal behaviors and the use of behavioral health services, (b) build awareness of the issue and its risk factors, and (c) provide information on how to access help when needed.[32, 33, 34]
- Ageism has significant negative impacts on individuals, how systems of care function, and how society treats older adults. On the individual level ageism lowers feelings of self-efficacy and the isolating experience of marginalization. The experience of ageism and institutional results of ageism can contribute to premature loss of independence, increased mortality, disability, depression, and suicide among older adults who might otherwise lead healthy lives. On the societal level media, films, and advertisements create and perpetuate negative attitudes toward older adults.
- A broad base of support that crosses disciplines is necessary for the success of a suicide prevention initiative.[35] Community-based prevention activities are more likely to be effective when they involve a mixture of governmental and non-governmental groups and community members.
- Funding and in-kind resources are necessary to implement community-based programs.

Objective 2.0: Develop state and local partnerships and the resources to support those partnerships.

Ideas for Action:

- Build new or expand existing local older adult coalitions to promote suicide prevention and mobilize organizations engage in prevention.
- Mobilize statewide organizations including commissions, associations, businesses, faith communities, and governmental offices to implement provisions of this Plan.
- Promote public policies that will reduce the risk of suicide among older adults.
- Increase the number of counties that integrate late life suicide prevention strategies into their county mental health plans that (a) coordinate across county agencies, (b) involve the private sector, and (c) implement and evaluate prevention strategies.
- Increase the number of county multidisciplinary teams that provide assessment and intervention for psychological, physical and social problems.
- Work with local, state and federal governments, non-profit organizations and foundations to secure resources for suicide prevention.

Objective 2.1: Increase awareness that suicide is preventable and reduce the stigma associated with aging and the use of treatment services.

Ideas for Action:

- Conduct a coordinated public education campaign.
- Create suicide awareness materials and presentations for use by community organizations and the faith community.
- Implement late life suicide prevention education into the programs and activities of state, professional, social, fraternal, faith based and other groups.
- Educate legislators and other policy makers about older adult suicide prevention.
- Educate the professional community about older adult behavioral health issues and suicide.
- Integrate education on behavioral health, aging and suicide prevention into health curriculum in middle and high schools and colleges.

Objective 2.2: Improve reporting of suicides and behavioral health issues in the media.

Ideas for Action:

- Provide Centers for Disease Control and Prevention and American Foundation for Suicide Prevention reporting guidelines to media representatives.
- Provide reporting guidelines to key partners in suicide prevention, such as mental health professionals, aging services workers, community leaders, and advocates.
- Establish a citizen's group to monitor local media reporting of suicide and behavioral health issues.
- Update, repeat, and reinforce media guidelines regularly to ensure that both new and experienced editors stay informed.
- Disseminate information on older adult mental health and suicide to local media outlets.

Objective 2.3: Provide suicide intervention skills training for community members.

Ideas for Action:

- Train individuals to teach suicide intervention skills to community members, professionals, and first responders in Oregon.
- Provide ongoing technical assistance to trainers.

Objective 2.4: Reduce social isolation and increase a sense of social support among older adults.

Ideas for Action:

- Educate older adults, families, and other community members about the importance of social connection to a sense of well-being.
- Increase outreach and home visits to isolated older adults.
- Develop telephone support, help, and assessment intervention for older adults.
- Publicize crisis line services among older adults.
- Publish crisis line numbers in local phone books.
- Establish bereavement support in communities for older adults.
- Expand peer-counseling programs to include bereavement support skills.

Objective 2.5: Enhance the abilities of older adults to cope with difficult challenges.
Ideas for Action:

- Increase access to home care, rehabilitation services, and pain management.
- Focus medical and social services on reducing disability and enhancing independent functioning.

Objective 2.6: Reduce access to lethal means among older adults at-risk for suicide.
Ideas for Action:

- Increase the proportion of primary care clinicians and other clinicians who routinely assess the presence of lethal means such as firearms, medications, and poisons in the homes of suicidal older adults.
- Educate older adults and their families about actions needed to reduce the risks associated with access to lethal means.
- Work with Oregon Gun Owner's Association to develop suicide prevention information for gun owners and provide materials to customers.
- Develop and implement guidelines for pharmacists, hospitals, and ambulatory care clinics for safer dispensing of medications for older adults at high risk of suicide.

Objective 2.7: Subvert negative societal stereotypes about aging. Expand the societal definition of retirement to include an understanding of the value of older adults as role models, wisdom-keepers, mentors, and living historians.
Ideas for Action

- Conduct "introduction to aging" workshops for journalists.
- Conduct reading and discussion groups with children with material that uses images of active, healthy older adults.
- Establish connections for children with active older adults that include opportunities for sharing stories, mentorship, physical activity, and learning.
- Set up volunteer programs that recruit older adults as role models that can share their knowledge and experience through activities such as: para-educator opportunities in schools, public speakers bureau for presentations at colleges, and mentoring programs for young professionals. Emphasize strategies that maintain bonding between generations.

Objective 2.8: Develop public policy to assure that older adults have increased opportunities to engage in society in the fullest way.
Ideas for Action:

- Establish a task force to investigate and promote recommendations to reduce social, healthcare, and market discrimination against older adults.
- Establish a task force to evaluate building, transportation and other built environment codes and regulations, and promote recommendations for changes in regulation, rules, development practices, community input, design, and public policy that will better meet the needs of older adults.

Strategy 3: Public health surveillance, program evaluation, and research

Rationale and Implementation Considerations:

- Data from public health surveillance about suicides in older adults, including associated circumstances and risk factors, provide the foundation necessary to promote evidence-based policy development, program development and evaluation.
- Currently our knowledge about the effectiveness of suicide prevention programs is extremely limited. Program evaluation should be incorporated into every prevention activity so that we can learn what works and how to most efficiently use and effectively advocate for prevention resources.
- Research to guide the development of new prevention approaches also is needed Encouraging relationships among Oregon researchers and between researchers and prevention practitioners can help to encourage research in this area and ensure that research is relevant to practice.

Objective 3.0: Enhance public health surveillance systems to capture more detailed information on suicide events, victims and survivors.

Ideas for Action:

- Improve the capacity of existing injury surveillance systems, such as Oregon's Violent Death Reporting System and the Behavioral Risk Factor Surveillance System, to capture information about suicides in older adults.
- Expand the Adolescent Suicide Attempt Data System to include adults.
- Evaluate surveillance systems with information about suicides to determine the quality of data and additional data needs, and implement the results of that evaluation.

Objective 3.1: Encourage evaluations of suicide prevention programs implemented in Oregon.

Ideas for Action:

- Increase the number of prevention efforts that have an evaluation component.
- Provide technical assistance and guidance about evaluation to program programs.
- Develop and disseminate written reports summarizing evaluation findings.

Objective 3.2: Improve research-based knowledge about late life suicide and suicide prevention practice.

Ideas for Action

- Develop a state agenda for research on suicide among older adults.
- Create an older adult suicide researchers' network.

Conclusions:

While this plan represents the hard work of many contributors, a plan itself will not save lives. The challenge for the future is to take this plan and use it to galvanize and guide action in Oregon to prevent older adult suicide.

Appendix A

The Epidemiology of Suicide Among the Older Adults in Oregon

Epidemiologic study of suicide, non-fatal suicidal behavior and suicide risk among older adults can assist the state and communities to gauge the magnitude and scope of the problem of suicide among older adults. Oregon's public health surveillance activities can provide communities and the state a valuable resource that can be used to increase awareness of the problem, identify problems, target populations for intervention, identify interventions to address problems, measure progress, and inform public policy.

Data sources for epidemiologic investigation include: the Oregon Violent Death Data System (includes: medical examiner reports, police reports, death certificates), the Oregon Hospital Discharge Index, the Oregon Behavioral Risk Factor Surveillance System, and the WISQARS data base at the Centers for Disease Control and Prevention. This profile of suicide deaths among older adults includes data from all of these sources.

Older Adult Suicide Rate in Oregon and the US

Suicide is the second leading cause of injury death and the eight leading cause of death overall among Oregon's older adult population. Each year approximately 100 of Oregon's older adults are victims of a suicide death. Approximately 1 in 5 of all reported suicides in Oregon occur among older adults. In 2003, individuals over the age of 65 comprised 13% of the state's population but accounted for 22% of the total suicides.

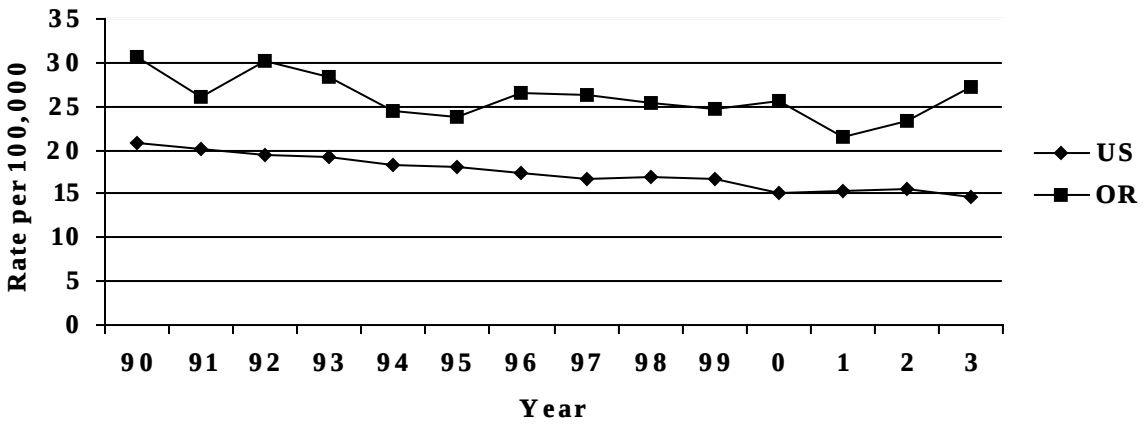
Oregon's older adult suicide rate has been higher than the national death rate for over a decade. In 2003, Oregon had the fourth highest older adult suicide rate in the country (behind Nevada, Wyoming and Alaska). The state rate was 27.12 per 100,000 compared to 14.61 per 100,000 for the nation. Death rates in the nation and in Oregon have been stable, with a slight decrease between 1990 and 2003 (see figure 1).

Table 1. Suicide deaths and death rates per 100,000 among adults aged 65+, by age, gender, and mechanism, OR, 1999-2003, n=546

		Total	65-74	75-84	85+
All Suicide	Both Sexes	546 (24.61)	205 (18.66)	237 (29.02)	104 (34.23)
	Male	472 (49.80)	175 (34.25)	209 (61.73)	88 (89.42)
	Female	74 (5.82)	30 (5.11)	28 (5.86)	16 (7.79)
Poisoning	Both Sexes	46 (2.07)	19 (1.73)	19 (2.33)	8 (2.63)
	Male	25 (2.64)	14 (2.74)	7 (2.07)	4 (4.06)
	Female	21 (1.65)	5 (0.85)	12 (2.51)	4 (1.95)
Hanging /suffocation	Both Sexes	43 (1.94)	12(1.09)	16 (1.96)	15 (4.94)
	Male	29 (3.06)	8 (1.59)	14 (4.13)	7 (7.11)
	Female	14 (1.10)	4 (0.68)	2 (0.42)	8 (3.89)
Firearm	Both Sexes	434 (19.56)	163 (14.84)	193 (23.63)	78 (25.67)
	Male	403 (42.52)	147 (28.77)	180 (53.16)	76 (77.23)
	Female	31 (2.44)	16 (2.72)	13 (2.72)	2 (0.97)

Source: Oregon Vital Statistics, 1990-2003, CDC WISQUARS, 1999-2003

Figure 1. Suicide rates among individuals aged 65+, US and OR, 1990-2003



Source: Oregon Vital Statistics, 1990-2003, CDC WISQUARS, 1999-2003

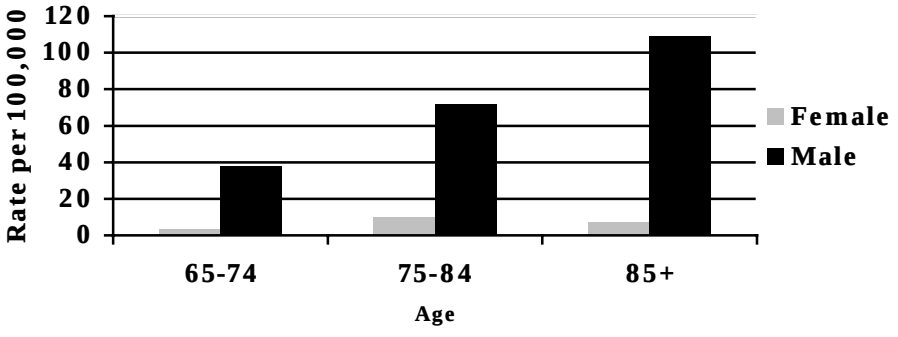
Age, Gender and Race

There is variation in suicide rates in the age groups after the age of 65. Suicide rates increase dramatically after the age of 65 (figure 2).

Eighty-six percent of the victims were males and the rate for males was nearly nine times higher than the rate for females (52 per 100,000 vs. 6 per 100,000, respectively). Sixty-three percent of the victims were over the age of 74. 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.

Whites, particularly white males, were over-represented in the suicide data (see figure 2). Ninety-nine percent of the victims were white, 87% of them were white males. The rate for white males began to rise significantly around age 65 and peaked around age 85.

Figure 2. Suicide rates by age group and gender, OR, 2003 n=122



Source: Oregon Vital Statistics, 2003

Mechanisms of Death

Death certificates indicate that firearms were the mechanism of death in the majority of cases among male and female suicide victims. Overall, in 2003, firearms were the mechanism of death for 79% of suicide victims, among 85% of male victims and 41% of female victims. Other mechanisms of death included poisoning (9%) and suffocation (8%).

Depressed Mood and Treatment

According to the Oregon Violent Death Reporting System that collects detailed circumstantial data on suicide deaths, in 2003, 50% of male and 61% of female suicide victims were reported to have a current depressed mood. Investigations also report on current treatment or lack of current treatment for this problem. Among older adult suicide victims 20% of males and 54% of females were reported to be currently depressed and currently in treatment for depression.

Data on depression are limited by the fact that it is not systematically noted in death investigations of suicides. In addition, it may be difficult to ascertain whether or not depression was present for socially isolated decedents. For these reasons the prevalence of depressed mood noted here is probably under-estimated.

Physical Health Problems and Risk [c]

Thirty-six percent of suicide victims were reported to have visited a physician in the last 30 days prior to their death. Seventy-six percent of male suicide victims and seventy-two percent of female victims were reported to have some physical health problem. The most common illnesses reported:

- 23% had heart disease;
- 19% had cancer;
- 18 % had chronic respiratory disease;
- 10% had stroke; and
- 6% had diabetes.

Declining health was reported among 58% of the suicide victims. In addition, 36% had a loss of autonomy or independence related to health status, and 25% suffered from chronic pain.

Social Isolation [d]

Social isolation and failed or lack of marital or co-habiting partnerships are thought to be important risk factors. Table 1 illustrates the marital status of male and female suicide victims as compared to older adults dying of all causes in Oregon between 1999 and 2003.

[c] Oregon Violent Death Reporting System, 2003

[d] Oregon Violent Death Reporting System, 2003

Table 2. Marital status at time of death among older adult suicides and older adults who died of all causes, by gender, OR, 1999-2003

	Males		Females	
Marital Status	**Suicide Victims**	**All Causes**	**Suicide Victims**	**All Causes**
Married	47%	60%	26%	22%
Divorced	16%	11%	27%	11%
Widowed	30%	26%	44%	64%
Single, never married	6%	4%	3%	3%

Source: Oregon Vital Statistics

The proportion of divorced individuals among suicide victims is much higher among women and slightly higher among men when compared to deaths by all causes. The proportion of married individuals is much lower among male suicide victims, generally because females live longer than their male partners. Twenty-six percent of male suicide victims and 41% of female suicide victims were reported to be living alone or in isolation at the time of death.

Precipitating Events[2]

Acute crises are not thought to be the underlying cause of many suicides among older adults as most suicides among this age group are not the result of impulsiveness. However, when acute crises occur among those who are predisposed toward suicide, these acute crises can alert clinicians, family and friends of the need to take immediate action to prevent a suicide. In 2003 53% of male suicide victims and 18% of female suicide victims had experienced a crisis. Crises identified included:

- Loss of a spouse or friend who is the last of a dwindling peer group,
- Financial crisis related to costs of medical care
- Ability to maintain independent living,
- Diagnosis of a new serious illness, and
- Move to a new living situation or need to transition to supervised care in the last two weeks prior to death.

In the literature, recent loss of a spouse is identified as a risk factor and as a precipitating event preceding an older adult suicide. The recent death of a spouse occurred only among 5% of older male suicide victims and 12% of older female suicide victims in Oregon. Deaths of a family member or a friend similarly occurred in only a minority of cases (9% of suicides among males and 12% of suicides among females).

Alcohol and Other Substance Abuse[2]

The role of alcohol and drugs in suicide is not clearly understood. Alcohol and drugs can be the mechanism of death, they can contribute to reducing inhibitions, they can be used as self-medication, and any combination there of. Alcohol and/or other substance abuse were found in a minority of cases. Although alcohol use and dependence is probably under-reported, alcohol intoxication was suspected at the death scene in only 11% of cases, and only 8% of victims tested positive for blood alcohol. There were no reports of other substance abuse among older adult suicide victims.

Nonfatal Attempts[e]

Two-hundred-fifty-two nonfatal suicide attempts among older adults were identified in Oregon's 1998–2002 hospital discharge databases. The majority of hospitalizations (51%) occurred among individuals aged 75 years and older. Sixty-five percent of cases were females and 35% were males. Inpatient treatment costs exceeded 2.6 million dollars.

While rates of suicide death are much higher among older adults than youth aged 10-24, the numbers of hospitalization among older adults is lower (Table 3).

Table 3. Comparison of suicide attempt hospitalization among youth and older adults, OR, 1998-2002

Age Group	Males	Females
10-24	647 (31%)	1425 (69%)
65+	88 (35%)	164 (65%)

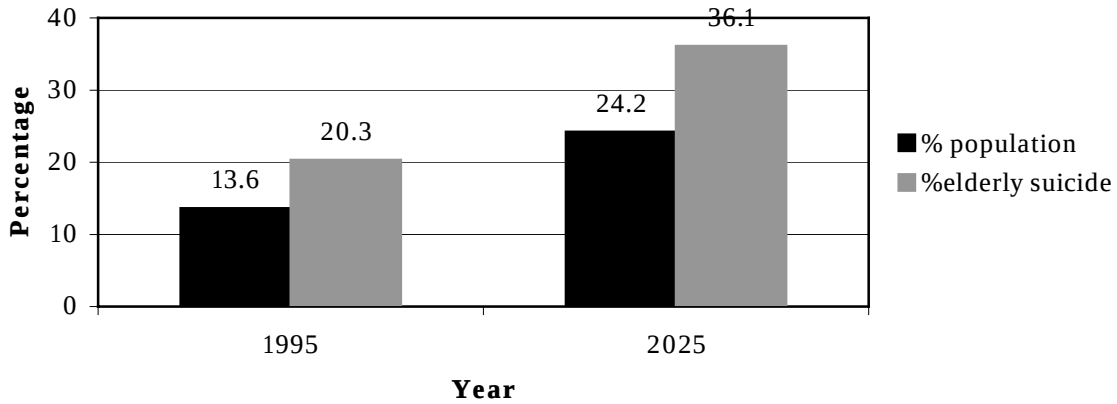
Source: Oregon Hospital Discharge Index

Among older adults who were hospitalized after a suicide attempt, poisoning was the mechanism of injury in 87% of cases. Other mechanisms of injury included: cutting and piercing (8%), and firearms (4%). The average length of stay among older adults was 3.5 days.

Projections

According to the US Census Bureau, Oregon's older adult population will double during the next three decades. By 2025, Oregon will have the 4th highest proportion of older adult residents in the nation (1). In 1995, older adults represented 13.6% of Oregon's total population. By 2025, that percentage is expected to increase to 24.2% (see figure 3). If the rate of older adult suicide remains the same as the proportion of the older adult population increase, Oregon will see 78% more deaths by suicide in 2025.

Figure 3. Current and projected older adult population and suicides, OR, 1995 and 2025



Source: Oregon Vital Statistics and Portland State Center for Population Statistics

[e] Oregon Hospital Discharge Index, 1998-2002

Risk Behavior[f]

The Oregon Behavioral Risk Factor Surveillance System collects data on a number of factors known to put older adults at increased risk for suicide. Responses below are a number of risk categories, questions, and percentage of older adults (65+) responding to questions in the survey. Complete survey questions and responses can be found on the web at: http://www.oregon.gov/DHS/ph/chs/brfs/brfss.shtml

Table 4. Risk factors for suicide among older adults measured in Oregon BRFSS, 2003 and 2004

Risk Factor	**% 65 & older reporting**
Social support:	
I rarely or never get the social support that I need	10%
I would like to be doing more social activity	27%
No social activity w/ friends, family, neighbors in past 2 weeks	5%
Life satisfaction: "I am dissatisfied or very dissatisfied with my life	4%
Autonomy/independence: # days in past 30 that poor physical or mental health kept you from doing usual activities such as self-care, work, or recreation	
1-14 days	23%
15-29 days	7%
30+ days	7%
"I need help with personal care needs" (eating, bathing, dressing)	10%
"I need help with activities" (chores, shopping, business, travel)	31%
"I am limited due to physical, mental, or emotional problems"	34%
"I consider myself disabled"	21%
Trouble learning, remembering or concentrating due to health	17%
Physical health: Been told by a doctor you have arthritis, heart disease and/or diabetes	84%
Mental health & alcohol abuse: ***Number of days in past 30 days mental health not good***	
1-14 days	12%
15-29 days	2%
30+ days	3%
5 or more alcoholic drinks on 1 or more occasions in past 30 days	5%
Access to lethal means: Firearms in the home	
Males	55%
Females	25%
Hunger: Oregon older adults living in food insecure households	6%
Veteran Status: Oregon older adults receiving some or all of medical care from VA facilities	17%
Served in military	35%

[f] Oregon Behavioral Risk Factor Surveillance System, data from questions in years, 2002, 2003, 2004. Note: The objective of the BRFSS is to collect uniform on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the adult population. Data are collected from a random sample of adults (one per household) through a telephone survey.

APPENDIX B

THE LANGUAGE OF PREVENTION SCIENCE APPLIED TO SUICIDE AND ATTEMPTED SUICIDE IN LATER LIFE

Intervention Terminology	Approach	Target	Objectives	Examples of Possible Prevention Efforts
Universal Prevention	Population	Entire population, not identified based on individual risk.	Implement broadly directed initiatives to prevent suicide-related morbidity and mortality through reducing risk and enhancing protective factors.	1) Education of the general public, clergy, the media, and health care providers concerning ▪ normal aging ▪ ageism and stigma re: mental illness ▪ pain and disability management ▪ depression ▪ suicidal behaviors
Selective Prevention	Population High Risk	Asymptomatic or pre-symptomatic individuals or subgroups with distal risk factors for suicide, or who have a higher-than-average risk of developing mental disorders or other more "proximal" risk factors.	Prevent suicide-related morbidity and mortality through addressing specific characteristics that place elders at risk.	1) Promote church-based and community programs to contact and support isolated elders 2) Focus medical and social services on reducing disability and enhancing independent functioning 3) Increase access to home care and rehabilitation services 4) Improve access to pain management and palliative care services 5) Treat elders with chronic pain syndromes more effectively

Intervention Terminology	Approach	Target	Objectives	Examples of Possible Prevention Efforts
Indicated Prevention	High Risk	Individuals with detectable symptoms and/or other proximal risk factors for suicide.	Treat individuals with precursor signs and symptoms to prevent development of disorder or the expression of suicidal behavior.	1) Train gatekeepers in recognition of symptomatic and at-risk elders 2) Link outreach and gatekeeper services to comprehensive evaluation and health management services in a continuum of care 3) Implement strategies to provide more accessible, acceptable, and affordable mental health care to elders 4) Increase screening/evaluation/referral/treatment in primary care settings for elders with depression, anxiety, and substance misuse 5) Improve providers' assessment and restriction of access to lethal means

Appendix C

Key Contacts and Resources

Oregon State Government

Department of Human Services:

Office of Disease Prevention and Epidemiology
Injury and Violence Prevention Program
800 NE Oregon St. Suite 772, Portland, OR 97232
http://www.oregon.gov/DHS/ph/ipe

Janice Alexander, PhD, Injury Epidemiologist
(971) 673-1033
Janice.D.Alexander@state.or.us

Xun Shen, MD, MPH, Oregon Violent Death Reporting System Epidemiologist
(971) 673-1098
Xun.Shen@state.or.us

Lisa Millet, MSH, Section Manager
(971) 673-1059
Lisa.M.Millet@state.or.us

Center for Health Statistics, Mortality Statistics
800 NE Oregon St. Suite 200, Portland, OR 97232
Dave Hopkins, MS, Research Analyst
(971) 673-1162
David.D.Hopkins@state.or.us
http://www.oregon.gov/DHS/ph/chs/index.shtml

Office of Seniors and People with Disabilities:
500 Summer St. NE E-13, Salem, OR 97305
Lynda Crandall, Chronic Care Coordinator
(503) 945-5918
Lynda.Crandall@state.or.us
http://www.oregon.gov/DHS/aboutdhs/structure/spd.shtml

Jennifer Mead, MPH, Health Promotion Coordinator
(971) 673-1035 and (503) 945-6412
Jennifer.Mead@state.or.us
http://www.oregon.gov/DHS/ph/hpcdp/index.shtml

Office of Mental Health and Addiction Services
2575 Bittern N.E., Salem 97309
Sandra Moreland, PhD, Older Adult Services Coordinator
(503) 945-9715
Sandra.Moreland@state.or.us
http://www.oregon.gov/DHS/mentalhealth/index.shtml

Gero Outreach Team
Oregon State Hospital
2600 Center St. NE
Salem, OR 97301-2682
Rebecca Curtis
Jeanne Dalton, RN, ANP, PMHNP
503-945-7136
rebecca.l.curtis@state.or.us
Jeanne.R.Dalton@state.or.us

Governor's Commission on Senior Services:
Department of Human Services, Seniors & People with Disabilities
500 Summer N.E. E-02, Salem, 97301-1075
Marc Overbeck, Legislative and Advocacy Specialist
(503) 945-6406
Marc.Overbeck@state.or.us
http://www.oregon.gov/DHS/spd/adv/gcss/home.shtml

Oregon Health Sciences University, Department of Psychiatry
Multnomah Pavilion, Room 2316
OHSU, UHN-80
3181 SW Sam Jackson Park Rd
Portland, OR 97239-3098
(503) 494-8144
psych@ohsu.edu

Community Based Organizations/nonprofits

Association of Oregon Community Mental Health Program Directors
Gina Firman, Executive Director
1201 Court Street, NE, Suite 201
Salem, OR 97301
(503) 399-7201

Conference of Local Health Officials
Linda Fleming, Executive Director
P.O. Box 428
Fossil, OR 97830
(541) 763-3740
Linkflem@centurytel.net

Living Works also known as Applied Suicide Intervention Skills Training
http://www.livingworks.net/
ASIST Oregon contact: Gary McConahay, PhD
(541) 858-8170
Gmcconahay@orbsinc.org
http://www.jcmhd.com/suicideprevention.htm

Oregon Association of Area Agencies on Aging and Disability
Jaqueline Zimmer, Executive Director
3410 Cherry Ave. NE, Salem, OR 97309
(503) 463-8692
http://www.o4ad.org/

National Association for the Mentally Ill, Oregon
David Gallison, Executive Director
3550 SE Woodward Street
Portland, OR 97202
(503) 230-8009 and (800) 343-6264
namioregon@qwest.net
http://www.nami.org/MSTemplate.cfm?Site=NAMI_Oregon

Northwest Chapter of the American Foundation for Suicide Prevention
AFSP Northwest
P.O. Box 25587
Portland, OR 97298-0587
afspnw@yahoo.com
(503) 650-5595
http://www.afspnw.org/home.html

Oregon Partnership Helpline
(800) 923-HELP
http://www.orpartnership.org/

QPR Institute: Question, Persuade, Refer Suicide Intervention Skills Training
(888) 726-7926
http://www.qprinstitute.com/

Suicide Bereavement Support in Oregon
(503) 285-1714
http://www.oregon.gov/DHS/ph/ipe/ysp/sbs.shtml#about

The Dougy Center (bereavement support)
3909 SE 52nd Ave
Portland, Oregon
(503) 775-5683
http://www.dougy.org

Yellow Ribbon Suicide Prevention Program
Tyler Barges
Troutdale, Oregon
(503) 314-8025
bargastyler@hotmail.com

National Organizations

American Association of Suicidology
4201 Connecticut Ave., NW Suite 408
Washington, DC 20008
(202) 237-2280
info@suicidology.org
http://www.suicidology.org

American Foundation for Suicide Prevention
120 Wall Street, 22nd Floor
New York, New York 10005
(888) 333-AFSP (2377)
inquiry@afsp.org
http://www.afsp.org

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
4770 Buford Highway, Mailstop K60
Atlanta, Georgia 30341-3724
(770) 488-4362
DVPINFO@cdc.gov to send messages or questions
WISQARS (Web-based Injury Statistics Query and Reporting System): Fatal Injuries: Mortality reports
http://webappa.cdc.gov/sasweb/ncipc/mortrate.html
Information on suicide
http://www.cdc.gov/ncipc/factsheets/suifacts.htm

International Friends and Families of Suicides
http://www.friendsandfamiliesofsuicide.com/

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
NAMI Helpline: 800.950.NAMI (6264)
(703) 524-7600
http://www.nami.org

National Institutes of Mental Health
Facts on: Depression in Older Adults, Depression and Other Illness
Information About Medications

http://www.nimh.nih.gov/healthinformation/depoldermenu.cfm
Medline Plus – Health Information: Suicide
http://www.nlm.nih.gov/medlineplus/suicide.html

National Organization for People of Color Against Suicide
4715 Sargent Road, NE
Washington, D.C. 20017
(866) 899-5317
nopcas@onebox.com
http://www.nopcas.com

National Resource Center for Suicide Prevention and Aftercare/The Link Counseling Center
348 Mt. Vernon Highway NE
Atlanta, Georgia 30328-4139
(404) 256-9797
linknrc@bellsouth.net
http://www.thelink.org

National Suicide Prevention Lifeline
(800) 273-TALK (8255)
TTY: (800) 799-4TTY (4899)
http://www.suicidepreventionlifeline.org/

Organization for Attempters and Survivors of Suicide in Interfaith Services (OASSIS)
101 King Farm Blvd, #D401.
Rockville, MD 20850
(240) 632-0335
jamestclemons@aol.com
http://www.oassis.org

Pacific Institute for Research and Evaluation
Calverton Office Park
11710 Beltsville Drive, Suite 300
Calverton, MD 20705-3109
(301) 731-9891
info@pire.org
http://www.pire.org

Substance Abuse and Mental Health Administration
http://www.mentalhealth.samhsa.gov/cmhs/nspi/

Suicide Awareness Voices of Education (SAVE)
http://www.save.org/

Suicide Prevention Action Network USA
1025 Vermont Avenue NW #1200
Washington, D.C. 20005
(202) 449-3600
info@spanusa.org
http://www.spanusa.org

Suicide Prevention Resource Center
Lloyd Potter, Director
(877) 439-7772
http://www.sprc.org/

The National Strategy for Suicide Prevention
http://www.mentalhealth.samhsa.gov/suicideprevention/

The National Hopeline Network
(800) SUICIDE or (800) 784-2433
http://www.hopeline.com/

The Samaritans Suicide Prevention Hotline
P.O. Box 1259
Madison Square Station, New York, NY 10159
(212) 673-3000
http://www.samaritansnyc.org/

Training Institute for Suicide Assessment and Clinical Interviewing
www.suicideassessment.com

University of Rochester Medical Center
Center for the Study of Prevention of Suicide
Suicide Prevention in Later Life link:
http://www.rochesterpreventsuicide.org/elders.html

Yellow Ribbon Suicide Prevention Program®
Light for Life Foundation International
PO Box 644
Westminster, CO 80036-0644
(303) 429-3530
ask4help@yellowribbon.org
www.yellowribbon.org

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