Submitted Testimony by Melvin Kohn, MD MPH
State Epidemiologist
Public Health Division, Oregon Department of Human Services

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Mr. Chair and members of the Committee, for the record I am Dr. Mel Kohn, State Epidemiologist in the Public Health Division at the Oregon Department of Human Services. In that capacity I oversee a wide variety of public health programs including communicable disease control, chronic disease prevention and injury prevention.

Thank you for inviting me to speak with you today about the work a group of us in Oregon are doing in older adult suicide prevention. I especially want to thank Senator Smith and his wife for the courageous leadership they have provided for suicide prevention.

Most people are surprised to learn how big a problem suicide is. Every year in the US there are about 20,000 homicides, but about 30,000 suicides. In Oregon almost three quarters of our violent deaths are suicides. In 2003 almost 600 Oregonians died from suicide, and that's more than the number that died from car crashes.

The rate of suicide increases dramatically with age (Figure 1). In recent years in Oregon the rate of suicide among those above age 65 was three times the rate for those aged 10-24. This is not unique to Oregon: for all states the age group with the highest suicide rate is older adults.

Because of the large toll from older adult suicide in Oregon our injury prevention program, together with partners from our agency working in mental health and in senior services, convened a statewide planning process to create an Older Adult Suicide Prevention Plan. I have provided each of you with a copy, in addition it is available on our website (http://egov.oregon.gov/DHS/ph/ipe/esp/docs/plan.pdf). Through a grant from the Centers for Disease Control we convened a multidisciplinary workgroup that reviewed available data and the research literature, and interviewed experts in the field, as well as service providers and older adults. With this information we developed a prevention framework. We then held six community forums around the state to gather public input on the proposed framework. Based on what we learned during this process we wrote the Plan.

For this process we were fortunate that Oregon had been funded by the Centers for Disease Control for the National Violent Death Reporting System. That data source allowed us to learn many details about the circumstances of older adult suicides in Oregon that were useful for crafting our prevention approach. For example, almost 50% of men and 60% of women above age 65 who died by suicide were reported to have a depressed mood before death. However, only a small proportion of these depressed people – 14% of the men and 29% of the women – were under treatment for their depression, suggesting that screening and treatment for depression might have saved lives. Ninety three percent of decedents had a chronic illness, and over a third of decedents had visited a physician in the last 30 days of their life, suggesting that primary care office visits might be a feasible opportunity for intervention. Similarly, more than a third of decedents were isolated or lived alone, suggesting that providing some social supports might have been helpful.

However, no single intervention or program will fix this problem. A multi-faceted approach is needed. In accord with what we learned from our Oregon data, our plan has two main strategies: clinically based suicide prevention, and community-based suicide prevention. Some examples of clinically based activities in the plan are promoting screening, assessment and treatment for depression by primary care providers, and overcoming barriers to care. Some of the community-based activities in the plan include programs to increase public awareness about the problem, reduce social isolation and provide social services to help older adults cope with difficult challenges they may face. As this list of activities makes clear, multidisciplinary collaboration is the key to success in addressing this problem.

While older adult suicide might seem like a sad topic, our experience with this planning process was extremely positive. Healthcare providers, social service providers and community members recognized the enormous need and the potential for prevention related to this issue, and were eager to collaborate. We have also been fortunate to receive a small grant from the Substance Abuse and Mental Health Services Administration to begin to implement the plan. With those funds we are developing and implementing training for physicians on screening and assessment for suicide risk in the primary care setting. In addition we are using these funds to conduct community forums in 13 regions of Oregon and assist these areas in implementing the physician training and other aspects of the plan in their area. The plan will be implemented primarily through existing service delivery systems as resources allow.

In closing I want to ask all of you to continue to call attention to this problem, as you've done with this hearing today, and to integrate your awareness of this problem in with other efforts you undertake to help older Americans. Of course all this work takes resources, and I hope that you will support funding for efforts to address this problem, particularly at the state and local level.

Thank you for your attention.