**The Incidence of Suicide by Age in the USA**

The incidence of a disease in epidemiology refers to the proportion of a particular population found to be burdened by a medical condition. It is important for this information to be collected as it would help in making informed decisions on how to deal with the disease. The incidence of suicide by age will be discussed as of the statistics of 2016.

In 2016, the incidence of suicide was highest in adults of age range between 45 and 55 years and mostly among the white men (19.7%) (AFSP 2018). The second highest incidence was among the old aged 85 or older (18.97%) (AFSP 2018). In general, compared to the middle-aged or the older adults, the young groups have had lower rates of suicide. In the same year, teenagers and young adults of ages between 15 and 24 experienced suicide incidences of 13.11% (AFSP 2018). In the female, highest rates of suicide occurred for those aged 45-54 (10.3 per 100,000) (Sprc.org, 2018). For males, those aged 65 and older recorded the highest suicide rates (32.3 per 100,000) (Sprc.org, 2018).

**Main social determinants contributing to suicide**

Divorce has been attributed as a cause of the reduction of an individual’s social integration and regulation. This is because it results in disruption of both family and social ties. Divorce itself is also perceived as a deviation from the societal norms. It is, therefore, a source of trauma that could initiate suicide. It is thus likely that in a society with high divorce rates there may be a higher suicide rate (Jalles and Andresen 2015, p.1).

Alcohol consumption has been associated with increased suicide rates. The association has been thought to be through unobserved factors (Jalles and Andresen 2015, p.1). According to Jalles and Andresen (2015), most drunkards undergo episodes of psychological episodes like loss of friends and lack of societal support. It is, therefore, possible that alcohol consumption is related to the above factors, increases rates of committing suicide and mostly affects young males.

Inequality also impacts on suicide rates. However, the casual path as to why someone might expect inequality to impact on suicide is non-trivial (Jalles and Andresen 2015, p.1). Communities that receive low capital could experience elevated stress levels. Inequality, therefore, contributes to reducing social integration and increased mortality (Hatzenbuehler 2011, p.896).

**Potential interventions at different levels to reduce both the burden of suicide and the inequalities**

There should be a restriction of access to means that can cause self-harm. In local interpretation, the restriction means limiting access to firearms, farm chemicals or high places. The World Health Organisation recommends active involvement of the community to create locally practical ways of implementing interventions at community level limit access to ways of self-harm; there should be collaborative efforts among health and other relevant sectors to limit access to the common suicide means.

Establishment of policies that will lower harmful alcohol use as a means of suicide reduction (Vijayakumar et al. 2011, p.244). It is necessary to restrict alcohol availability as a means of lowering the harmful use of alcohol especially in a community with high alcohol use.

The Media should also be encouraged to adhere to the responsible reporting of suicide incidences. The role played by the media in terms of prevention of suicide has not been appreciated (Vijayakumar et al. 2011, p.244). However, it is evident that responsible reporting of suicide cases saves lives. The media is encouraged to avoid language that normalizes suicide and always give information to the masses on how they can get help (Vijayakumar et al. 2011, p.244).

In conclusion, it is apparent that prevalence of suicide cases is a concern that needs to be addressed by the healthcare setup. In collaboration with stakeholders, it is important to get the right information on the causes of suicide with respect to the age groups. The causes realized can then be addressed using appropriate interventions with the aim of reducing the number of deaths as a result of suicide.

**List of References**

AFSP. (2018). *Suicide Statistics — AFSP*. [online] Available at: https://afsp.org/about-suicide/suicide-statistics/ (Accessed 20 May 2018).

Merson, M.H., Black, R.E. and Mills, A.J. eds., 2012. *Global health: Diseases, Programs, Systems and Policies*. Jones & Bartlett Publishers.

Naidoo, Jennie & Wills, Jane, MSc, (author.) & Naidoo, Jennie. Health promotion 2009, *Foundations for health promotion*, Third edition, Baillière Tindall/Elsevier, Edinburgh

Jalles, J.T., and Andresen, M.A., 2015. The social and economic determinants of suicide in Canadian provinces. *Health economics review*, *5*(1), p.1. Available from: doi: 0.1186/s13561-015-0041-y

Sprc.org. (2018). *Suicide by Age | Suicide Prevention Resource Center*. [online] Available at: http://www.sprc.org/scope/age (Accessed 23 May 2018).

Nimh.nih.gov. (2018). *NIMH » Suicide*. [online] Available at: https://www.nimh.nih.gov/health/statistics/suicide.shtml (Accessed 20 May 2018).

Vijayakumar, L., Umamaheswari, C., Ali, Z.S.S., Devaraj, P. and Kesavan, K., 2011. Intervention for suicide attempters: A randomized controlled study. *Indian Journal of Psychiatry*, *53*(3), p.244. Available from: doi: 10.4103/0019-5545.86817.

Hatzenbuehler, M.L., 2011. The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics*, *127*(5), pp.896-903. Available from: doi:10.1542/peds.2010-3020.