Older People

Suicide Prevention Australia

POLICY POSITION

October 2022

POSITION

1. Commonwealth, state and territory governments should fund specific mental health and suicide prevention services for older people, including tailored aftercare, postvention, in-reach service provision into residential aged care, and targeted supports at key life stages of transition and social demographics with recognition that an attempt by an older person is more likely to result in death by suicide.
2. State and territory governments to roll out targeted suicide prevention training specific to older people for face-to-face workers who are likely to encounter older people who may be experiencing suicidality (e.g. aged care facilities, GP practice staff, nurses, independent living units, support services, Support at Home staff who deliver aged care in private homes, informal carers) and ensure the training includes addressing stigma and ageism.
3. Commonwealth, state and territory governments to support alternative measures to address social isolation, loneliness and sense of loss of purpose among older people (e.g. social prescribing and community-based programs and interventions in community spaces) as part of primary healthcare and preventative strategies, including funding to support the 'link worker' and peer workforce.
4. Commonwealth Government should establish a centre of research excellence to lead national research specific to older persons mental ill-health and understanding suicide among Australian older people.
5. General practitioners and registered nurses need education and training in geriatrics, suicide prevention, and referral pathways for older people.
6. Suicide Prevention Australia supports the Royal Commission into Aged Care Quality and Safety Final Report recommendations 59 (Australian governments to fund outreach older persons mental health services), 61 (enhance access to mental health assessments in residential aged care and allied health services), and 114 (mental health training for the aged care workforce).

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CONTEXT AND COMMENTARY

The Australian Institute of Health and Welfare (AIHW) defines older people as 65 years and over.[1] Older people in Australia can experience a range of factors that can lead to an increase in risk of suicide, such as: bereavement, financial distress, social isolation and loneliness, loss of purpose, loss of ability to live independently, living with chronic health issues and existing mental ill-health conditions, and retirement.[2]

In 2020, males aged over 85 years accounted for the highest age-specific suicide rate in Australia (36.2 per 100,000 persons), consisting of 3.1% of all suicides among Australian males.[3] The suicide rate among males aged 85 years and over was 36.2 deaths per 100,000 population which is double that of the suicide rate among all males in Australia (18.6 per 100,000 population).[4] Among females aged 85 and over, the age-specific suicide rate was 6.2 per 100,000 persons. The suicide rates for Australians aged 85 and over among females and males was significantly higher than the age-specific suicide rate in all other age groups.[5] In 2020, the rate of suicide for males aged 65–69 was 17.5 per 100,000 population.[6,7]

Data from the Australian Bureau of Statistics (ABS) reports 37% of people aged 65 and over in Australia were born overseas (1.2 million), and 18% speak a language other than English at home with 6% of older Australians speaking English either not well or not at all.[8]

The ABS has projected that older people in Australia will make up between 21% and 23% of the total population by 2066, an increase from 16% in 2017.[9] It is critical that governments address the suicide prevention needs amongst this growing population.

American research demonstrated the ratio of attempts to dying by suicide is 4:1 among older people compared to 25:1 for adults, meaning they are more likely to die from a suicide attempt than younger age groups, and that their attempt is more likely to result in death than injury.[10,11] Data on suicide attempts among Australian older people is currently not available. Older people express suicidality differently, often with fewer warning signs, and generally choose more lethal means.[12,13]

An international systematic review of suicidal behaviour among people aged 65 years and over found risk factors more associated with suicide attempts to include depressive disorders, psychological factors, and disability.[14] Suicide risk factors found among those who died by suicide included poor medical condition, bereavement, any psychiatric disorder (depression, anxiety and bipolar disorders) and living alone. The Australian Human Rights Commission report one in four older Australians live in poverty, and 7% of the Australian homeless population are aged 65 years and over.[15] Physical conditions and some disabilities are risk factors for suicide that can be reduced if appropriate support is provided among older people.[16]

In our annual State of the Nation in Suicide Prevention survey, over 40% of respondents identified older people as a priority group at risk requiring further support.[17]

TARGETED SUICIDE PREVENTION FOR OLDER PEOPLE

There are a range of environmental and lifespan factors which can increase the risk of suicidality among older people. These can include but are not limited to retirement transition, residential aged care transition, bereavement, and loss of independent living due to health and/or disability conditions associated with aging. Our members report death ideation to be common among older people; which is linked to increased risk for suicide.[18]

A study into suicide deaths among nursing home residents in Australia identified 141 suicides among nursing home residents occurring at rate of 0.02 deaths per 100,000 resident bed days.[19] More than half of the residents who died by

suicide had diagnosed depression and had resided in the nursing home for less than 12 months.[20] The study reported key factors among those who died by suicide as health deterioration, isolation and loneliness, and difficulty transitioning to living in a nursing home.[21]

Transitions from employment to retirement can impact suicidality among older Australians.[22] Research found the risk of attempted suicide among people aged 45 years and over to be higher among those who were not in the labour force and not retired, those who retired involuntarily, and those who were unemployed.[23]

Among older people living in independent living units (ILU), environment, sociability, and relationship breakdown can be factors for suicidality.[24] Research shows for those who live alone in ILUs and don't venture further than the internal floor area of their unit, the strongest relationships between depression/anxiety, loneliness, and suicidality was demonstrated. Furthermore, ILU residents who were divorced were found to be more likely to be depressed or anxious, and married people were less likely to be lonely.[25]

Social isolation and loneliness can have significant impacts and pose harms to both mental and physical health of Australians.[26] Research has shown social isolation to pose more significant health risk than 'smoking, poor diet and lack of exercise'[27], and loneliness has been found to increase the risk of premature death by approx. 30%.[28]

An Australian study reports older people who are single parents, widowed, divorced, or separated experience high levels of loneliness.[29] Approximately one third of older males who are single parents experience emotional loneliness, and older widowed men and separated men also report high levels of loneliness.[30] Older women in de facto relationships report the highest average rates of loneliness.[31]

A review into an older people's aftercare service delivery model in NSW found the existing evidence base for aftercare service models is not suitable for older people based on the threshold for assessment.[32] In addition, a systematic review into aftercare for older people following self-harm identified that dedicated aftercare interventions are required for older people.[33] Older people have different needs to the broader adult population, and suicidality often is not explicitly expressed due to focus on physical health issues, ageism and stigma surrounding underlying mental ill-health conditions. Evidence suggests a lower threshold for referral for aftercare is needed as older people often don't have clear markers for distress, along with early referral to specialist older people's mental health services at the time of suicidality presentation.[34]

International research into the impact of loneliness and suicide in later life in rural China found loneliness, hopelessness, and depressive symptoms to be associated with death by suicide.[35] An elevated risk of suicide in older people in rural China was found among people who were unemployed, living alone, had less social support, experienced symptoms of depression, and showed higher levels of hopelessness and loneliness.[36]

Suicide prevention efforts need to be targeted to addressing older people and be tailored to the risk factors for suicide that are associated with aging in later life. As older people are less likely to seek help for mental ill-health concerns in formal or clinical settings[37,38] , supports for older people at risk of suicide should be co-designed with older people.

EQUIPPING THE PEOPLE-FACING WORKFORCE AS COMMUNITY CONNECTORS THROUGH TRAINING

Studies show that many older people have contact with a general practitioner (GP) in the weeks before self-harming for any motivation (e.g. attempt or not).[39] A qualitative study into how Australian GPs conceptualise self-harm in older patients found that while GPs can identify a range of factors (e.g. physical and mental illness, hopelessness, loneliness, lack of social support) contributing to self-harm, they did not see a role for themselves in addressing these issues.[40] GPs reported lacking confidence, appropriate skills and referral pathways to support these patients.[41]

Similar findings were reported in a study examining the implications of healthcare service use among older people in Australia. It revealed primary healthcare providers are often not equipped with the appropriate tools to provide expert assessment and care planning for complex needs, and may not see this as their role to do so.[42]

An Australian study on emergency nurses found 51% of survey participants recognised suicide as a common event for older people, but only 16% reported receiving suicide prevention training, and 11% felt confident in managing suicidal behaviour.[43]

General practitioners, nurses and health workers should be trained in suicide prevention specific to older people that targets stigma and ageism in assessment and treatment. Research suggests that mental ill-health and suicidality disclosures can be dismissed by health practitioners due to viewing depression as "understandable" and "justifiable".[44]

Our members who provide suicide prevention services to older Australians highlighted ageism as a significant issue impacting older people. Common narratives of attitudes exist that normalise experiencing depression, burden, and suicidality among older people as a result of aging.[45] According to a recent report released by the Australian Human Rights Commission, ageism is the most accepted form of prejudice.[46] Ageism and mental ill-health stigma can be fundamental barriers to help-seeking among older people, with many stigmatising views shared by the older people themselves around aging and mental ill-health.

Another Australian review further identified ageism as a significant barrier to the effectiveness of suicide prevention among older people due to differences in their help-seeking and service use behaviours, and suicidality presentations and outcomes.[47]

NSW has funded older persons suicide prevention gatekeeper training for three years due to the high rates of suicide among men over 85 years of age, and as older people are less likely to seek the help of a mental health professional.[48] The training educates on the common causes of suicidal behaviour, warning signs and how to question, persuade and refer someone who may be suicidal. In a three month follow up evaluation of the training program, 40% of respondents reported experiencing an encounter that required using knowledge of suicide prevention to assist an older person in crisis, and 100% of respondents were able to connect and empathise with the person in need of assistance.[49] Also, 70% reported being able to directly ask the person about their suicidality, and 40% were able to successfully assist the person with a referral.[50]

Suicide Prevention Australia supports the Royal Commission into Aged Care Quality and Safety Final Report recommendation to enhance the current aged care workforce through training and education which includes mental ill-health (Recommendation 114),[51] and believe this can be strengthened by including suicide prevention for senior Australians, and suicide prevention training for support at home staff who deliver aged care in people's private homes. We further support Recommendation 59, that Australian governments fund outreach to older persons mental health services, and Recommendation 61 to enhance access to mental health assessments in residential aged care and allied health services.[52]

State and territory governments should roll out targeted community connector suicide prevention training specific to older people, for face-to-face workers who are likely to encounter older people who may be experiencing suicidality. This is to ensure older people receive the support they need.

SOCIAL ISOLATION AND LONELINESS AMONG OLDER PEOPLE

In Australia, 19% of people aged 75 and over experience loneliness.[53] Research further reports that 50% of individuals aged 60 years and over are at risk of social isolation, with one third who will experience loneliness in later life.[54]

The COVID-19 pandemic is likely to have exacerbated loneliness among older Australians due to physical distancing

measures, difficulties in adapting to technology resulting in social isolation (e.g. not going places to avoid using QR codes, difficulty connecting online with family and friends), fear and anxiety of contracting COVID-19 due to higher risk of fatality from the disease, and avoid accessing necessary healthcare due to online modes of service delivery.

A survey of the experiences of older Australians during the COVID-19 pandemic further identified that financial distress, challenges in their caring responsibilities, barriers to accessing carer supports, and social isolation and loneliness were heightened during the pandemic.[55]

Alternative and innovative approaches to addressing loneliness are emerging overseas. For example, 'social pescribing' or 'non-medical prescribing', which involves the process of healthcare providers referring people in the community to existing community-based non-clinical supports. These supports may include social support services, volunteering opportunities, arts activities, community gardens, and community groups. Research estimates that approximately 20% of the people who consult their GP, do so for social issues.[56] The Victorian Royal Commission into mental health recommended in the final report (Recommendation 15) to implement a social prescribing trial in each region in Victoria by the end of 2022.[57]

Many neighbourhood and community centres are often first responders to distress in the community and provide critical place-based infrastructure. The Royal Commission into Victoria's Mental Health System reported evidence that the declining role of community-based organisations and supports can increase feelings of social isolation.[58]

While we don't know the economic impact loneliness has on the Australian economy, in the US it is estimated that a lack of social connection among older adults can cost the government approximately $6.7 billion per year.[59,60]

Commonwealth, state and territory governments should support alternative measures to address social isolation and loneliness among older people (e.g. social prescribing and community-based programs and interventions in community spaces) as part of primary healthcare and preventative strategies, including funding to support the 'link worker' and peer workforce.

MORE RESEARCH IS NEEDED

Further research and funding opportunities are required to encourage research specific to older persons mental ill-health and understanding suicidality among senior Australians. Given the environmental and lifespan risk factors for suicide associated with ageing, suicide prevention research is needed specific to a variety of senior settings including aged care facilities, older people living in assisted living units, and older people who live independently.

To be able to effectively target suicide prevention efforts, national datasets that provide demographic data are required. The Commonwealth Government should fund national research specific to older persons' mental ill-health and understanding suicide among older Australians.

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There are crisis services available 24/7 if you or someone you know is in distress

Lifeline: 13 11 14
www.lifeline.org.au

Suicide Call Back Service: 1300 659 467
www.suicidecallbackservice.org.au

Acknowledgements Statement

Suicide Prevention Australia acknowledges the unique and important understanding provided by people with lived and living experience. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. Advice from individuals with lived experience helped guide the analysis and recommendations outlined in this policy position.

As the national peak body for suicide prevention, our members are central to all that we do. Advice from our members, including the largest and many of the smallest organisations working in suicide prevention, as well as practitioners, researchers and community leaders is key to the development of our policy positions. Suicide Prevention Australia thanks all involved in the development of this policy position.