



SUICIDE IN OLDER PEOPLE: TRENDS, APPROACHES AND FUTURE CHALLENGES

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Suicide is a human tragedy; one which extends to people of all ages. Globally, it remains a significant cause of premature death, with the World Health Organization estimating 804,000 suicide deaths occurred worldwide in 2012; representing an annual global age-standardized suicide rate of 11.4 per 100,000 population (15.0 for males and 8.0 for females). Today, older adults have higher rates of death by suicide than younger people in most countries of the world, typically highest in those aged 70 years or older for both men and women and it has been consistently reported in the literature that one older person dies by suicide for every four attempts.

More recent data reporting in Australia by the National Coronial Information System reveals 5360 self-harm fatalities of persons aged 65 and over were reported to state and territory Coroners between

July 2000 and December 2015. The total number of deaths comprised persons aged 65-74 (2630- 49.1%), 75-84 (1887 - 35.2%) and 85 and over (843- 15.7%). Men comprised 4120 deaths (76.9%) and women comprised 1240 deaths (23.1%). Although such data are sensitive to the accuracy of the registration of the causes of death, suicide among older adults remains a significant concern.

Despite the current high rate of suicide in older people, suicide rates among the elderly have, in fact, declined dramatically over time. Examination of rates among people aged 65 and over in the United States from 1933 to 1978, demonstrates that declines for older people as a whole have predominantly been produced by decreases among men, whereas decreases among women's rates have had little impact. Continuing this trend, both adult

and elderly suicide rates across Australia have declined, albeit irregularly, between 1964 and 1996, with a concomitant rise in suicide rates for youth. A critical question is why these trends in decline have occurred for older people. According to at least one observer, how much of the decrease might be the result of the use of psychotropic medication is not known, or of increased therapeutic efforts on the part of suicide prevention programs, centres and community mental health programs; or the increased socio-economic security and health care resulting from the implementation of Social Security and Medicare legislation. All are possible factors.

Declines over time may be more attributable to improvements in the quality of life of older people. This suggestion was also recently echoed by leading

scholars in the field. During the 2017 regional meeting of the International Association for Suicide Prevention (IASP) World Congress, broad consensus was reached that despite well-intentioned efforts, suicide prevention for older people may in fact be having paradoxical effects. Adding further complexity is the societal debate about - and in some countries the legalisation of - assisted suicide for older people; a debate that is now garnering unprecedented international momentum. Traditionally, such discussions have centred on the rights of those living with terminal or life-limiting illness to request assistance in dying from their physician as a way of relieving intolerable suffering. However, old age rational suicide has been defined as nonimpulsive suicide driven by what is perceived to be an irremediable poor quality of life (in the context of ageing) and not prompted by an underlying psychiatric illness. Taking this viewpoint into account, perhaps an even greater paradox is that as improvements in quality of life and life-sustaining measures may mitigate suicide in older people, they are also significantly contributing to increases in life expectancy. With numbers of older adults rapidly expanding throughout the world (particularly in those aged 80 and over) it is forecast that the absolute number of deaths by suicide in older adult populations is likely to increase over the coming decades.

This prediction was the impetus for the formation by IASP of the 'Suicide among Older Adults' task force during the IASP World Congress in Durban, South Africa in 2005. Among the initiatives of this peak international body are supporting research and networking between researchers dedicated to the study and prevention of suicide in older adults through international conference symposia, conduct of systematic reviews and internationally collaborative research projects. But despite a growing body of work that has seen significant contributions to theory, research and knowledge translation, the field of older adult suicide prevention remains in its relative infancy. Internationally, 'suicide prevention' is typically organised around the identification of discrete goals that are targeted to reduce overall rates of suicide.

Such measures include reducing harm in high risk groups; promoting well-being in the broader population; reducing access to and lethality of means; improving the reporting of suicide and suicidal behaviours in the media and promoting research; with the major aim of achieving an overall reduction in the number of deaths by suicide. However, the current approach to how the federal government commissions suicide prevention services in Australia has led to a system that has been described as 'complex and fragmented.' Currently, older people are underrepresented in national and state policy directives and NSW is the

only state in Australia with a dedicated suicide prevention network aimed at this segment of the population.

Perhaps of greatest significance, suicide prevention in terms of policy, practice and research has long been led by medicalised discourses that have placed a disproportionate emphasis on risk and risk factors including mental illness. An overreliance on psychology and psychiatry in developing strategies for suicide prevention has largely squeezed out other ways of interrogating suicide or making recommendations for suicide prevention. Accordingly, the risk is to only think about suicide almost solely in terms of individual mental illness and risk. This has given rise to commentary that, as a consequence, "an individualised, 'internalised,' pathologised, depoliticized and ultimately tragic form of suicide has come to be produced, with alternative interpretations of acts of self-accomplished death marginalised or foreclosed".

In contrast, Suicide Prevention Australia's national action plan Transforming Suicide Prevention Research is grounded in a principles-based approach which aims to assist in determining priorities for suicide prevention research, funding and policy directives. Importantly, the plan emphasises that such principles should focus the system on 'the needs of people, their families, communities and the overall health and wellbeing of the Australian population'. Equally, such research should be ethical, meaningful and informed by the voice of lived experience. However, re-vision of approaches to suicide prevention does not only extend to policy and research; care provision to the older person must be delivered by a workforce ready and inspired to think differently about suicide in older people. For example, the growing need to acknowledge that older people's values are expressed in a multiplicity of ways and that it is quite plausible that an older person may choose to 'reject a life lived without pleasure in the specter of a future bad death'.

Nonetheless, Karen Hitchcock's poignant contribution to the Quarterly Essay entitled *Dear Life: On Caring for the Elderly* makes a persuasive case for a life-affirming approach in all of life (and death's) manifestations. But as Hitchcock warns, such an approach comes at a price: 'to offer truly adequate care, however, will necessitate major system overhauls: better care, not less care'. Both arguments are equally compelling - and needed. Regardless of the stance we take, we must occupy a position ultimately grounded in the understanding of an older person's suicidal distress and the meanings they attribute to living (and dying). Moreover, we must locate this approach within the context of cultural and ethical social relations.

Preventing suicide in the elderly means taking account of events and experiences that interact with each other. This is because in most cases, suicide results from a combination of factors rather than a single cause. At the population level, recent research suggests that key risk factors for suicide among older adults include mental ill health (particularly depression), substance use problems (including abuse of prescription medications), physical ill health, disability and pain, social isolation, stressful life events and accumulative losses. As with suicide among other groups, access to lethal means is also a key consideration. For some individuals who seek to die by suicide, the interval between thinking about and acting on suicidal urges is usually a matter of minutes. If individuals identify a potentially lethal method to kill themselves, such as drinking poison, ask "Do you have access to this method?" Additionally, for each lethal method, ask "How can we go about co-developing a safety plan to help ensure that you and your environment are safer, so that you'll be less likely to use this method to harm yourself?" The person should leave the encounter they have with the mental health worker with specific safety and contingency plans that address each of the foreseeable changes (or tipping points).

In addition, protective factors that may buffer the risk of suicide in older individuals include receiving effective therapeutic care for mental and physical health problems, social connectedness, having a sense of belonging, purpose or meaning, as well as effective skills in coping and adapting to change. For some older persons, cultural or religious beliefs that discourage suicide are also known to be protective. In mental health nursing, the emphasis should be on helping the therapeutic relationship enabling the person to feel felt. When therapeutic relationships are not intimate they are of limited protective value.

References available on request.

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