INSIGHTS

A SERIES OF EVIDENCE SUMMARIES

69

Suicide thoughts and behaviour in later life

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Key points

- The unique factors which contribute to suicide actions in later life are often more difficult to recognise than contributing factors in younger individuals.
- Suicide thought may be passively expressed and can be triggered by the experience of existential loneliness or a sense of a 'completed life'. This can give rise to self-neglect, particularly of one's own health, and death hastening behaviour such as the voluntary stopping of eating and drinking, as well as more purposive suicide acts.
- Taking a life course including a trauma-informed approach can help practitioners identify contributory risk and protection factors.
- Ageism and stigma can mean that suicidal thought and action are less likely to be recognised in later life.
- Existing suicide prevention interventions are not sufficiently nuanced for older people.
- Practitioner skills and knowledge on how to screen, approach and discuss the topic of suicide in later life should draw on principles of time, space, and compassion.

Introduction

Suicide prevention is a priority for public health. The United Nations and the World Health Organization have coordinated a global response to suicide prevention (WHO, 2014). In the UK, suicide prevention strategies are developed by its four devolved governments. Documentary analysis of sampled strategies, however, revealed that these strategies say relatively little about people in later life (Hafford-Letchfield and colleagues, 2021).

Suicide rates in many countries are higher among older people in comparison with other age groups (Shah and colleagues, 2016). An analysis of trends in deaths by suicide over the past five years in Scotland shows that rates of suicide have fallen for most age groups, except for those aged 45-54 years and in females aged 55-64 years (Barry and colleagues, 2022). More recently, age related data on completed suicide in Scotland shows an increasing trend over the age of 65 since 2020 (NRS, 2022). High rates of suicide among older adults are thought to be a consequence of the ageing population demonstrating more determined and planned suicide acts, coupled with fewer warnings, or detection of suicidal intent.

For instance, self-harm and suicide behaviour in older people is more likely to result in death, compared to younger age groups (Monforte-Royo and colleagues, 2011; Wand and colleagues, 2018).

The prevalence of suicide in later life may also be under-estimated and under-recorded due to its unique presentation. Deaths in older people that result from more passive acts of suicide, such as the voluntary stopping of eating and drinking (VSED) and refusing medication, are unlikely to be formally investigated as potential suicide deaths and are, therefore, less likely to be recorded (Deuter and colleagues, 2016). Such acts may be considered a rational decision, or interpreted as a legitimate exit, when people experience dramatic changes in social status and role (Berniere and colleagues, 2020; Hafford-Letchfield, 2022a).

Ageism in society has also been identified as a barrier to people seeking help and getting support (Ayalon and Shiovitz-Ezra, 2011). Structural ageism and internalised stigma can promote views that poor physical and mental health is a normal part of ageing, which may in turn not be routinely investigated or treated (Stanley and colleagues, 2016).

The field faces challenges in relation to how suicide thought and behaviour in later life is recognised, and whether a specific model for late life suicide can provide an enhanced understanding of the ageing experience (Van Orden and Conwell, 2016). An emerging body of evidence articulated in this guide describes how aetiology, epidemiology and presentation of suicide thought and actions during later life is a different phenomenon from that experienced in other times of the lifecourse.

AIMS

This *Insight* is targeted at:

- Practitioners who work with older people and may want to know more about how to address suicidal thought and behaviour in this population
- Specialist suicide prevention providers who are interested in tailoring their existing services for people in later life (by 'later life' we mean people aged 65 years or older)

It summarises the key messages from the research evidence and emerging themes on how to improve recognition, responsiveness, and access to support.

The policy context

The Scottish Government and the Convention of Scottish Local Authorities (COSLA) developed *Scotland's Suicide Prevention Plan* (2022-2025), *Creating hope together*. This makes specific reference to older adults in outcome three and action area five. It calls for a compassionate response and to develop new approaches to prevent suicidal behaviour in older adults, with a focus on delivering action in key settings. This includes engaging with people with lived experience; reviewing and synthesising the evidence around the needs, risk and protective factors; effective responses; and implementing learning from reviews of suicide deaths in older adults.

While the plan addresses the suicide prevention needs of the whole population – especially where there are known risk factors, such as poverty, or being from marginalised or minority groups – there is less research and fewer interventions aimed at suicide prevention skills specific to people in later life. *A fairer Scotland for older people* (Scottish Government, 2019) aims to address barriers and deliver improvement that tackles inequalities for people in later life that are also known to impact on suicide. There are resources

available to enhance the capacity of the workforce in this area through building skills and knowledge (NHS Scotland and Public Health Scotland, 2022).

Overview of the body of evidence

Research suggests that there are a range of unique factors that contribute to suicide thought and behaviour in later life. These include increased social isolation, childhood and/or life-long trauma(s), cumulative loss and complicated bereavement experiences, financial distress, material disadvantage, feeling like a burden and deteriorating health that can increase with age (De Leo, 2022; Hafford-Letchfield and colleagues, 2022b).

There have been several reviews exploring ageing in relation to suicidal behaviours. Some have focussed on exploring this topic from a theoretical point of view (Stanley and colleagues, 2016), while others have focussed on specific risk factors such as socioeconomic status (Ju and colleagues, 2016), the social determinants of health (Carvalho and colleagues, 2020; Dautovitch and colleagues, 2021) and gender (Heisel and colleagues, 2020).

A conceptual framework for suicide-related expression in later life

Hafford-Letchfield and colleagues (2022b) developed a conceptual framework from a scoping review of the literature which describes how we might better understand the pathways to suicide in later life. This framework captures the complexity of terminology used to describe suicide related behaviours and presentations unique to ageing. This provides a first step in helping policy makers, researchers, professionals, and people who work and live with older adults to progress towards identifying more tailored preventive measures and early interventions targeting suicide-related behaviours that are unique to, but common in, later life. The remainder of this Insight draws on this conceptual framework to summarise some of the key themes from this body of work.

Four key concepts on suicide expression in later life, the relationship between each, and factors that protect against their development are described in Figure 1 (below).

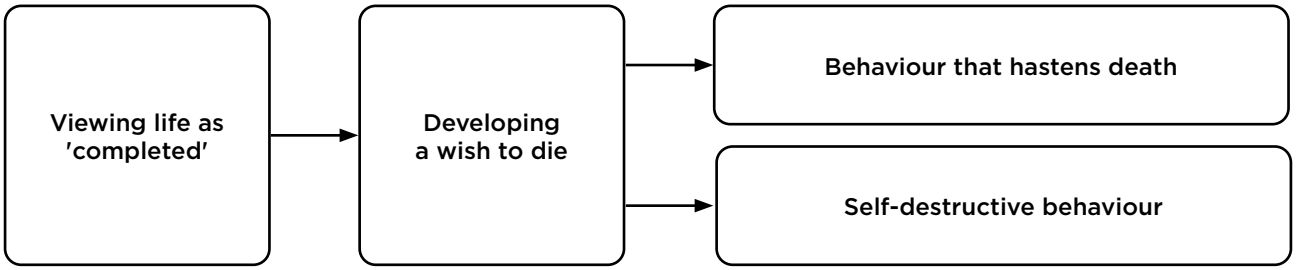
The four concepts are:

1 Completed life and existential loneliness (including feeling 'tired of life')
2 Death wishes, thoughts, and ideation
3 Death hastening behaviours and advanced directives (eg, voluntary stopping of eating or drinking)
4 Self-destructive or self-injurious behaviours (including self-neglectful behaviours).

Based on the identified protective factors, we recommend that those working in social care and social work aim to develop an enhanced understanding of older individuals' conditions or attributes (living environment, conditions, skills, strengths, resources, personal character, support networks or coping strategies). This will aid strategies designed to enhance protective factors, as well as inform the development of any psychosocial or peer-led interventions to prevent the development of the identified suicide expressions.

VIEWING LIFE AS COMPLETED

Richards (2017) described a 'sense of a completed life' as feeling unable or unwilling to connect or feeling disconnected with life. A major theme was the person's anxiety about further loss of self-determination and self-sufficiency in their future.



Protective factors: social connectedness; satisfaction in one's social life; high level of purpose; perceived control over one's life; low levels of perceived burdensomeness and/or hopelessness; low levels of functional disability.

Figure 1. A conceptual model of the 'grey areas' of suicide-related expression in later life (Hafford-Letchfield and colleagues, 2022b)

Existential loneliness has been differentiated from other types of loneliness where people feel isolated and acutely aware of their own mortality. A synthesis of studies (Bolmsjö and colleagues, 2019) revealed that failure to have needs met in a crisis and lack of authentic communication gave rise to overwhelming negative feelings, emotion or moods including sadness, hopelessness, grief, meaninglessness and anguish.

DEVELOPING A WISH TO DIE

Monforte-Royo and colleagues (2011) talk about the lack of terminological and conceptual precision in defining the construct of death ideation in later life, and the need to distinguish between a generic wish to die, the explicit expression of a wish to die, and a request for euthanasia or physician-assisted suicide.

Further differentiation between thoughts, wishes and intentions has been associated with a diagnosis of depression (Raue and colleagues, 2010) which is significantly associated with increased mortality. However, Fässberg and colleagues (2012) found that most of their participants (77.4%) who reported thinking about their own death at least once per month were not diagnosed as depressed.

Studies exploring why a wish to die in later life develops, point to feelings of being a burden and hopelessness (Guidry and Cukrowicz, 2016); a dissatisfaction in one's social life (Bernier and colleagues, 2020); viewing one's life as having no purpose; and perceiving a lack of control over one's life (Bonnewyn and colleagues, 2014). Changes in health that impact day to day functioning (Fässberg and colleagues, 2016), problematic drug and alcohol use (Cavalcante and Minayo, 2015) and personal experience of violence, and abandonment in earlier life, are also associated with the wish to die.

These findings suggest that a wish to die by suicide is expressed in highly complex ways through an older person's life course. Personal character, coping strategies and social support play a role in the way that individuals deal with challenging events or situations (Rurup and colleagues, 2011). Balancing positive and negative feelings towards living and dying was important in whether the person went on to complete suicide (Van Wijngaarden and colleagues, 2016).

BEHAVIOURS THAT HASTEN DEATH

Actions that hasten death may include voluntary and or/deliberate stopping of eating and drinking (VSED),

which highlight ethical debates and considerations (Rodríguez-Prat and colleagues, 2018). Advanced directives, for example, can be extremely complex where the person is living with dementia (Steinbock and Menzel, 2018; Trowse, 2020).

Stängle and colleagues (2019) attempted to distinguish between different forms of VSED, its cause and associated intentions. Exploring meaning in the wish to hasten death in patients with advanced illness indicated that VSED may be a response to physical, psychological and/or spiritual suffering; a means of taking control and a deliberate expression of personal autonomy (Rodríguez-Prat and colleagues, 2018). The research indicates the importance of exploring all possible areas of distress to include existential and social aspects, as well as the legal context.

In England, care staff participating in a study by Hafford-Letchfield, and colleagues (2020) described a sense of helplessness in not knowing what to do when care home residents 'gave up' (ie, engaged in death hastening behaviours). Staff expressed tensions in providing the right support and creating spaces to respond to such challenging situations. Person-centred care helped to alleviate personal stressors, as did investment in relationships within which the resident could confide and express themselves. Building a team around them required appropriate expertise and indicated a need for improved training. Engaging residents in expressing their wishes around dying, care and safety planning particularly when transitioning into more dependent care was recommended in supporting older people living their final years in care home settings.

SELF-DESTRUCTIVE BEHAVIOUR

This can include self-harm[1], indirect and direct self-destructive or self-injury through purposive actions. A review of the prevalence, risk factors and characteristics of self-harm in later life (Troya and colleagues, 2019[2]) found moderate evidence that a previous history of self-harm, previous and current psychiatric treatment, and sociodemographic factors (single, living alone and younger older adults aged 60–74 years old) were significant risk factors for repletion of self-harm. Alcohol/drug use, female

1 Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act, and is an expression of emotional distress" (National Institute for Health and Care excellence (NICE) Guidelines, CG16 & 133).

2 In this review, the NICE definition was used and did not include indirect self-harm (eg, refusal to eat/drink, self-neglect).

gender, psychiatric history, and a diagnosis of musculoskeletal conditions such as arthritis were also associated with repetition of self-harm.

One review looked at self-injurious behaviour in people with dementia living in nursing homes (Mahgoub and colleagues, 2011). The most common direct self-injurious behaviour included self-pinching, scratching, and banging one's fist against objects or less commonly, pulling one's own hair and self-hitting. Wand and colleagues (2018) examined the reasons why older people have self-harmed and suggested that both active and passive self-harm should be considered as distinct entities as the underlying motivations and intentions differ. They also observed that for some older people self-neglect may reflect impaired coping skills or cognitive impairment.

Older adults who self-harm have a sixty-seven times higher risk of suicide compared with younger populations (Murphy and colleagues, 2012). There is increased risk of repetition in those with a previous history (Troya and colleagues, 2019). Socio-demographic factors including being single, living alone and being a younger older adult (60–74 years old), were more strongly associated with its repetition.

Time spent in hospital with self-harm is longer and medical complications are more likely. As most studies are based in hospital settings, our knowledge of self-harm is not representative. It does not consider self-harm that does not result in hospital admission.

Troya and colleagues' (2019) study focussed specifically on self-poisoning which they found to be distinctive in later life compared with other populations. This is possibly due to increased access to prescribed medication for complex health problems and antidepressants (Hedna and colleagues, 2020).

Screening, assessment and help-seeking

A key feature in preventing suicide is to accurately and routinely assess and screen for suicide ideation. There is a need for more age-specific screening and diagnostic measures (Gleeson and colleagues, 2021).

Currently, there is little consensus as to how best to screen for suicide ideation in older people and how to assess wider factors described earlier. This points to the need for holistic psychosocial assessment. Professionals may lack training in

how older people express concerns about their mental health, or in recognising the subtle clues that suggest more passive expressions of suicide.

Screening of suicide ideation in older people is not routine across settings, especially outside of health (Gleeson and colleagues, 2021). Numerous studies have highlighted a reluctance to speak openly about mental health among this generation (eg, Hafford-Letchfield and colleagues, 2022a). In contrast, there is a preference for talking therapies among older people given that those over 85 years are up to a third more likely to be prescribed antidepressants compared to those between 55 and 85 years (Frost and colleagues, 2020).

Older people, however, may not be offered talking therapies. They may be reluctant to discuss psychological or emotional distress with care professionals, have low expectations and experience self-stigma (Hafford-Letchfield and colleagues, 2022a). Many older people who die by suicide have been shown to have visited a GP in the previous 30 days where they discussed problems that were somatic in nature rather than psychological (Neufeld and O'Rourke, 2009). Additionally, GPs report that they do not always have the time and sensitivity needed to properly uncover and respond to these issues (Frost and colleagues, 2018).

Suicide screening may also decrease with increasing age. Wider screening for suicide ideation in older people, across a range of social care settings, may be indicated. Screening and assessment could take more account of protective factors by asking questions about social connections and support and to ensure cultural sensitivity towards marginalised groups (Gleeson and colleagues, 2021). Helping people to identify risk reduction interventions, such as therapeutic support and collaborative safety planning, could lead to enhanced safety and quality of care, which is more acceptable to people. It promotes a sense of hope and agency (McLaren and colleagues, 2022) by identifying and encouraging an individual's own psychological resources and resilience in working towards their own goals when challenges arise. A study of lay perspectives on suicide thought in later life (Hafford-Letchfield and colleagues, 2022) identified that relationship and language are key in enabling discussion and the importance of professionals learning to identify implicit/passive suicidal expressions in later life and being willing to take up opportunities to address it.

BEREAVEMENT BY SUICIDE

While there is some work to explore suicide bereavement support (McDonnell and colleagues, 2020; Scottish Government, 2022) there is limited work focussing on the experiences of suicide bereavement of those aged 60 years old and over. Only two studies have specifically explored age related factors on the impact of a suicide and how people re-orientate their later lives after such a devastating loss (Hyboldt and colleagues, 2020; Hafford-Letchfield and colleagues, 2021).

The absence of suicide bereavement support at any stage in life, contributes to a person's lack of self-care, and for some, leads to extreme post-traumatic stress. For example, the loss of a significant person by suicide can heighten the awareness of growing older alone and developing a fear of becoming more vulnerable (Hafford-Letchfield and colleagues, 2021; Hyboldt and colleagues, 2020). Experiencing a bereavement by suicide can also increase the likelihood of subsequent suicidal behaviours for the bereaved (Hafford-Letchfield and colleagues, 2021).

The practice implications of these findings point to asking about history of suicide bereavement and how this experience has affected the person's life and their current wellbeing.

Summary

Early detection of expression of these different areas is crucial. Expressions of living a completed life may transition to a desire to die or attempts to hasten death (Hafford-Letchfield and colleagues, 2020), and appear to precede direct suicide attempts (Kjølseth and colleagues, 2010). Being able to differentiate these from a broader acceptance by people that their lives are coming to an end or the sense of a completed life, is important as a wish to die can manifest independently of diagnosed depression. There are also wider narratives on the value of some people's lives over others, and tensions with

> The belief that life is not worth living is likely to represent dissatisfaction with quality of life and is essential to discuss

desires for agency and control. These are reflected in the debates on euthanasia and assisted dying (Scottish Parliament, 2019).

More importantly, the belief that life is not worth living is likely to represent dissatisfaction with quality of life and is essential to discuss with individuals facing such circumstances – as are wishes to die/suicide ideation. This calls for closer examination of the impact of service culture and service quality on people's experiences.

Implications for the social services workforce

ADOPT THE RIGHT APPROACH

Practitioners supporting or caring for older people need the right language, confidence, and skills to discuss issues concerning suicide thought and actions in later life. This is required for them to take the initiative and articulate their concerns when these are observed. It includes knowing where and when to sensitively seek appropriate and expert advice and support, and being able to access learning resources to enhance the capacity of the workforce in this area through building skills and knowledge (NHS Scotland and Public Health Scotland, 2022).

DEVELOP EARLY INTERVENTION STRATEGIES

The development of early intervention and prevention strategies in response to early expression could focus on protective factors that addresses the range of issues that contribute to suicide thought and behaviour such as promoting participation, autonomy and person-centred support.

UNDERTAKE TRAINING

Given the risk of suicide in later life, and some of the unique ways in which it may be expressed (existential loneliness, wish to die, self-neglect), all staff working with people in later life should be trained to recognise and improve awareness at the everyday level. This is where subtle interactions take place, such as in personal care or in the person's own home environment. Interdisciplinary work can encourage ethical reflexivity in relation to improving the quality of life of people who prefer to die than to continue living.

ENCOURAGE PARTICIPATION

Involve people and their carers in discussing mental health and wellbeing in later life. Consider community asset-based approaches that compliment medical interventions to address common issues such as loneliness, and that tackle the interpersonal and structural impacts of ageism.

NORMALISE DISCUSSION ABOUT COMPLETED LIFE

Recognise the impact of service culture and service quality on people's experiences. Make active use of tools that promote end of life planning and advanced directives. Normalise opportunities to talk, review and express people's thoughts and fears about their completed life without being silenced or accused of being morbid, and use care plans to revisit and review any concerns about mental health and suicide ideation.

BE TRAUMA INFORMED

Adopt a trauma-informed approach to service delivery, acknowledging the importance of adopting a non-pathologizing and strengths-based approach to help prevent possible re-traumatisation of older adults within practices.

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Jolie Goodman is an artist who has worked from a survivor perspective in mental health for over two decades. Before going freelance last year, she was Programmes Manager for Empowerment & Later Life for the Mental Health Foundation. Jolie's daily drawing practice can be seen on Instagram @jolie.goodman.

Dr Jeffrey R Hanna is a Research Associate at the Institute of Nursing and Health Research, Ulster University. His research interests and profile include cancer care, bereavement, suicide prevention and positive mental health outcomes. Alongside this, he is undertaking an MSc in Professional Nursing at Queen's University Belfast.

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