Suicide Prevention
for Older People

Early intervention, assessment and referral options for staff working with older people who may be at risk of suicide

Training Manual
FOREWORD

Preventing suicide requires an holistic approach to service delivery requiring a range of organisations and individuals working in partnership. One of the key focus areas in NSW is to enhance the effectiveness of individuals working with older people at risk of suicide. While not all suicide deaths can be prevented, effective and appropriate early intervention at the right time may help to prevent some suicide deaths. The diversity of circumstances and psychological factors that may lead people to attempt suicide need to be considered in implementing effective prevention strategies. Therefore, of particular importance to suicide prevention are the many staff, across a variety of settings, who work with older people.

The Suicide Prevention for Older People, Training Manual, is designed to improve the awareness of suicidal behaviour in older people. In addition, it aims to provide workers with information about early intervention and assessment strategies, and how to refer older people to appropriate services.

This one-day training package was initially developed by the South Western Sydney Area Health Service (SWSAHS), in consultation with the Elderly Suicide Prevention Network – ESPN (NSW), and the Centre for Mental Health. In a second phase of development, the Hunter Institute of Mental Health conducted seven pilot workshops across four Area Health Services in NSW to further enhance and refine the package.

This training package is commended in addressing suicide prevention training for older people. We hope this manual becomes a valuable resource for all those involved in caring for older people.

Professor Beverley Raphael
Director
Centre for Mental Health

Dr Scott Clark
Area Director for Mental Health
South Western Sydney Area Health Service

Professor Trevor Waring
Director
Hunter Institute of Mental Health

Mr Matthew Dougherty
Chair
ESPN (NSW)
# CONTENTS

<table>
<thead>
<tr>
<th>Page Range</th>
<th>Section Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-6</td>
<td>Instructions for educators</td>
</tr>
<tr>
<td>7</td>
<td>Summary of workshop</td>
</tr>
<tr>
<td>9-24</td>
<td>Session 1: Overview of ageing, mental health and suicide</td>
</tr>
<tr>
<td>25-42</td>
<td>Session 2: Understanding suicide risk in older people</td>
</tr>
<tr>
<td>43-54</td>
<td>Session 3: Working with older people at risk of suicide</td>
</tr>
<tr>
<td>55-68</td>
<td>Session 4: Ongoing care and support of older people</td>
</tr>
</tbody>
</table>

**Overhead transparency masters:**

1. Workshop overview
2. Questions about ageing, mental health and suicide (2.1-2.6)
3. Session 1 summary
4. Difference between suicide rates and numbers
5. Lifespan perspective of suicide rates
6. The ageing population
7. Suicide in older people
8. Weighing up the risk
9. Understanding the continuum of suicidal behaviour
10. Levels of risk
11. Session 2 summary
12. Mental health problems in the elderly
13. Differentiating depression, dementia and delirium
14. Responding to older people at risk
15. Factors to consider before asking questions
16. Types of questions to ask an older person
17. Session 3 summary
18. Care and Support Options (18.1-18.3)
19. Information required by the referral agency
Handouts:

1. Workshop overview
2. Presenting concerns of older people
3. Research on attitudes to ageing, mental health and suicide
4. Suicide terminology
5. Lifespan perspective of suicide rates
6. Suicide rates for older people in NSW
7. Issues surrounding suicide in older people
8. Resilience and risk factors for suicide in older people
9. Depression
10. Delirium, dementia and depression
11. Anxiety disorders and depression
12. Psychosis and depression
13. Treatment of mental health problems in older people
14. Vignette
15. Questions for identifying older people at risk
16. Information required by referral agencies
17. Vignettes
18. Policy Directions
19. Resources

Appendices:

1. Further notes for educators
2. Description of a needs assessment
3. Example of an attendance list
4. Example of an evaluation questionnaire
5. Example of an attendance certificate
6. Acknowledgements
7. References
ICONS INDEX

Throughout this training manual you will encounter the following icons:

The presentation icon
This will indicate that a new concept is to be introduced and discussed by the educator.

The overhead icon
This will signify that an overhead transparency will need to be utilised.

The activity icon
This will indicate that a learning activity will need to take place. The type of activity will be identified in the heading below the icon, and may include brainstorming, a small group exercise or a large group discussion.

The handout icon
This will signify that a handout will need to be distributed to the workshop participants.

The video icon
This icon indicates where the video scenario “Asking questions about suicide” is to be played. The video is an accompaniment to this module.
INSTRUCTIONS FOR EDUCATORS

The **Suicide Prevention for Older People: Training Manual** provides a guide for mental health educators on how to conduct a one-day workshop focusing on suicide prevention and older people. This workshop has been designed to provide education on suicide prevention for older people for both health and non-health workers. The appropriate target audience are workers with **clinical and/or assessment and referral responsibilities for older people**.

The workshop focuses on understanding suicide risk in older people, strategies for early intervention and prevention, as well as methods of responding to varying levels of risk.

**Programme**

The workshop is divided into four training sessions of one and a half hours each (except session one which is 1 hour 45 minutes) in length that are presented over one day or across several sessions, depending on local needs.

- **Session 1** Overview of ageing, mental health and suicide
- **Session 2** Understanding suicide risk in older people
- **Session 3** Working with older people at risk of suicide
- **Session 4** Ongoing care and support of older people

**Educator skills**

Training in suicide prevention is a demanding role. For this reason, it is advised that **two educators conduct each workshop**. At least one educator should have worked in a clinical setting with older people with suicidal behaviour. One educator should manage the content of the training and one should monitor and respond to group reactions. Some participants may have experienced the loss of a friend, relative or client through suicide death. The workshop contains confronting issues for all people, however, those who have been bereaved may be particularly affected. Part of your role in conducting the workshop is to ensure participant safety and wellbeing. It is important to reiterate that participants should do whatever they need in order to feel...
secure. This may include working privately rather than in a group, leaving the workshop for a period of time or discussing issues with you or someone else after the workshop.

It is recommended that educators hold a planning meeting prior to the workshop to clarify roles. In the planning meeting it will be important to discuss the specific needs of the participants, who will facilitate each session and the collation of training materials.

It is important that educators have sufficient background knowledge on older people, mental health issues and suicide prevention in order to effectively facilitate the workshop. Educators may wish to use the reference list (appendix 7) to obtain further information. It is also important for educators also keep up-to-date on changes in the field of suicide prevention for older people by regularly reviewing new literature, policies and guidelines.

**Training approach**

The workshop utilises a number of individual and group strategies that acknowledge and build on the skills of the adult learner. These strategies are designed to enhance the learning experience of participants by allowing an opportunity for issues to be explored and ideas shared. The workshop uses a number of strategies to facilitate learning:

- Large group discussions and brainstorms to explore ideas and complex issues
- Presentation of new concepts including the use of overheads
- Small group exercises and activities to integrate learning
- Handouts to provide a summary of the information presented for later reference.

**Equipment**

Educators will need to obtain basic training equipment to conduct the workshop. This will include:
- An overhead projector
- Butcher’s paper and markers
- A whiteboard and pens
- A VHS video recorder and television (for session 3)

**Note** – a PowerPoint presentation has been developed for educators who are more comfortable with this presentation medium, and is provided as a supplement to this training manual.

**Number of participants**

The recommended number of participants for the workshop is twenty. This number is suggested as the workshop is intended to be interactive and may become difficult to manage if numbers exceed this.

**Session plans**

Session plans are provided to give clear guidelines on how to conduct each session of the workshop. Session plans are divided into a number of topics with aims and objectives given for each topic. To aid educators in the use of the session plans, icons are provided.

Handouts and overheads that accompany each session are clearly numbered and may be photocopied from the originals at the back of the manual.

**Customising the workshop**

Session plans have been designed to achieve specific learning objectives. However, educators may find that some groups have slightly different learning needs and minor modifications may be required. Any amendments to session plans should be aimed at enhancing specific knowledge and skill areas. It is not recommended that the sequence of sessions be changed as the workshop has been designed so that skills from one session form the basis for additional sessions.

Customising the workshop to suit local needs requires careful needs assessment and adaptation of the material to suit the target audience where necessary. Steps in the process of customising the workshop are listed below.
Step 1 – Conduct a needs assessment. A detailed description of carrying out a needs assessment specific to this workshop is provided in appendix 2.

Step 2 – Read the session outlines in the training manual. The programme has been written with a primary target group in mind (refer to appendix 2 for a detailed description of primary and secondary target groups). If your potential participants are workers from primary target group areas, then all of the material in the session plans should be covered in the workshop programme. Major modifications of the programme for secondary target groups (such as General Practitioners and specialist mental health workers) should be carried out by experienced educators utilising additional material that corresponds with the level of responsibility for suicide risk assessment and management of these groups.

Step 3 – Plan your workshop based on your understanding of your potential participants and the time available to run the workshop. At this point you should be sure that there is organisational support for the workshop and that any necessary funding (for catering, venue hire, etc.) is available.

Conducting the workshop as a series of short sessions

The workshop can be conducted as a series of short sessions if a full day is not available for training. It is recommended that the programme be offered over four sessions based on the structure of the workshop. When conducting the workshop over a number of sessions, it will be important to allow time at the start of each new session to review the previous session and discuss any questions or issues that participants may have. Each session plan has a summary and this may be used to facilitate the review process.

Allocation of time

Included in the session plans are suggested time allocations. These time allocations are only to be considered as a guide. Break times have not been included and are left to the discretion of the educator. As with all educational programmes, breaks are important for maintaining concentration and should be provided according to the needs of the group.
Management of time is an essential educator skill, especially during group exercises and feedback sessions. However, at times there will be key issues for particular groups that may need comprehensive discussion. If a special topic is identified that cannot be covered within the scope of the workshop, then it may be possible to note this with the group and schedule a follow-up session at a later date.

**Preparing to conduct the workshop**

Before conducting this workshop, you will need to be familiar with the session plans. You will need to prepare the training area and collate relevant materials including making a copy of the handouts provided for each session. Good preparation is the key to conducting a successful workshop.

Educators need to have read background material about older people and suicide. As the workshop covers potentially sensitive material that can affect participants, it is important to ensure that time is allocated at the end of the workshop (and sometimes, during) to deal with any issues arising in a comprehensive manner. In addition, identifying local support services for participants may be required.

**Tips on language**

Suicide terminology can be confusing and some terms are more acceptable than others. For training purposes it is recommended that you use the following terms:

**DON’T use:**

- Successful suicide
- Completed suicide
- Committed suicide
- Suicide completer

**INSTEAD use:**

- A person who died from suicide
- Suicide death

**DON’T use:**

- Unsuccessful attempt
- Incomplete suicide

**INSTEAD use:**

- Attempted suicide
Attendance lists

It is good teaching practice to keep a record of all participants who are invited to attend and those that actually attend the workshop. It is recommended that you ask workshop participants to sign an attendance list. An example of an attendance list can be found in appendix 3.

Evaluation

Evaluating the effectiveness of the workshop will assist in ensuring that you are meeting the needs of the target audience. Feedback will also help in improving the workshop in the future. A sample evaluation form is included in appendix 4.

The evaluation form provided in the appendices is only a basic framework. For a more detailed evaluation, educators need to assess the learning objectives provided for each session and for the individual topics within sessions. Topic aims and objectives provide a clear outline of the expected learning for each session. Educators should be familiar with these objectives and carefully monitor group discussions and activities for evidence that the learning objectives are being attained.

Acknowledging participation

Finally, it is important to acknowledge participation in the workshop. Certificates of attendance are a good way to do this. A sample certificate is included in appendix 5.
SUMMARY OF WORKSHOP

Session 1 – Overview of ageing, mental health and suicide (1 hour 45 minutes)

1.1 Workshop introduction
1.2 The ageing process
1.3 Exploring attitudes to ageing
1.4 Promoting engagement and early intervention with older people
1.5 Session summary

Session 2 – Understanding suicide risk in older people (1 hour 30 minutes)

2.1 Older age and suicide: some facts
2.2 Risk factors
2.3 Protective/resilience factors
2.4 Introduction to levels of risk
2.5 Session summary

Session 3 – Working with older people at risk of suicide (1 hour 30 minutes)

3.1 Older people mental health and suicide
3.2 Identifying and responding to older people at risk
3.3 Asking questions about suicide risk
3.4 Session summary

Session 4 – Ongoing care and support of older people (1 hour 30 minutes)

4.1 Care and support options
4.2 The referral process
4.3 Exploring case scenarios
4.4 Pulling it all together
4.5 Session summary
Session 1

Overview of Ageing, Mental Health and Suicide
SESSION 1 – OVERVIEW OF AGEING, MENTAL HEALTH AND SUICIDE

Topics
1.1 Workshop introduction
1.2 The ageing process
1.3 Exploring attitudes to ageing
1.4 Promoting engagement and early intervention with older people
1.5 Session summary

Duration
Approximately 1 hour and 45 minutes

Materials
- Overheads 1 to 3
- Handouts 1 to 3
- Butcher’s paper and markers
- Whiteboard and pens

Aims
- To engage participants by providing an overview of the workshop;
- To discuss mental health problems and suicide in older people by building on participant knowledge about ageing; and
- To explore how attitudes to ageing, mental health and suicide may influence identification of and response to mental health problems for older people.
Learning objectives

By the end of this session, participants will be able to:

- Describe the impact of the physical, psychological and social changes of older age on mental health;
- Discuss misconceptions around ageing and the impact of these on detection of mental health problems and suicide risk in older people;
- Identify early intervention strategies for mental health problems in older people; and
- List worker and service characteristics that promote and limit responses to mental health problems in older people.

Running this session

Use session 1 to gain participant enthusiasm, and increase your understanding of the knowledge and learning needs of participants. The more you know about the participants, the greater the likelihood that the workshop will target their key concerns and workplace issues.

The opening session of the workshop should also provide participants with a clear sense of what they will be learning and all the arrangements for the day. If you are running this workshop as a series of short sessions, you can modify the session by using overhead 1 (Workshop overview) to describe the whole programme and what components you will be covering in your first and subsequent workshops.

Special considerations

Participants are likely to be familiar with some of the subject matter in this session (for example, the process of ageing). It is very important to acknowledge the experience and knowledge of group members by drawing out and building on their expertise. Depending on the group you are working with, you may need to acknowledge the likelihood that some material will be familiar to them, but that you will be asking them to think about it in a different way. During session 1 it is also important to reassure participants that they will be able to learn some effective skills about suicide prevention for older people. You should acknowledge the sensitivity of the subject matter and remind participants to pay attention to their own self-care needs.
# SESSION 1 TRAINING SUMMARY

This summary can be used as a guide while you are conducting the session. Refer to the Topic Plans for detailed information.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Topic 1.1 Workshop introduction</th>
<th>Topic 1.2 The ageing process</th>
<th>Topic 1.3 Exploring attitudes to ageing</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 minutes</td>
<td><strong>Session introduction</strong></td>
<td><strong>Common changes in older age</strong></td>
<td><strong>Attitudes towards ageing, mental health and suicide</strong></td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Overhead 1 – Workshop overview</strong></td>
<td><strong>Activity 2 – Identifying common changes in older age</strong></td>
<td><strong>Presentation – The importance of attitudes</strong></td>
</tr>
<tr>
<td>15 minutes</td>
<td><strong>Handout 1 – Workshop overview</strong></td>
<td><strong>Handout 2 – Presenting concerns of older people</strong></td>
<td><strong>Overheads 2.1–2.6 – Questions about ageing, mental health and suicide</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Participant introductions and expectations</strong></td>
<td><strong>Activity 3 – Presenting concerns of older people</strong></td>
<td><strong>Activity 4 – Group responses to questions about ageing, mental health and suicide</strong></td>
</tr>
<tr>
<td>20 minutes</td>
<td><strong>Activity 1 – Getting to know each other</strong></td>
<td><strong>Implications of the changes in older age for mental health</strong></td>
<td><strong>Research findings related to attitudes</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Presentation – Group agreements</strong></td>
<td><strong>Handout 2 – Presenting concerns of older people</strong></td>
<td><strong>Handout 3 – Research on attitudes to ageing, mental health and suicide</strong></td>
</tr>
<tr>
<td>40 minutes</td>
<td><strong>Topic 1.4  Promoting engagement and early intervention with older people</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>Understanding engagement and early intervention with older people</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Presentation – What is engagement?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activity 5 – Engagement strategies and characteristics that influence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>engagement with older people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 minutes</td>
<td><strong>Challenges to engagement and early intervention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activity 6 – Exploring barriers to engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>Strategies for increasing engagement and early intervention with older people</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activity 7 – Early intervention strategies with older people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Topic 1.5  Session summary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overhead 3 – Session 1 summary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SESSION 1 TOPIC PLANS

Topic 1.1 Workshop introduction (20 minutes)

**Topic aim**
To introduce the workshop content, and to introduce group members and identify expectations about the workshop.

**Topic objectives**
By the end of this topic participants will:
- Be introduced to other group members;
- Identify one learning expectation for the workshop; and
- Understand the format for the workshop.

---

**Session introduction (5 minutes)**
Welcome participants to the workshop and introduce yourself, providing information on your background and experience. Provide a brief summary of your background, with the aim of demonstrating your interest and expertise in the workshop subject matter. Inform participants of arrangements for the workshop including breaks, toilets, telephones and catering.

Present **Overhead 1: Workshop overview**
Outline the basic structure for the day including any new skills and knowledge that it is hoped will be gained. For example, say:

- Session 1 will examine the process of ageing and impact of mental health problems for older people.
- Session 2 will provide information on older people, suicide and mental health problems.
- Session 3 will address ways of working with older people at risk of suicide.
- Session 4 will examine the process of planning immediate and ongoing support of people who may be at risk of suicide.

Distribute **Handout 1 – Workshop overview**, which provides participants with a guide for the day and a list of topics to be covered.
Participant introductions and expectations (15 minutes)

**Activity 1 – Getting to know each other**

Ask each participant to briefly introduce themselves to another member of the group (preferably someone they do not already know) by breaking into pairs and exchanging information about the following:

- Name
- Job
- Place of work
- Expectations for the workshop.

On task completion, ask participants to return to the large group and introduce his or her partner to the other group members. List participants’ expectations about the workshop on butcher’s paper.

**Sample responses**

Participants will attend this workshop with a range of agendas and motivations. A participant’s experience and knowledge are likely to vary but all participants will be expecting to gain additional knowledge, ideas or skills to build confidence and reduce anxiety.

**Activity variation**

_Rather than breaking into pairs, go around each person in the large group, asking them to say their name, job, place of work and expectations for the workshop._

**Presentation – Group agreements**

Explain that having some group agreements may help to ensure that everyone feels comfortable discussing issues with the group:

- **Confidentiality:** to ensure that participants feel secure that their views will not be reported outside the group;
- Respect for the opinions of others: to facilitate group discussion;
- **Punctuality:** to ensure the workshop runs to schedule;
- **One person speaks at a time:** to facilitate group learning;
- **Sensitivity:** to promote participant self-care during the workshop as people may be affected by discussing death and suicide;
- **Mobile phone and pager use:** during breaks only (unless ‘on call’); and
- **Self-care:** to be aware of own needs throughout the workshop as sensitive and potentially distressing material is discussed, and to take action accordingly, eg ask for help, leave the group.
**Topic 1.2 The ageing process (20 minutes)**

**Topic aim**
To raise awareness of possible underlying mental health problems related to common changes in older age.

**Topic objectives**
By the end of this topic participants will be able to:
- Describe biopsychosocial changes in older age; and
- Link biopsychosocial changes to possible mental health problems for older people.

---

**Common changes in older age (10 minutes)**

Explain that in order to understand suicide risk in older people it is important to reflect on the ageing process itself. Emphasise that during this workshop, **older age will be defined as 65 years of age and over**.

**Activity 2 – Identifying common changes in older age**

*Ask:*
*Reflecting on the experience of older people that you know, what major changes occur during older age? Ask participants to identify physical, psychological and social changes in older age.*

Write the group responses on the whiteboard under the headings physical, psychological and social.

**Sample Responses**

**Physical**
- Limitations in physical functioning.
- Possible disease/disability.
- Cognitive changes.
- Increases in medication due to health problems.
- Continued sense of wellbeing.

**Psychological**
- Loss of significant relationships (partner).
- Processes of reminiscence.
- Maturation of emotional response to life events/experiences.
- Ability to cope with loss and change.
- Spiritual development.
- Psychological effects of physical illness and/or pain.

**Social**
- Respect.
- Increase or decrease in family supports.
• Sense of belonging with ‘grey power’, i.e. identification with and sense of belonging to peers.
• Changes in networks, role in society, familial roles, accommodation and finances.

_Activity variation_

_Some educators may prefer to seek group responses on changes in older people without mentioning the domains of physical, psychological and social change. The three categories can be used after responses are obtained to sum up the activity. For example, circle groups of ideas on the whiteboard and explain whether they are examples of physical, social, or psychological changes._

✓ _Summary point_

_Ageing is a normal process. Personality, personal coping style and circumstances (such as health, education and socioeconomic status) have a large impact on the response of an individual to changes that occur in older age._

_An older person may experience:_
• Increased resilience as a result of maturation
• Strengthened personality traits
• Acceptance of life
• A broader perspective.

_An older person may also experience feelings of helplessness, loss of power and role, and consequent psychological stress._

**Implications of the changes in older age for mental health (10 minutes)**

_Distribute Handout 2 – Presenting concerns of older people, which participants will use to complete the following activity (activity 3)._

_Explain that we will now explore how the concerns that older people present may be connected to underlying mental health concerns._
Activity 3 – Presenting concerns of older people

Ask:
*What underlying mental health concerns might be related to the presenting concern listed on Handout 2?*

Ask participants to record responses on the handout in the spaces provided.

**Sample responses**

The background and experience of the group will influence the responses you receive to activity 3. For example, community health workers will be likely to see more older people with physical illness and disability, and workers in a day centre may see older people who are socially isolated or experiencing dementia. Following are examples of presenting concerns and possible related underlying mental health concerns. (Note that participants are not expected at this stage to discuss specific mental health problems and disorders in detail, however, names of disorders and general comments may arise during the discussion.)

**Loneliness/grief**
Impact of accumulated losses, loss of available supports, loss of significant roles, isolation, eg as a result of migration and cultural issues.

**Poor sleep / “off my food”**
Recurrence of mental health problems as a result of increased stressors, possible underlying mental health concern such as anxiety and depression.

**Nothing to live for anymore/feelings of depression**
Loss of significant roles, grief and loss issues, experiencing chronic pain, illness or disability.

**Pain/physical complaints**
Physical pain as a result of injury or illness (such as a fractured hip), psychological pain may be reported as physical symptoms (somatisisation).

**Not interested in activities/cannot do much/burden on society**
Impact and response to cumulative losses or change, impact of personal patterns of coping on these changes.

**Memory problems**
May indicate depression or dementia. Anxiety could also cause some concentration problems that may be perceived as cognitive impairment.

**‘Euthanasia’ request**
Experience of and/or fear of physical and/or psychological pain as a result of illness, injury, loss, loneliness, lack of support.
**Activity variation**

*If there is sufficient time available, ask participants to carry out the activity in groups of 3-4 people. After allowing a short time for discussion, ask each group to feed back their ideas to the larger group. (Only use this approach if you are confident that the participants will be able to explore underlying mental health problems with less input from you. This method will take longer and is best used if you have plenty of time left in the session.)*

---

**Topic 1.3 Exploring attitudes to ageing**

**(20 minutes)**

**Topic aim**
To identify the impact of attitudes toward ageing on the detection of mental health problems and suicide risk in older people.

**Topic objectives**
By the end of this topic participants will be able to:
- Identify and list common attitudes towards ageing;
- Identify attitudes that limit the ability to notice, assess and respond to underlying mental health problems in older people; and
- Become more aware of their own attitudes towards underlying mental health problems in older people.

---

**Attitudes towards ageing, mental health and suicide**

**(15 minutes)**

**Presentation – The importance of attitudes**

Explain that we are now going to discuss the impact that people’s attitudes towards ageing may have on the detection of underlying mental health problems and possible suicide risk in older people. Explain that consideration of attitudes towards older people is equally important to understanding the nature of changes in ageing, as attitudes have an enormous bearing on the ability to detect and respond to signs of mental health problems and/or suicide risk.

Present **Overheads 2.1 - 2.6: Questions about ageing, mental health and suicide**

Explain that some stereotypic attitudes about ageing have a greater impact on our ability to detect mental health problems and depression. Use overheads 2.1 - 2.6 to carry out the following activity (activity 4).
Activity 4 – Group responses to questions about ageing, mental health and suicide

Facilitate a large group discussion by reviewing each question on overheads 2.1 to 2.6. Trainers will need to keep the bottom half of the overhead “The Research Says…” covered while participants have an opportunity to briefly discuss their thoughts about each question. Reveal the summary points on the bottom half of the overhead to compare responses with what the research says.

Sample responses

Participants should be encouraged to provide an honest view of each of the questions in a non-judgmental atmosphere. The questions are answered in detail on handout 3 (with some brief points included on the lower half of each overhead). Educators should familiarise themselves with handout 3 in order to guide the discussion of each question.

Through the process of discussing the questions on overheads 2.1 through 2.6, participants may also identify a number of common misconceptions held about older people. Discussion of misconceptions should be encouraged and related back to misconceptions specific to mental health problems for older people. Some common misconceptions that may be identified during the discussion include:

- Older people cope better with loss because they have had more experience of it
- Loss of perceived future plans is less traumatic for older people as they have lived their lives
- Ignoring grief and loss makes the pain go away quicker
- ‘Understandable’ depression cannot be treated (i.e. if depression is perceived as an expected consequence of the experience of getting older)
- Symptoms of depression such as loss of interest in life, or a poor appetite, are a normal part of old age
- Everyone gets demented
- Old age equals being sick and not being able to do things
- People with dementia cannot get depressed
- Older people do not contribute anything to society – they are a burden
- All older people are the same, regardless of health, background or economic circumstances.
Research findings related to attitudes (5 minutes)

Distribute [Handout 3: Research on attitudes to ageing, mental health and suicide](#)

This handout provides an analysis of the questions on overheads 2.1 to 2.6. Highlight any points that have not been raised in the discussion of overhead 2.

**Topic 1.4 Promoting engagement and early intervention with older people (40 minutes)**

**Topic aims**
To identify the challenges and opportunities in focussing on underlying mental health problems and possible suicidality in older people; and
To identify current and possible additional strategies for increasing the focus on mental health problems in older people.

**Topic objectives**
By the end of this topic participants will be able to:
- Identify characteristics that promote engagement with older people;
- Discuss the advantages of intervening early with older people in relation to underlying mental health problems and possible suicide risk; and
- Identify challenges to engagement and early intervention with older people, and list strategies for responding to challenges.

**Understanding engagement with older people (10 minutes)**

**Presentation – What is engagement?**

Explain the importance of engagement in working with older people to detect underlying mental health problems and possible suicidality.

State that engagement is the process of developing a helpful working relationship or therapeutic alliance with a person. Engagement involves connecting with a person so that they feel confident to talk openly and reveal more of their ‘inner world’. Engagement occurs at many levels and often requires creative approaches.

Explain further that the ability to intervene early with an older person may be influenced by how well workers can engage with older people and discuss their possible mental health concerns. Through engagement, the opportunity to learn more about an older person and their presenting concerns is created. This may lead to opportunities to
intervene and address problems earlier. State that effective engagement and early intervention for mental health problems are positive strategies for suicide prevention in older people.

Explain that we will now explore some of the characteristics of engagement and factors that impact on our ability to engage with older people.

**Activity 5 – Engagement strategies and characteristics that influence engagement with older people**

Ask:
*What are some of the strategies and characteristics that workers need to engage older people?*

*What are some of the strategies and characteristics that are required of services to engage older people?*

Draw two columns on the whiteboard and record participants’ responses.

**Sample responses**

**Worker characteristics:**
- Professionalism
- Demonstrated respect for the older person, for example, not treating the older person as childlike, seeking permission before using first name
- An understanding of the ageing process
- Empathy and provision of sense of reassurance and hope
- Ability to listen and allow the older person to ‘tell their story’
- Sense of humour
- Being non-judgmental and non-threatening
- A regard for confidentiality (note however, that confidentiality cannot be promised if a person is at risk of harming themselves or someone else)
- Patience
- The ability to acknowledge limitations and mistakes
- Ability to carefully explore problems or issues that are difficult to discuss or not overtly expressed
- Projection of willingness and ability to offer practical assistance
- Encouragement of an appropriate level of partnership.

**Service characteristics:**
- Ease of access, especially provision of outreach services
- Responsiveness to changes in needs
- Respectful and have an understanding of the needs of older people
- Services that acknowledge and incorporate the need for emotional supports.
Summary point

By engaging with an older person, an opportunity to explore underlying mental health problems is created. This may lead to more information on the psychosocial concerns of the older person and a subsequent opportunity for early intervention.

Challenges to engagement and early intervention (20 minutes)

Explain that participants will now be asked to identify barriers to engagement and strategies for addressing these barriers.

Activity 6 – Exploring engagement issues

Ask participants to break into three groups to consider barriers to engagement with older people. Allocate one of the factors below to each of the three groups and ask them to brainstorm barriers to engagement and record their responses on butchers paper.

- Worker factors
- Service factors
- Factors intrinsic to the older person.

Obtain feedback from each group after the activity and allow other participants to add to the list.

Sample responses

Worker factors:
- Need more skills in how to address problems.
- Do not know what to do once problem identified.
- Stigma – not wanting to talk about mental health problems with older people.
- Fear of discussing suicide issues.

Service factors:
- Lack of time.
- No/limited access to other specialist services, e.g. specialist mental health services.
- Not the business of my service.
- Other priorities.
- Lack of appropriate places to talk.
- Lack of assessment tools.

Factors intrinsic to the older person:
- Older people may be reluctant to discuss the issues.
- Symptoms of depression, anxiety or other mental health problems may inhibit engagement.
- Cultural and linguistic barriers.
Strategies for increasing engagement and early intervention with older people (10 minutes)

Activity 7 – Early intervention strategies with older people

Using the list of barriers obtained from Activity 6, ask the group to brainstorm additional ways that their organisation(s) could improve engagement and early intervention with older people.

You may wish to record responses on the whiteboard.

Sample responses

**Worker factors:**
- Improve personal skills and knowledge (e.g. this workshop).
- Learn about identifying and providing early intervention for depression and other mental health problems in older people.
- Increase knowledge about suicide risk to increase awareness and decrease anxiety.

**Service factors:**
- Improve links with specialist service where available.
- Consider service role in relation to suicide prevention.
- Work with other services to develop partnerships that increase responsiveness to older people’s needs.

Topic 1.5 Session Summary (5 minutes)

Display **Overhead 3 – Session 1 summary** to recap and guide your discussion of issues covered in session one.

Highlight that activities and discussion in session one has identified that:

- Age is characterised by biopsychosocial changes that may often be associated with major life change and stress.

- Some changes (or combination of changes) can impact on mental health.

- Beliefs, attitudes and values about ageing can limit access for older people in seeking help for mental health problems and possible suicidality. Specifically, people working with older people may not associate physical illness with mental illness, or may believe that losing an interest in life is normal for older people.

- Being aware of ageing changes can help us increase early intervention to possible mental health and suicide risk problems in older people.

- Effective engagement and an early response to possible underlying mental health problems are positive strategies for suicide prevention in older people.
Session 2

Understanding Suicide Risk in Older People
# SESSION 2 – UNDERSTANDING SUICIDE RISK IN OLDER PEOPLE

<table>
<thead>
<tr>
<th>Topics</th>
<th>2.1</th>
<th>Older age and suicide: some facts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.2</td>
<td>Risk Factors</td>
</tr>
<tr>
<td></td>
<td>2.3</td>
<td>Protective/resilience factors</td>
</tr>
<tr>
<td></td>
<td>2.4</td>
<td>Introduction to levels of risk</td>
</tr>
<tr>
<td></td>
<td>2.5</td>
<td>Session summary</td>
</tr>
</tbody>
</table>

## Duration
Approximately 1 hour 30 minutes

## Materials
- Overheads 4 to 11
- Handouts 4 to 8
- Overhead projector
- Whiteboard and markers
- Butchers paper and pens

## Aims
- To provide an overview of the unique characteristics of suicide in older people and discuss specific risk and resilience factors for suicide in older people.

## Learning objectives
By the end of the session participants will be able to:
- Discuss the unique characteristics of suicide in older people;
- Identify risk and protective factors for suicide in older people;
- Explain the process of weighing up risk and protective factors to understand suicide risk; and
- Consider the level of suicide risk in specific situations.
Session 2 focuses on providing important background information on suicide in the elderly. Participants are asked to think about the factors that may contribute to suicide rates for older people. This leads into a number of activities where participants are asked to brainstorm specific risk and resilience factors as they relate to the elderly, and to discuss weighing up the level of risk. Session 2 involves a number of activities, and planning will have to ensure that activities do not run over time. If, however, you feel a particular activity or discussion has raised important issues for the group and has taken more time than you had planned, then it may be possible to modify later activities as you go. It is best to be aware of topics and activities to be covered in Sessions 3 and 4 to reduce the chances of repetition.
### SESSION 2 TRAINING SUMMARY

This summary can be used as a guide while you are conducting the session. Refer to the Topic Plans for detailed information.

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 35 minutes | **Topic 2.1   Older age and suicide: some facts** | **Session introduction**
Handout 4 – Suicide terminology
Overhead 4 – Difference between suicide rates and numbers |
| 10 minutes | **Understanding statistics** | Overhead 5 – Lifespan perspective of suicide rates
Handout 5 – Lifespan perspective of suicide rates
Activity 8 – Considering factors that may contribute to suicide rates
Handout 6 – Suicide rates for older people in NSW |
| 15 minutes | **Implications of the ageing population** | Overhead 6 – The ageing population |
| 5 minutes | **Issues surrounding suicide in older people** | Overhead 7 – Suicide in older people
Activity 9 – Understanding issues surrounding suicide in older people
Handout 7 – Issues surrounding suicide in older people |
| 15 minutes | **Topic 2.2   Risk factors** | Identification of risk factors for older people
Presentation – Risk factors for older people
Activity 10 – Identifying risk factors |
| 20 minutes | **Topic 2.3   Protective/resilience factors** | Understanding resilience in older people
Presentation – What do we means by resilience factors?
Activity 11 – A model of resilience
Handout 8 – Resilience and risk factors for suicide in older people
An analogy for risk and resilience
Overhead 8 – Weighing up the risk |
<table>
<thead>
<tr>
<th>15 minutes</th>
<th><strong>Topic 2.4  The continuum of suicidal behaviour and levels of risk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td><strong>Continuum of suicidal behaviour in older people</strong></td>
</tr>
<tr>
<td></td>
<td><em>Overhead 9 – Understanding the continuum of suicidal behaviour</em></td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>Understanding levels of risk</strong></td>
</tr>
<tr>
<td></td>
<td><em>Presentation – Overview of levels of risk</em></td>
</tr>
<tr>
<td></td>
<td><em>Overhead 10 – Levels of risk</em></td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Topic 2.5 Session Summary</strong></td>
</tr>
<tr>
<td></td>
<td><em>Overhead 11 – Session 2 summary</em></td>
</tr>
</tbody>
</table>
SESSION 2 TOPIC PLANS

Topic 2.1 Older age and suicide: some facts (35 minutes)

Topic aim
To provide some basic facts to support the importance of a workshop on suicide prevention for older people.

Topic objectives
By the end of this topic participants will be able to:
- Explain terminology that may be used when discussing suicide and suicide prevention;
- Discuss the rates of suicide in older people compared to the overall population;
- Discuss the impact of the ageing population on suicide in older people; and
- Identify policy directions that target suicide prevention for older people.

Session introduction (10 minutes)

Explain that in session 2 we will begin by analysing statistics on suicide and consider the implications of rates in differing age groups of older people. Explain that up to this point in the workshop, suicide has been discussed without defining terminology and that we will now spend a few moments reviewing terms that may be found in literature and reports about suicide. Emphasise that we will not use all of the terms during the workshop, and that any additional terms that are important to the workshop will be explained as they arise. Encourage participants to seek clarification of terminology throughout the workshop if needed.

Present **Handout 4 - Suicide terminology**

Read through the terms and definitions as a large group. Clarify any questions about terms as they arise.
Explain the difference between suicide rates and suicide numbers:

**Suicide rate** – shows how often an event occurs per a larger group of the population e.g. 5 per 100 000 means that there would be 5 suicide deaths for every 100 000 of the whole population

**Suicide numbers** – the total number of people who have died by suicide.

Explain the advantage of using rates of suicide rather than numbers, as this allows for comparisons across different groups, such as age and gender. Explain further that as suicide is a rare event, it is important to realise that in a small population (for instance when suicide death rates are broken down into 5 year categories), even one or two deaths can double the observed suicide rate.

**Understanding statistics (15 minutes)**

Present **Overhead 5 - Lifespan perspective of suicide rates** and distribute a copy of the graph (**Handout 5**) to participants.

Provide the following introductory information:

- The suicide death rates for all ages (including older people) have remained relatively stable over time
- Suicide death rates for people aged 65 years and older have remained high compared to the general population since 1964/65.

Discuss the graph highlighting the following:

- The graph shows rates of suicide death for all of Australia, however, the trends are very similar for NSW
- The rate of suicide for older men is about as high as that for younger men (note the two peaks for men on the graph), however, emphasise that the actual numbers of older men who die by suicide are smaller due to the lower numbers of people in older age groups
- The suicide rate for older men is higher than that of older women
- The suicide rate for older women is about the same level as the general population
- Suicide rates for older women are relatively stable across different older age groups
The issue of suicidal intent related to older people is discussed in more detail in topic 2.4.

- Suicide rates for older men increase as age increases
- Men over 85 had the highest suicide rate for any age group in 1996/97 (Centre for Mental Health, 2000), however, note again that the actual numbers of older men who die by suicide are small but the rate is high because of the low numbers of people in older age groups
- Men are more likely to use highly lethal means resulting in death rather than self-harm
- Women are more likely to use means such as overdose that may not result in death
- Note that highly lethal intent may mean that the time available to intervene for an older person at risk is low, therefore early intervention is extremely important.

**Hospitalisation rates for men:**
- Suicide attempts resulting in hospitalisation are slightly higher in older males than older females.
- This may provide an opportunity for intervention during hospitalisation after a suicide attempt. It is important to note, however, that intervening prior to a suicide attempt is always the priority, due to the lethality associated with suicide in older men.

**Activity 8 – Considering factors that may contribute to suicide rates**

Discuss the following issues in a large group:

What factors may be contributing to the rise in suicide rates for men as they get older?

Why might rates of suicide be higher for older men than older women? What gender differences might contribute to this?

**Sample responses**

- Longer life span may mean older men experience the death of their spouse (men may have relied on spouse for social/community contact).
- Longer life span may be combined with increased experience of illness/disability.
- Women may be more likely to have a range of supportive networks to rely on.
- Men are less likely to ask for help due to cultural expectations.
Handout

Distribute **Handout 6 - Suicide rates for older people in NSW**

Explain that this handout summarises the main findings on suicide in older people in NSW.

**Summary point**

It is often very difficult to understand why suicide rates change for particular age groups over time. Our understanding of what may be contributing to suicide rates for older people can be enhanced by considering:

- Trends over time
- Possible contributing circumstances for older people (such as the impact of bereavement and illness or disability)
- Significant differences between older people such as gender, cultural and linguistic diversity and Aboriginal and Torres Strait Islander background.

### Implications of the ageing population (5 minutes)

Present **Overhead 6 - The ageing population**

Overhead 6 provides details on the estimated increase in numbers of older people in the population in future years. Explain that the impact of ageing in Australia will mean that suicide numbers in older age groups may increase as the numbers of older people increase. It is assumed that an increase in the number of deaths may lead to more families, carers, and workers experiencing the impact of a suicide death. Emphasise that statistics can only be used as a guide but they can be very helpful to note trends and enable a proactive response.

### Issues surrounding suicide in older people (5 minutes)

Present **Overhead 7 - Suicide in older people**

Overhead 7 lists the issues surrounding suicide in older people. Use the following activity (activity 10) to discuss each point on the overhead.
Activity 9 – Understanding issues surrounding suicide in older people

Ask:
Why might suicide risk in older people have the characteristics listed in overhead 7?

Discuss responses as a group.

Sample responses

It may be useful to discuss examples from your own experience, and use prompt questions to elicit the following responses:

- Social isolation may mean older people are less likely to ask for help or be found after a suicide attempt
- Complex presentation of an older person, including experience of physical and/or mental health problems, may mean that cues are hard to detect
- Older people may be reluctant to talk about emotional issues
- Older people may perceive they have little or no other choice due to complex circumstances leading to increased intent/higher lethality
- Stigma around mental health problems may mean that older people are too ashamed to contact a mental health service or talk about depression or other issues with a General Practitioner or community worker.

✓ Summary point

Each person’s experience of life events is unique, however understanding issues can assist us in determining when a person may be at risk of suicide.

Handout

Distribute Handout 7 - Issues surrounding suicide in older people and explain that it provides a summary of the characteristics of suicide in older people.
Topic 2.2 Risk Factors (15 minutes)

Topic aim
To identify suicide risk factors for older people.

Topic objectives
By the end of this topic participants will be able to:
• Explain the concept of risk factors; and
• Identify risk factors for older people in a number of domains.

Identification of risk factors for older people

Presentation - Risk factors for older people

Explain that sometimes it is difficult for an older person to identify the positive aspects of their lives and when this happens, an older person may become at risk of suicide. Emphasise that suicide risk is multi-factorial and usually a result of a number of factors occurring for an individual at a given time. Explain that we will now look at identifying risk factors for older people.

Activity 10 – Identifying risk factors

Explain that this exercise is designed to get participants thinking about some of the factors that might place an older person at risk of suicide.

Ask participants to break into four small groups and allocate each group one of the following four categories:
1. Personal risk factors
2. Familial risk factors
3. Interpersonal risk factors
4. Societal risk factors

Each small group should record their responses on butchers paper and report back to the larger group at the completion of the exercise. Allow time for discussion and input from the larger group.

Sample responses

Personal risk factors:
• Male
• Feelings of hopelessness and loneliness
• Personality traits that inhibit openness to experience
• Life stressors, including grief and loss experiences
• Unremitting physical symptoms such as terminal illness, acute physical illness, and chronic pain
• Experience of depression, substance abuse, past attempts
Familial risk factors:
- Lack of family support
- Loss of loved ones
- Feelings of not being part of a family or other supportive group
- Impact of retirement on family relationships
- Relocation limiting access to family/friends
- Isolation from family and community
- Family history of suicide or mood disorder

Interpersonal risk factors:
- Inability to communicate with peers
- Lack of supportive others
- Relationship difficulties
- Poor help seeking skills
- Reluctance to express emotions to others

Societal risk factors:
- Lack of accommodation options and financial support
- Impact of living in residential care (increased rates of depression)
- Social isolation of older people
- Negative community attitudes towards older people
- Lack of opportunity for meaningful participation of older people

Activity Variation
Rather than breaking into small groups, the activity can be done as a large group.
Ask participants: What are some of the factors that you think might place an older person at risk of suicide?
Draw a grid on the whiteboard. List the factors under the headings personal, interpersonal, familial and societal risk factors.

Topic 2.3 Protective/resilience factors (20 minutes)

Topic aim
To present a model of risk and resilience by identifying how resilience factors may influence suicide risk.

Topic objectives
By the end of this topic participants will be able to:
- Define resilience;
- Identify possible resilience factors in a number of domains; and
- Describe the analogy of a set of scales for understanding the relationship between risk and protective factors.
Understanding resilience in older people
(15 minutes)

Presentation – What do we mean by resilience factors?

Resilience can be seen as those personal, societal, family and interpersonal factors that contribute to a person’s ability to maintain their health and wellbeing. Resilience can include factors such as:

- Things that help you keep going (e.g., personal factors, family support, society support)
- Personality characteristics
- Your attitude to problems
- How well you respond to stressors
- Your ability to overcome obstacles or challenges in life
- Your beliefs and attitudes to problems
- Your sense of hope, optimism and future.

Activity 11 – A model of resilience

Ask participants to think of an older person they know who has managed life’s difficulties well.

Draw a four-box grid on the whiteboard using the headings personal, interpersonal, familial and societal resilience factors. Elicit suggestions of resilience factors and write these under the appropriate heading.

Sample responses

If the group suggests few resilience factors, offer suggestions from the sample responses listed below. Also discuss examples of older people where resilience factors played an important role based on your own experience.

Personal resilience factors:
- Sense of humour
- Problem solving skills
- Ability to acknowledge and express emotions
- Sense of achievement/success/esteem
- Knowledge of support networks

Familial resilience factors:
- Family support
- Other supportive relationships, for example with another adult
- Connectedness to family and/or community
Interpersonal resilience factors:
- Ability to identify need for and ask for help
- Social skills
- Likeability
- Sense of humour
- Supportive peer group/network

Societal resilience factors:
- Accessible services oriented to older people
- Community awareness if issues for older people
- Access to financial and housing support
- Community values participation of older people

Activity Variation

Break participants into four small groups and ask each group to brainstorm and record resilience factors on butchers paper. Allocate each group one of the four listed factors, ie personal, familial, interpersonal and societal. Allow each group the opportunity to report back to the larger group and discuss their responses.

Alternative Variation for Risk and Resilience Activities:

If you are running out of time, it is possible to join the group activities on risk and resilience. After completing the presentations on “risk factors” and “what do we mean by resilience factors”, break into four small groups. Ask each group to discuss and record both risk and resilience factors related to one of the following categories – personal, interpersonal, familial and societal factors. Allow time for feedback and discussion with the larger group.

Distribute Handout 8 - Resilience and risk factors for suicide in older people

Explain that this handout provides an overview of risk factors associated with older people who die by suicide. The handout also describes resilience factors that may be protective for an older person.

✓ Summary point

It is important to know about risk and resilience factors to determine background influences that increase or decrease the risk of suicide in an older person. The overall aim of suicide prevention is to help older people recognise their strengths and assist them to find solutions to their problems.
An analogy for risk and resilience (5 minutes)

Present **Overhead 8 - Weighing up the risk**

Overhead 8 shows a pair of scales. Explain that:

- Assessing risk is like studying the balance of a pair of scales, with risk factors on one side and protective factors on the other.
- The equilibrium point is not necessarily the best outcome, but one in which protection outweighs risk.
- Assumptions cannot be made about how risk factors will affect a particular individual (risk factors can be experienced differently by different people), therefore weighing up risk is an individualised process, subject to variability.
- As lifetime and circumstantial risk and protective factors change, so does the balance on the scales, leading to variability in suicide risk at any given time.
- When asking questions about suicide risk, it is important to consider both risk factors that tip the balance towards high-risk, and protective factors that act like buffers and decrease the risk.

Give an example as follows, using the analogy of the set of scales:

An 85-year-old man (risk factor 1) whose wife has recently died (risk factor 2) is about to move out of his family home into hostel accommodation (risk factor 3). However, he is part of a group of supportive older men who meet regularly for social activities (protective factor 1), has good problem solving skills (protective factor 2) and has close relationships with his children and grandchildren (protective factor 3). Depending on the significance of the risk factors for this man, the actual risk of suicide may be very low.
Topic 2.4 – The continuum of suicidal behaviour and levels of risk (15 minutes)

Topic aim
To provide a framework for understanding the continuum of suicidal behaviour and levels of risk as a beginning point for considering how to respond to an older person at risk of suicide.

Topic objectives
By the end of this topic participants will be able to:
• Discuss the continuum of suicidal behaviour;
• Describe various levels of suicide risk;
• Discuss possible factors that may indicate the level of suicide risk; and
• Discuss preliminary considerations for responding to situations where suicide risk is suspected.

Continuum of suicidal behaviour in older people (5 minutes)

Present Overhead 9 – Understanding the continuum of suicidal behaviour

Introduce the idea that suicidal behaviours occur on a continuum. This continuum ranges from ‘risk-taking behaviour’ (for older people this may mean things such as neglect of self-care needs) through to suicide attempts and death by suicide. Explain further that suicide risk is not static, and is influenced by a combination of risk and protective factors for each individual.

Acknowledge the difficulty of differentiating behaviour that is ‘normal’ in terms of ageing (e.g. acceptance of death as a normal part of life) from suicidal intent. Explain that this differentiation can be made by considering two factors:

1. Intent – whether the older person has made a decision to end their life; and
2. Context – factors in a person’s life that may indicate they believe suicide to be a solution to their problems.

Explain that in terms of intent, it is important to note that older people are more likely to die from a suicide attempt than younger age groups, i.e. the ratio attempts to suicide deaths is higher for younger people (300:1) than older people (4:1) (Baume & Snowden, 1999). This means that a suicide attempt by an older person is more likely to result in death than an injury. Another implication of the ratio of attempts to deaths in older people is that the ‘window’ for detecting suicide risk is very small, and consequently a proactive response to signs of distress is very important in preventing suicide death.
Understanding levels of risk (10 minutes)

Presentation – Overview of levels of risk

Explain that an understanding of the factors that contribute to different levels of suicide risk can assist workers to make decisions about how to respond appropriately.

It is very important to note that assigning a level of risk for an individual is only relevant at that particular moment and based on the discussion of risk factors at that time. It is vital that suicide risk be monitored carefully as changes can occur for an individual that alter their experience of risk and protective factors.

Explain that we will explore options for care and support in detail in session 4, however, it is very important to note that when suicide risk is suspected, a comprehensive assessment of suicide risk should be sought by an appropriate mental health expert.

Present Overhead 10 - Levels of Risk which outlines some examples of situations or characteristics which may place an older person in a low, medium or high risk category.

Low risk:
- Recent upsetting events or problems.
- Evidence of support network.
- Sense of hope evident.
- Older person able to find solutions to problems with support.

Medium risk:
- Reports of low mood/feelings of life not being worth living.
- Lower levels of support and linkage with services.
- Sense of helplessness/hopelessness.
- Older person has some difficulty seeing solutions to problems.
- Thoughts of death (suicidal ideation).
- Some withdrawal from social supports.
- No specific plan.

High risk:
- Combination of stressors including social, psychological and physical factors.
- Risk factors including widows, experience of depression or physical illness
- Expressions of suicidal ideation.
- Recent or past suicide attempt/s.
- No support network evident (or withdrawal from social supports).
• Older person does not believe there is any way to resolve/solve their current problems.
• Overwhelming hopelessness or despair.
• Presence of a plan.
• Access to the means to carry out the plan.

**Topic 2.5 Session summary (5 minutes)**

Display *Overhead 11 – Session 2 Summary* to recap and guide your discussion of issues covered in session 2.

In particular activities and discussions in session two have highlighted that:

• Rates of suicide for older men is about as high as that for younger men, while suicide rates for older women are about the same level as the general population;
• Suicide in older people has unique characteristics, including less likelihood of suicidal thoughts being disclosed and a higher likelihood of death after a suicide attempt;
• Suicide risk can be assessed by considering risk and resilience factors;
• Suicide risk is variable and cannot be assessed only once; and
• The overall aim of suicide prevention is to help older people recognise their strengths and assist them to find solutions to their problems.
Session 3

Working with Older People At Risk of Suicide
### SESSION 3 – WORKING WITH OLDER PEOPLE AT RISK OF SUICIDE

| Topics | 3.1 Older people mental health and suicide  
3.2 Identifying and responding to older people at risk  
3.3 Asking questions about suicide risk  
3.4 Session summary |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration</strong></td>
<td>Approximately 1 hour 30 minutes</td>
</tr>
</tbody>
</table>
| **Materials** | Overheads 12 to 17  
Handouts 9 to 15  
Video: “Asking questions about suicide risk”  
Butchers paper and markers  
Whiteboard and pens  
Overhead projector  
VHS video recorder and television |
| **Aims** | To enable participants to discuss the impact of mental health problems and other factors on possible suicidality, and to practice asking questions about suicide risk. |
By the end of this session, participants will be able to:

- Describe presentations where depression and other mental health problems may be of concern (including differentiation between depression, dementia and delirium);
- Discuss the benefits of responding to mental health problems early in relation to suicide prevention and older people; and
- Ask clear, direct questions about suicide risk.

The focus of this session is on the application of knowledge from sessions 1 and 2 to situations involving suicide risk. The session begins by providing important background information on mental health problems for older people and the impact these issues may have on suicide risk. The session involves a number of activities and discussions and you will need to plan carefully to ensure activities do not run over time. The session ends by demonstrating (via a video scenario) how to ask questions about suicide risk and allows participants the opportunity to practice asking questions themselves. This is an important part of the workshop and appropriate time should be allocated to this activity.
### SESSION 3 TRAINING SUMMARY

This summary can be used as a guide while you are conducting the session. Refer to the Topic Plans for detailed information.

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td><strong>Topic 3.1 Older people, mental health and suicide</strong></td>
</tr>
<tr>
<td>25 minutes</td>
<td><strong>Understanding mental health problems and suicide risk</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Presentation</strong> – Link between mental health problems and suicide</td>
</tr>
<tr>
<td></td>
<td><strong>Overhead 12</strong> – Mental Health problems in the elderly</td>
</tr>
<tr>
<td></td>
<td><strong>Activity 12</strong> – Knowledge of mental health problems</td>
</tr>
<tr>
<td></td>
<td><strong>Overhead 13</strong> – Differentiating depression, dementia and delirium</td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Further information on mental health problems for older people</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Handouts 9-13</strong> - (Summaries of each mental health problem)</td>
</tr>
<tr>
<td>15 minutes</td>
<td><strong>Topic 3.2 Identifying and responding to older people at risk</strong></td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>Vignette</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Handout 14</strong> – Vignette</td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Activity 13</strong> – Identifying issues in vignette</td>
</tr>
<tr>
<td>40 minutes</td>
<td><strong>Topic 3.3 Asking questions about suicide risk</strong></td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Introduction to asking questions about suicide risk</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Presentation</strong> – Why practice asking questions about suicide risk?</td>
</tr>
<tr>
<td></td>
<td><strong>Overhead 15</strong> – Factors to consider before asking questions</td>
</tr>
<tr>
<td>15 minutes</td>
<td><strong>Asking questions about suicide risk</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Overhead 16</strong> – Types of questions to ask an older person</td>
</tr>
<tr>
<td></td>
<td><strong>Video</strong> – Asking questions about suicide</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------</td>
</tr>
</tbody>
</table>
| 20 minutes| **Practice asking questions about suicide risk**  
Handout 15 – Questions for identifying older people at risk  
Activity 14 – Practicing asking questions |
| 5 minutes | **Topic 3.4 Session Summary**            | Overhead 17 – Session 3 summary            |
SESSION 3 TOPIC PLANS

Topic 3.1 Older people, mental health and suicide (30 minutes)

Topic aim
To identify and discuss specific mental health problems that have a significant bearing on suicide risk in older people.

Topic objectives
By the end of this topic participants will be able to:
- Define and list the symptoms of specific mental health problems;
- Identify key differences between depression, delirium and dementia; and
- Identify that depression is the most common disorder experienced by older people who die by suicide.

Understanding mental health problems and suicide risk (20 minutes)

Presentation – Link between mental health problems and suicide

Explain that it has been clearly identified that most older people who die from suicide have experienced a mental health problem prior to their death. Explain that depression is the most common mental health problem experienced by older people prior to suicide. Reiterate that in session 1 the challenges to identifying and responding to mental health problems in older people were explored and it was noted that depression in older people is often not detected.

State that a number of specific screening tools for detecting depression are available, however, they will not be discussed during the workshop. Explain that an important focus of the workshop is detecting signs of depression during routine interactions with older people.

Present Overhead 12 - Mental health problems in the elderly.

Explain that the overheads outline some brief definitions of depression, dementia, delirium and anxiety which will assist participants to complete the following activity (activity 12).
**Activity 12 – Knowledge of mental health problems**

Ask participants to break into four small groups and allocate each group one of the following mental health problems:

- Depression
- Dementia
- Delirium
- Anxiety

Ask each small group to brainstorm the common signs and symptoms of the disorder. Groups should record their responses on butchers paper.

Allow each group to report back, and as each disorder is discussed, draw out any details that have been overlooked.

**Sample responses**

Responses will vary depending on the background of participants. Some groups will require more support to define and discuss symptoms of mental health problems than others. Educators should refer to handouts 9-13 for detailed information on depression, delirium, dementia, and anxiety.

**Activity variation – large group exercise**

Activity 12 can be done as a large group exercise. Ask the group to brainstorm the common signs and symptoms of each mental health problem (depression, dementia, delirium and anxiety) and record responses on the whiteboard. This may be the preferred option if you have doubts about the groups’ ability to generate signs and symptoms without prompting and guidance.

Display **Overhead 13 – Differentiating depression, dementia and delirium**, and use it to facilitate a discussion of how workers would normally differentiate between the common signs and symptoms of depression, dementia and delirium in the elderly.

**Further information on mental health problems for older people (5 minutes)**

Distribute a copy of the following handouts to each participant:

- Handout 9 – Depression
- Handout 10 – Delirium, dementia and depression
- Handout 11 – Anxiety disorders and depression
- Handout 12 – Psychosis and depression
- Handout 13 – Treatment of mental health problems in older people
Explain that handouts 9-13 provide detailed information on some of the mental health problems that may affect older people, as well as a summary of current treatment strategies.

An additional handout on psychosis has been included for participants. This mental health problem has not been flagged for discussion during the workshop due to the relatively low incidence of psychosis among older people. However, the handout contains important information that participants can refer to after the workshop.

**Topic 3.2 Identifying and responding to older people at risk (15 minutes)**

**Topic aim**
To identify the importance of combining health promotion strategies with awareness of mental health and suicide issues for older people, in order to increase the chance of detecting early warning signs and intervening earlier.

**Topic objectives**
By the end of this topic participants will be able to:
- Discuss vignettes, identifying issues and possible responses; and
- List key considerations when responding to older people who may be at risk.

**Vignette (10 minutes)**

Distribute **Handout 14 - Vignette**

Explain that in the next activity (activity 13) participants will examine the hypothetical situation described in handout 14.

**Activity 13 – Identifying issues in vignette**

Read the vignette outlined in handout 14. Based on the information in the vignette, discuss as a group some of the concerns you would have about this lady, Beth.

**Sample response**

Beth is a 76-year-old widow who was discharged home from an acute care hospital after a multiple diagnosis of pulmonary oedema and anaemia. She has borderline diabetes and needs her blood sugar level checked twice a week. She also has a large ulcer on her right lower leg that requires second daily dressing. She has impaired mobility and walks with a frame due to osteoarthritis. She and her husband migrated to Australia nearly forty years ago. Beth has lived alone since the death of her husband ten years ago. She has no children. When you visit she appears tired and eager for
you to leave. She answers some of your questions but supplies only short answers. She is very concerned about her decreasing self-care abilities, having too many tablets to take and the side effects of these, such as having to go to the toilet often. She appears anxious and fearful about the possibility of re-location to a nursing home, as she does not want to live in residential care. She is overly appreciative of your help, claiming she is a real burden on you and society at large. She says she is managing to the best of her ability but does not think that is good enough and is not sure if life is worth living.

**Concerns**

- Current physical concerns and disability.
- Mental state – query anxiety and/or depression.
- Query underlying meaning of comment about not feeling life is worth living.
- Low level of family and other supports – possible isolation.

**Activity Variation – small group exercise**

Ask participants to break into groups of 4–5 people. Ask participants to discuss the vignette in handout 14 and summarise their concerns about Beth. Participants should discuss their responses with larger group on completion of the exercise. It would be best to use the small group activity if the activity variation (large group activity) was used for activity 13.

**Summary point**

When considering mental health problems, it is important to focus on the lived experience of the older person and be aware that something seemingly insignificant may be crucial. It is important to ensure assessment by a qualified practitioner if it appears a mental health issue may be present.

**Responding to older people at risk (5 minutes)**

Present **Overhead 14 - Responding to older people at risk**

This overhead summarises key strategies for responding to older people at risk and highlights the importance of early intervention.
**Topic 3.3 Asking questions about suicide risk (40 minutes)**

**Topic aim**
To develop skills, understanding and confidence in asking older people at risk direct questions about suicide.

**Topic objectives**
By the end of this topic participants will be able to:
- List four factors to consider before asking questions about suicide risk; and
- Practice asking sample questions about suicide risk.

---

**Introduction to asking questions about suicide risk (5 minutes)**

**Presentation – Why practice asking about suicide risk?**

Explain to participants that if an older person is suspected to be at risk of suicide, it is important to explore the issue further. State that the best way to do this is by asking questions about suicide risk, however, this may seem daunting at first. Explain that practicing asking about suicide risk usually makes the process easier and helps workers to become aware of the questions they feel comfortable asking and that enable them to explore a range of risk factors for a particular person. The remainder of this session will focus on learning about how to ask directly about suicide risk in order to establish the level of risk and respond appropriately.

**Display Overhead 15 – Factors to consider before asking questions about suicide risk** and ensure the following key issues are raised:

**Introductions**

If you have only just met the older person, it is important to clearly introduce yourself. Tell them who you are, where you are from, and how you might be able to help. Do not assume that someone else will have explained who you are and why you have come to talk to them. It is important to think about the questions you may ask prior to meeting the older person.

**Safety**

Before asking any questions about suicide risk you need to ensure the safety of the older person by having any physical illness or injury attended to (for example, in the case of a person who has attempted suicide). It is also important to ensure your own safety including the possibility that the older person may have a weapon.
Establish rapport
Take time to learn about the older person’s background and interests before any issues related to suicide risk are raised. It may be the case that concern about suicide risk emerges during the course of an interview with an older person. Use your judgement of the development of rapport to gauge when an appropriate moment to raise these concerns might be. As noted in session 1, the process of engagement is extremely important in being able to explore issues around suicide risk.

Create awareness of limits of confidentiality
Once you have begun to talk about suicide risk with an older person, it is important that they understand the limits of confidentiality. Older people may be assured of confidentiality unless there is a significant risk of harm to themselves or others.

Acknowledge distress
All discussions should be taken at a slow pace. It is best not to rush into questions about suicide risk, but rather build up gradually as you come to understand the situation of the older person and their own experience of their past and current events. Remind the older person that they do not have to answer questions if they do not want to. It is also important to acknowledge that it may be very difficult for an older person to discuss some things.

Asking questions about suicide risk
(15 minutes)
Display Overhead 16 – Types of questions to ask an older person and explain that this overhead lists a series of questions that can be used to guide a discussion with an older person about suicide risk. Explain that when asking about risk of suicide, questions about history, intent, plans and means always need to be asked (as well as identifying any precipitating factors, such as a recent loss).

The following issues should be explored:

History
Has the person felt like this before?
Has the person harmed him/herself before?
Have you or others seen a recent change or a change over time, eg withdrawal?
Is there evidence of distress and a sense of hopelessness?

Intent
How serious is the intent to die?
What is the person’s reason for living?
What is the person’s reason for dying?

Plans
How much thought has the person put into devising a plan of how and when they person might die?
How specific is the plan?
What is the plan and what has the older person done about it?

Means
Does the older person have the means to die available to them?

Play Video – Asking questions about suicide risk.

Explain that they are about to watch a video scenario where a worker is asking an older person about their suicide risk. Ask participants to take note of the types of questions asked (which will be similar to those outlined in overhead 16) and the way they are asked.

The video scenario is only a guide to the way that questions can be asked. The way in which the questions are asked will vary depending on a number of factors – eg knowledge of the person, the environment (ie hospital setting, office, their home), their presentation at the time, the gender of the person and possible cultural differences.

Practice asking questions about suicide risk (20 minutes)

Distribute Handout 15 - Questions for identifying older people at risk of suicide and explain that the questions will act as a guide for the following activity (activity 14). The handout also provides two sample scenarios that participants may like to use to assist them in carrying out the role play.

Activity 14 – Practicing asking questions

Ask participants to break into pairs with one person taking the role of an interviewer and the other an older person. Ask the ‘interviewer’ to ask their partner questions about their suicide risk, based on the questions listed on handout 15. Ask the ‘older person’ to respond as if they were having suicidal thoughts. Handout 15 lists two sample scenarios that may be helpful for the person playing the role of the older person.

Remind participants to swap roles after completing the exercise. Emphasise to participants that the aim of the exercise is to explore how it feels to ask questions about suicide using a range of possible questions.

After the exercise is completed, ensure participants ‘de-role’ from the exercise (this can be done by stating that the role play has ended and that participants are now no longer in character). Facilitate a large group discussion by asking those in different roles to comment on the experience.
Asking questions about suicide risk enables a number of risk factors for an individual to be explored. If at the end of asking questions about suicide risk a worker had serious concerns about an older person, then support should be sought quickly for the older person.

Sample Responses

At the completion of the role play, the following questions may be used to guide the discussion:

**Questions for exploring the role of the interviewer:**
- What did it feel like to ask the questions?
- Did the questions feel comfortable to ask?
- What other questions would you have liked to ask?
- Was it easier than you thought?

**Questions for exploring the role of the ‘older person’:**
- What did it feel like to be asked the questions?
- What did it feel like to be asked directly about suicide risk?
- What else would you have liked to be asked or told?
- What factors helped you to discuss feelings about suicide? (eg the approach of the ‘interviewer’, the way they went about bringing up their concerns.)

---

**Topic 3.4 Session summary  (5 minutes)**

Display **Overhead 17 – Session 3 summary.**

Sum up the session by recapping on what has been covered. The following summary points can be used to guide your discussion.

- Suicide prevention for older people involves responding proactively to early indicators of mental health problems or concerns.
- The most common mental health problem associated with suicide in older people is depression. Detection and early response to depression is seen as the most effective way to prevent suicide in older people.
- Many interventions by people who work with older adults can be considered to be suicide prevention interventions. These include interventions that aim to ameliorate experiences of isolation, loneliness, hopelessness, and pain and suffering.
- When concerns about suicide risk arise, it is important to address the issues directly with the person and seek additional support.
Session 4

Ongoing Care and Support of Older People
## SESSION 4 – ONGOING CARE AND SUPPORT OF OLDER PEOPLE

| Topics        | 4.1 Care and support options  
|              | 4.2 The referral process  
|              | 4.3 Exploring case scenarios  
|              | 4.4 Pulling it all together  
|              | 4.5 Session summary  |

### Duration
Approximately 1 hour and 30 minutes

### Materials
- Overheads 18 to 19
- Handouts 16 to 19
- Overhead Projector
- Butchers paper and markers
- Whiteboard and pens
- Sheets of paper (one per participant)

### Aims
- To enable participants to consider and reflect on how what they have learnt about suicide and older people can be applied to their workplace and to the implementation of appropriate intervention strategies for older people at risk.

### Learning objectives
- By the end of this session, participants will be able to:
  - Identify a range of appropriate responses to an older person at risk;
  - Make informed decisions about provision of ongoing support for older people;
  - Identify effective methods of referring older people for assessment and support; and
  - Suggest ways that services could improve the identification and response to older people at risk of suicide.
Session 4 serves two primary functions: to enable participants to identify options for support of older people and ways of addressing suicide issues; and to summarise and conclude the whole workshop.

This session relies heavily on participant involvement in problem solving by considering their workplace and related services in the care and support of older people. It is anticipated that after this session, participants should have a positive sense of their ability to respond when they believe a person is at risk of suicide.

As there are significant differences between areas in the availability and range of resources and specialised services, it is important to ensure you understand the local service structures including the role of government and non-government services. You will need to research local services before conducting the workshop and become aware of any limitations to access that may impact on addressing suicide issues for older people.
# SESSION 4 TRAINING SUMMARY

This summary can be used as a guide while you are conducting the session. Refer to the Topic Plans for detailed information.

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 minutes</td>
<td><strong>Topic 4.1 Care and support options</strong></td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>Session introduction</strong></td>
</tr>
<tr>
<td></td>
<td>Overheads 18.1 – 18.3 – Care and support options</td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>Knowing when and where to make a referral</strong></td>
</tr>
<tr>
<td></td>
<td>Presentation – Making effective referrals for suicide risk assessment</td>
</tr>
<tr>
<td></td>
<td>Activity 15 – Identifying local referral options</td>
</tr>
<tr>
<td>15 minutes</td>
<td><strong>Topic 4.2 The referral process</strong></td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>The process of making an effective referral</strong></td>
</tr>
<tr>
<td></td>
<td>Activity 16 – Steps in the referral process</td>
</tr>
<tr>
<td></td>
<td>Overhead 19 – Information required by the referral agency</td>
</tr>
<tr>
<td></td>
<td>Handout 16 – Information required by referral agencies</td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Working with the referral agency</strong></td>
</tr>
<tr>
<td></td>
<td>Presentation – What happens after a referral is made?</td>
</tr>
<tr>
<td>30 minutes</td>
<td><strong>Topic 4.3 Exploring Case Scenarios</strong></td>
</tr>
<tr>
<td></td>
<td>Handout 17 – Vignettes</td>
</tr>
<tr>
<td></td>
<td>Activity 17 – Vignettes</td>
</tr>
<tr>
<td>20 minutes</td>
<td><strong>Topic 4.4 Pulling it all together</strong></td>
</tr>
<tr>
<td>15 minutes</td>
<td><strong>Identifying practice issues</strong></td>
</tr>
<tr>
<td></td>
<td>Activity 18 – Strengths and weaknesses of current practice</td>
</tr>
<tr>
<td></td>
<td>Activity 19 – Improving practice</td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Identifying further sources of information</strong></td>
</tr>
<tr>
<td></td>
<td>Handout 18 – Policy Directions</td>
</tr>
<tr>
<td></td>
<td>Handout 19 – Resources</td>
</tr>
<tr>
<td>5 minutes</td>
<td><strong>Topic 4.5 Session summary</strong></td>
</tr>
</tbody>
</table>
SESSION 4 TOPIC PLANS

Topic 4.1 Care and support options (20 minutes)

Topic aim
To identify a range of options for responding to suicide risk depending on situational demands and to identify locally available resources for intervention.

Topic objectives
By the end of this topic participants will be able to:
• List three different types of care and support options;
• Identify local referral options; and
• Apply knowledge of local resources and suicide risk to vignettes.

Session introduction (10 minutes)
Explain to participants that this session will explore the decision making process in providing care and support for an older person who is at risk of suicide. Explain that options for care and support in low-risk, medium-risk and high-risk situations will be examined.

Present *Overheads 18.1-18.3 - Care and support options*
These overheads describe three possible options for response to an older person based on levels of risk. Discuss each overhead, highlighting the discussion points following.

**Monitoring with no referral - Overhead 18.1**
Monitoring of an older person is likely to be selected when an older person presents with non-specific signs and symptoms of depression. Monitoring of the older person is likely to include reviewing and coordinating the current services that are provided to the older person and re-considering issues such as community participation and social isolation. People who require monitoring would generally be considered to be at low risk and would benefit from intervention such as increased visits or phone contact. Note that the older person’s General Practitioner is likely to have a pivotal role in the care and support provided to the older person requiring monitoring.

**Referral to community/crisis service - Overhead 18.2**
If suicidal ideation is present and persistent, or associated with features of a depressive or other mental health problem, then a referral to an appropriate mental health service is required. This may
The NSW Mental Health Act is described briefly in Handout 13 - Treatment of mental health problems in older people. For comprehensive information on the Act, refer to the Mental Health Act Guide Book (NSW Institute of Psychiatry, 1998).

Referral to hospital-based care - Overhead 18.3
Hospital care is likely to be the most appropriate option when suicide risk is immediate and high. In addition to this, hospital care is also appropriate when:
- The older person has little support within the community or access to services
- The older person has harmed himself or herself
- The older person is experiencing severe despair or depression
- There is a need to clarify diagnosis
- In-patient treatment is required to attend to other needs, such as medical conditions.

A hospital-based referral may include scheduling under the Mental Health Act, which involves involuntary admission when a person is considered to be at risk of harming themselves or others. Scheduling can only be carried out by qualified professionals and requires a referral for assessment in all instances.

Knowing when and where to make a referral (10 minutes)

Presentation – Making effective referrals for suicide risk assessment

Acknowledge that making referrals is likely to be a task that is familiar to many of the participants in the workshop. Explain that we will explore the referral process carefully from the point of view of making effective referrals for assessment of suicide risk. Explain that there are two important elements of making referrals for assessment of suicide risk:

1. Knowing when to make a referral
2. Knowing where to make a referral

State that we have determined in previous discussions and activities that any risk of suicide should be assessed by a mental health specialist.

State that knowing where to make a referral is determined largely by
locally available resources and that we will look carefully at the local service structures during this session and identify options for suicide risk assessment.

**Activity 15 – Identifying local referral options**

Ask: *What locally based referral agencies could you use for older people at risk of suicide?*

Trainers should ask participants to discuss community support as well as mental health options.

Record responses on the whiteboard – provide contact details if possible.

**Sample responses**

Local referral options may include some or all of the following:

- Adult mental health services
- Crisis services
- Emergency department
- General Practitioners
- Private counsellors, psychologists and/or psychiatrists
- Hospital-based psychiatric services
- Local support groups
- Local charities and other organisations
Topic 4.2 The referral process (15 minutes)

Topic aim
To discuss the referral process in order to ensure effective referrals for older people at risk of suicide.

Topic objectives
By the end of this topic participants will be able to:
• Identify the information to gather before making a referral; and
• List the information required by a referral agency when making a referral for suicide risk assessment.

The process of making an effective referral (10 minutes)

Activity 16 – Steps in the referral process

Ask:
What steps do you usually follow when making a referral?

Record responses on the whiteboard.

Sample responses

Ensure the following points are raised:

• Obtaining consent from the older person (involving the older person in considering treatment options can be a very valuable and empowering process and should be encouraged wherever possible – it is important to note that in some instances where an older person is at risk of harming themselves or others, then consent for treatment can be overridden)
• Collect information to make a referral
• Decide on the appropriate referral agency – this will require consideration of local resources as discussed at the start of the topic
• Make the referral
• Follow-up to ensure the appointment occurred.

Display Overhead 19 – Information required by the referral agency

Explain that this overhead provides a brief summary of the information required. Point out that it is better to provide too much information rather than too little. The information you provide will determine how the referring agent responds and how quickly. It is best to be prepared and gather all the relevant information before making the referral.
Information usually provided:

- Name
- Address
- Phone number
- Date of birth
- Your relationship to the older person
- Current problem and background to this problem.

Information if suicide risk assessment needed:

- All of the above
- Your concerns and how long you have had these concerns
- Your concerns regarding suicide risk specifically, e.g. presence of suicidal ideation, presence of a plan and access to means
- Information you have gathered on suicide risk for the older person, e.g. exploration of suicide risk and protective issues with the older person and with others involved with the older person.

✅ Summary point
When making a referral it is important to prepare all of the information before calling the referral agency. If the agency is not able to provide the help you are seeking, ask for advice about the most appropriate agency to refer to.

Distribute Handout 16: Information required by referral agencies

This handout summarises the most important information to have at hand before making a referral.

Working with the referral agency (5 minutes)

Presentation – What happens after a referral is made?

Explain that after making a referral, it is important to follow-up to ensure the older person you have referred attends the appointment (or is visited by the referral agency). Explain that good communication between agencies is important to ensure that suicide risk issues for older people are addressed proactively. Re-emphasise the importance of ensuring the referral and treatment process are discussed with the older person and that they are involved in planning treatment options as much as possible. Discuss participants’ experiences of working with referral agencies. In the discussion, identify the following roles that participants may have after making a referral:

- Mentoring
- Support
- Providing follow-up
- Advocacy for needs of older person
- Ongoing service coordination for the older person.
**Topic 4.3 Exploring case scenarios (30 minutes)**

**Topic aim**  
To give participants an opportunity to draw on knowledge from the workshop and apply this to a case scenario.

**Topic objectives**  
By the end of this topic participants will be able to:  
- Apply their knowledge of suicide risk and care and support options discussed in previous sections of the module; and  
- Discuss the concerns, decide on a plan of action, referral options and communicate the information to provide a referral agency for one case scenario.

Distribute **Handout 17: Vignettes** and explain that it will be used for the next activity (activity 17).

**Activity 17 – Vignettes**

Ask participants to break into groups of 4-5 people. Allocate a vignette from Handout 17 to each group.

Ask participants:  
*How would you respond to the vignette situation, bearing in mind the suicide risk and resilience issues discussed in session 2, and the local resources and services available?*

Ask participants to list:  
- issues and concerns for the person  
- what action they are going to take  
- who they will refer to  
- what information they will provide

Participants should document their responses on butchers paper. On activity completion, discuss responses as a large group.

**Sample responses**  
The responses to vignettes identified by participants will be influenced by the nature of local services, resources and policies and procedures. Some suggested responses for the vignettes are listed below.
Stress to participants that the response to suicide risk is dependent on the presenting level of risk. Always seek advice from others such as senior staff or mental health specialists if you are not sure as to what your response should be. Mental health assessment is indicated for any person at risk of suicide.

### Vignette 1

A woman 79 years of age involved with your service has recently been discharged following an overdose of Mogadon and wine. Her husband had died that week and the funeral was the day of the overdose. It was also the anniversary of the death of her son that week.

**Issues:**
- Grief and loss and bereavement – grief from death of son, recent loss of husband
- Safety – accidental or deliberate overdose and evidence of further risk (note that accidental overdose is a possibility and should not be overlooked when considering suicide risk issues)
- Alcohol or substance abuse
- Possible depression
- Social support level.

**Response:**
- Referral to assess suicide risk and mental state
- Determine level of support through considering family and social networks
- Address physical care needs
- Liaise with General Practitioner and other involved workers
- Grief and loss issues – consider whether it is appropriate for any referral for counselling so soon after the death of her husband
- Need for consistent ongoing monitoring of the situation

### Vignette 2

An 84-year-old woman who has received assistance with daily living activities over the past month says she is not feeling well and has lost interest in going out and involving herself with others. She has no appetite and is not sleeping at night.

**Issues:**
- Comments about poor health needing investigation
- Recent loss of interest in activities, not sleeping and poor appetite may suggest depression
- Query pain
- Query depression.

**Response:**
- Assessment for physical and mental health causes, including pain and cognitive decline (refer to General Practitioner)
- Assessment of support and care needs
- Promote client involvement in a day centre programme or other service to decrease social isolation.
Vignette 3
A man of 81 years of age has chronic obstructive airways disease and is currently physically sick and constantly breathless. His wife died 2 years ago and he finds it difficult to get out of the house very often. He often talks about how his mates are all dying around him, but this morning when you visit he seems more pre-occupied with death. He says that when he woke up in the morning he could not see the point of living.

Issues
- Chronic physical illness
- Social isolation
- Loss and grief – friends dying, death of wife
- Query depression
- Pre-occupied with death
- Suicide ideation – need to assess whether this is present, attempt to obtain corroborative evidence from family, friends or neighbours if possible
- Assessment of care needs
- History of lack of motivation – how long, gradual progression or rapid onset?

Response:
- Referral for physical and mental health assessment, possible hypoxia if using oxygen
- Ongoing monitoring of physical health needs and personal care (high risk may indicate need for ongoing monitoring of mental state and suicide risk)
- Encourage family support
- Support package, eg Community Options Programme or Community Aged Care Package due to high support needs
- Involve informal supports such as a community visiting service – church or volunteer group
- Consider counselling for grief and loss.

Vignette 4
A 95-year-old man who is frail and going blind and lives at home with his 93-year-old wife who has dementia. He has little insight into his wife’s dementia, and has become increasingly angry towards her, saying that ‘his wife never leaves him alone’. He has also expressed sadness over the loss of his wife as he knew her as her dementia has progressed. Over the past weeks, he has stopped his regular walk of ‘600 paces around the neighbourhood’, has stopped eating and is complaining of pain which, when further investigated, he denies. He is found in his bedroom trying to strangle himself with his pyjama pants. When help is sought he tells the neighbours that he is upset that they have interfered and that next time he will do it properly. When the ambulance officers arrive he tells them that he is fine and they do not take him to hospital.
Issues:
- Suicide attempt, high immediate risk with clear intent to die – urgent response needed
- Need for assessment of needs of wife
- Carer frail and disabled
- Agitated, recently stopped exercise and eating and undiagnosed pain
- Poor/breakdown in relationship with wife
- Little insight into dementia and angry towards her – query any abuse
- Carer stress issues including high risk of depression and complicated grief over gradual loss of partner (in mind, body and spirit, but not physically).

Response
- Immediate crisis – stay with situation until support arrives (General Practitioner, mental health service)
- Assessment for suicide risk and depression needed with hospitalisation a possible consideration (schedule)
- Care and support for wife – consider current supports in place and need for additional in-home services, respite care
- Medium-term needs - ongoing monitoring of situation, review support and care in the home, e.g. Community Options Program (COPS) or Community Aged Care Package (CACPS), day hospital for respite and physical health needs, possible counselling (individual or group).

**Topic 4.4 Pulling it all together (20 minutes)**

**Topic aim**
To provide an opportunity to reflect on current workplace practice in identifying older people at risk of suicide and referring them to appropriate services.

**Topic objectives**
By the end of this topic participants will be able to:
- Identify strengths and weaknesses of current practice in relation to suicide prevention for older people; and
- Identify strategies for improving areas of weakness.

**Identifying practice issues (15 minutes)**

Explain that this last exercise provides an opportunity to discuss the strengths and weaknesses of participants’ current work practice in relation to working with older people at risk of suicide. This exercise is designed to close the entire workshop by encouraging participants to reflect on the whole day’s training. It is important to emphasise that the exercise is **anonymous**.
Activity 18 – Strengths and weaknesses of current practice

Distribute a sheet of paper to each participant.

Ask participants to write down:
- Two work practices (skills/techniques) that they currently engage in that are consistent with good practice for working with older people at risk of suicide; and
- Two work practices (skills/techniques) that they currently engage in that are inconsistent with good practice for working with older people at risk of suicide.

When the exercise is completed, collect the papers, shuffle them and redistribute them among the group. Draw two columns on butcher’s paper, one labelled ‘strengths’ and one labelled ‘weaknesses’. Ask each participant (in turn) to read out the comments on the paper in front of them. List the comments under the headings on the butcher’s paper.

Sample responses

Responses will depend on the background and experience of the group. In all cases, the strengths list should be acknowledged and any practices of excellence commented on.

Activity 19 – Improving practice

Initiate activity by asking the participants to suggest ways of overcoming the listed weaknesses identified in activity 18. Encourage participants to reflect on strategies and suggestions for practice identified during the workshop.

Sample responses

It is important that workers identify strategies to support themselves and their co-workers in working with older people at risk of suicide.

These may include:
- Development of new protocols
- Supervision
- Support for staff
- Development of closer links with referral agencies
- Development of better coordination between a number of involved services.
Identifying further sources of information (5 minutes)

Distribute Handout 18 – Policy directions and explain that there are a number of NSW and National mental health promotion and suicide prevention policies and strategies. The handout outlines some of the key policies that have lead to the workshop.

Distribute Handout 19 - Resources

Explain that this handout lists some agencies and services that may be useful in obtaining additional information on suicide prevention issues for older people.

It may be helpful to compile a list of local services and resources prior to the workshop. This list should take into account local referral processes and protocols to ensure that participants are aware of the range (and limitations) of services available in their area.

Topic 4.5 Session summary (5 minutes)

Review participant learning needs identified at the beginning of the day, by displaying the participant expectations, which were recorded in session 1. Discuss each expectation and clarify whether this was covered in the course of the day.

Conclude the workshop with a review of what has been covered in the workshop.

- Mental health problems, particularly depression, and other factors such as loss, illness, disability and lack of social support contribute to suicide risk in older people.
- Depression in older age is treatable and responsiveness to early indicators of depression is seen as one of the most effective suicide prevention strategies for older people.
- Suicide risk can be assessed by asking questions about suicide, considering risk and protective factors, and considering the level of risk.
- Suicide prevention requires planning and coordination between services.

Thank participants for their participation in the workshop and present attendance certificates.

Ask participants to complete the evaluation form.

End of workshop
Overhead transparency masters:

1. Workshop overview
2. Questions about ageing, mental health and suicide (2.1-2.6)
3. Session 1 summary
4. Difference between suicide rates and numbers
5. Lifespan perspective of suicide rates
6. The ageing population
7. Suicide in older people
8. Weighing up the risk
9. Understanding the continuum of suicidal behaviour
10. Levels of risk
11. Session 2 summary
12. Mental health problems in the elderly
13. Differentiating depression, dementia and delirium
14. Responding to older people at risk
15. Factors to consider before asking questions
16. Types of questions to ask an older person
17. Session 3 summary
18. Care and support options (18.1-18.3)
19. Information required by the referral agency
WORKSHOP OVERVIEW

Session 1 - Overview of ageing, mental health and suicide
- The ageing process
- Exploring attitudes to ageing
- Promoting engagement and early intervention

Session 2 - Understanding suicide risk in older people
- Older age and suicide: some facts
- Risk and resilience factors
- Levels of risk

Session 3 - Working with older people at risk of suicide
- Older people, mental health and suicide
- Identifying and responding to older people at risk
- Asking questions about suicide risk

Session 4 - Ongoing care and support for older people
- Care and support options
- The referral process
- Exploring case scenarios
Question 1…

Are depression and suicidal ideation ‘normal’ parts of ageing?

The Research Says…

• Depression has been shown to decrease in prevalence with increased age.

• Emotional wellbeing generally increases with age unless an older person experiences major health problems, disabilities or social disadvantage.

• Older people who live in institutional settings have a higher incidence of depressive disorders than older people living in the community.
Question 2…

Do older people cope better with grief and loss than younger people?

The Research Says…

• The experience of the death of a loved one is more common in older adults, but older people experience grief in the same way as other age groups.

• The loss may possibly be experienced more deeply because of the length of significance of the relationship.
Question 3…

Why focus on suicide in older people – isn’t youth suicide more significant?

The Research Says…

• The rate of suicide for men 65+ is as high as the rate for young males between 18-25.

• Suicide is a tragedy no matter which age group is affected.

• Research has shown that physicians and older people in the general population are more tolerant of suicidal behaviour among older people compared to younger groups - stigma and ageism.
Question 4…
Do older people usually disclose sad feelings?

The Research Says…
• Many older people do not disclose how they are feeling.

• Older people may not disclose their feelings because of the shame related to having mental health problems or fear of consequences of bringing up such issues.
Question 5…

Can physical symptoms relate to mental health issues in older people?

The Research Says…

• Older people may present their concerns in ways which make the detection of depression challenging.

• For example, an older person may experience and describe emotional and mental health problems in terms of physical (somatic) symptoms.
Question 6…

Do older people who are suicidal seek help?

The Research Says…

• A significant proportion of people who die by suicide have seen their health care provider in the three months prior to death (however, the visit may not be specifically about suicidal ideation).

• Older people do not generally access mental health services, receiving their health care from doctors, community centres, and hospitals.
SESSION 1 --- SUMMARY

- Age is characterised by biopsychosocial changes that may often be associated with major life change and stress.

- Some changes (or combination of changes) can impact on mental health.

- Beliefs, attitudes and values about ageing can limit access for older people in seeking help for mental health problems and possible suicidality.

- Being aware of ageing changes can help us increase early intervention to possible mental health and suicide risk problems in older people.

- Effective engagement and an early response to possible underlying mental health problems are positive strategies for suicide prevention in older people.
DIFFERENCE BETWEEN SUICIDE RATES AND NUMBERS

SUICIDE RATE
How often suicide occurs per a larger group
e.g. 5 per 100 000

Rates enable the comparison of death rates
between populations with different age structures
by relating them to a standard population
(e.g. all Australians)

SUICIDE NUMBER
The total number of people who have died by
suicide
LIFESPAN PERSPECTIVE OF SUICIDE RATES

Suicide Rates (Australia),
5 yr Age Groups, 2000, by sex

Source: developed by Hunter Institute of Mental Health from ABS Suicide Catalogue No. 3309.0 (2000).
Rates are based on year of registration of death.
THE AGEING POPULATION

In 1996:
- 12% > 65 years
- 20% of those > 80 years

By 2016:
- 16% > 65 years
- 25% of those > 80 years

By 2050:
- 25% > 65 years

(Byrne, 1994)
SUICIDE IN OLDER PEOPLE

Characterised by:

✓ Less warning/explicit cues

✓ High lethality due to frailty or intent to die

✓ Less history of previous attempts

✓ Greater prevalence of depression in context of physical illness

✓ Hopelessness

✓ Less likelihood of contacting mental health services

(Fiske & Arbore, 2001)
WEIGHING UP THE RISK

PROTECTIVE FACTORS      RISK FACTORS

Note:

• Assessing risk is like studying the balance of a pair of scales

• Equilibrium is not necessarily the best outcome

• Assumptions cannot be made about how risk factors will affect a particular individual
Differentiating ‘normal’ behaviour from suicidal intent:

**Intent** – whether the older person has made a decision to end their life.

**Context** – factors in a person’s life that may indicate they believe suicide to be a solution.

**Ratio of suicide attempts to deaths:**
- younger people (300:1)
- older people (4:1)

Therefore the “window” for detecting risk is very small.
<table>
<thead>
<tr>
<th><strong>Low risk</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recent upsetting events or problems.</td>
<td></td>
</tr>
<tr>
<td>• Evidence of support network.</td>
<td></td>
</tr>
<tr>
<td>• Sense of hope evident.</td>
<td></td>
</tr>
<tr>
<td>• Able to find solutions to problems with support.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Medium risk</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reports of low mood/feelings of life not worth living.</td>
<td></td>
</tr>
<tr>
<td>• Lower levels of support and linkage with services.</td>
<td></td>
</tr>
<tr>
<td>• Sense of helplessness /hopelessness.</td>
<td></td>
</tr>
<tr>
<td>• Has some difficulty seeing solutions to problems.</td>
<td></td>
</tr>
<tr>
<td>• Thoughts of death (suicidal ideation).</td>
<td></td>
</tr>
<tr>
<td>• Some withdrawal from social supports.</td>
<td></td>
</tr>
<tr>
<td>• No specific plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>High risk</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Combination of stressors &amp; other risk factors.</td>
<td></td>
</tr>
<tr>
<td>• Expressions of suicidal ideation.</td>
<td></td>
</tr>
<tr>
<td>• Recent or past suicide attempt/s.</td>
<td></td>
</tr>
<tr>
<td>• No support network evident (or withdrawal from them)</td>
<td></td>
</tr>
<tr>
<td>• A belief there is no other way to resolve problems.</td>
<td></td>
</tr>
<tr>
<td>• Overwhelming hopelessness or despair.</td>
<td></td>
</tr>
<tr>
<td>• Presence of a plan.</td>
<td></td>
</tr>
<tr>
<td>• Access to the means to carry out the plan.</td>
<td></td>
</tr>
</tbody>
</table>
SESSION 2 -- SUMMARY

• Rates of suicide for older men is about as high as that for younger men & rates for older women are about the same as the general population.

• Suicide in older people has unique characteristics - eg higher likelihood of death after a suicide attempt.

• Suicide risk can be assessed by considering risk and resilience factors.

• Suicide risk is variable and cannot be assessed only once.

• The overall aim of suicide prevention is to help older people recognise their strengths and assist them to find solutions to their problems.
Mental Health Problems in the Elderly

**Depression** – defined as a persistent lowering of mood over a period of weeks or longer which has a sustained impact on physical, social and psychological functioning.

**Delirium** – an acute confusional state characterised by disorientation and fluctuating level of consciousness.

**Dementia** – Dementia is a syndrome rather than one disease affecting mental functioning – including memory, abstract thinking, social judgement and higher brain functioning.

**Anxiety** – Anxiety is a normal response to a scary, dangerous or unknown situation, however, an anxiety disorder has physiological and psychological symptoms caused by an internal intense fear or a more sustained worrying.
Some clinical features of delirium, dementia and depression

Complexities arise as a result of the:
- overlap b/w depression, dementia and delirium
- possibility of coexisting disorders

It is important that a correct diagnosis is made – so that appropriate intervention can be trialed.

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>Delirium</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in behaviour</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Change &gt; 12 months duration</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change &lt; 12 months duration</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Problems mainly with memory</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems mainly with attention and concentration</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

(Williams, 2000)
RESPONDING TO OLDER PEOPLE AT RISK

Pay attention to early signs of mental health problems:

✓ Talk to person alone
✓ Allow sufficient time
✓ Acknowledge difficulty of talking about sensitive topics
✓ Ask directly about suicidal thoughts or behaviour

Intervene early:

✓ Utilise health promotion approaches to increase support of older person
✓ Seek additional information to explore presenting concerns further
✓ Seek assessment of mental health problems if early signs are evident
FACTORS TO CONSIDER BEFORE ASKING QUESTIONS ABOUT SUICIDE

Introductions

- Who you are, where you are from, and how you might be able to help.
- Don’t assume that someone else has explained who you are and why you have come.

Safety

- Ensure the safety of the older person by having any physical illness or injury attended to.
- Ensure your own safety including the possibility that the older person may have a weapon.

Establish rapport

- Take time to learn about the older person.
- Use your judgement to gauge an appropriate moment to raise your concerns.

Create awareness of limits of confidentiality

- Assured of confidentiality unless there is a significant risk of harm to themselves or others.

Acknowledge distress

- Acknowledge that it may be very difficult for an older person to discuss some things.
- Discussions should be at a slow pace.
Types of questions to ask an older person:

History
- Has the person felt like this before?
- Has the person harmed him/herself before?
- Have you or others seen a recent change or a change over time, e.g. withdrawal?
- Is there evidence of distress and a sense of hopelessness?

Intent
- How serious is the intent to die?
- What is the person's reason for living?
- What is the person’s reason for dying?

Plans
- How much thought has the person put into devising a plan of how and when they might die?
- How specific is the plan?
- What is the plan and what has the older person done about it?

Means
- Does the older person have the means to die available to them?
SESSION 3 -- SUMMARY

- Suicide prevention for older people involves responding proactively to early indicators of mental health problems or concerns.

- The most common mental health problem associated with suicide in older people is depression. Detection and early response to depression is seen as the most effective way to prevent suicide in older people.

- Many interventions by people who work with older adults can be considered to be suicide prevention interventions. These include interventions that aim to ameliorate experiences of isolation, loneliness, hopelessness, and pain and suffering.

- When concerns about suicide risk arise, it is important to address the issues directly with the person and seek additional support.
CARE AND SUPPORT OPTIONS

1. Monitoring With No Referral

- Low risk
- Non-specific signs and symptoms of depression
- Reviewing and coordinating the current services
- Reconsidering issues such as community participation and social isolation
- Increased visits or phone contact
- GP Role
CARE AND SUPPORT OPTIONS

2. Referral to Community/Crisis Service

- Low to Medium Risk

- Suicidal ideation is present and persistent or associated with features of a depressive or other mental health problem

- Referral to an appropriate mental health service is required

- May include crisis services

- Mental health may be involved as consultants or visiting and treating the older person

- Identified support network
3. Referral to Hospital-Based Care

- Suicide risk is immediate and high

Also when:

- Little support within the community or access to services
- Harm to self
- Severe despair or depression
- A need to clarify diagnosis
- In-patient treatment is required to attend to other needs, such as medical conditions
- May include scheduling under the Mental Health Act (involuntary admission).
INFORMATION REQUIRED BY THE REFERRAL AGENCY

Information usually provided:
• Name
• Address
• Phone number
• Date of birth
• Your relationship to the older person
• Current problem and background to this problem.

Information if suicide risk assessment needed:
• All of the above
• Your concerns and how long you have had these concerns
• Your concerns regarding suicide risk - presence of suicidal ideation? a plan? access to means?
• Information you have gathered on suicide risk and protective issues with the older person and with others involved with the older person.
Handouts:

1. Workshop overview
2. Presenting concerns of older people
3. Research on attitudes to ageing, mental health and suicide
4. Suicide terminology
5. Lifespan perspective of suicide rates
6. Suicide rates for older people in NSW
7. Issues surrounding suicide in older people
8. Resilience and risk factors for suicide in older people
9. Depression
10. Delirium, dementia and depression
11. Anxiety disorders and depression
12. Psychosis and depression
13. Treatment of mental health problems in older people
14. Vignette
15. Questions for identifying older people at risk
16. Information required by referral agencies
17. Vignettes
18. Policy directions
19. Resources
Handout 1 – Workshop Overview

Session 1 – Overview of ageing, mental health and suicide (1 hour 45 mins)
- Workshop introduction
- The ageing process
- Exploring attitudes to ageing
- Promoting engagement and early intervention with older people
- Session summary

Session 2 – Understanding suicide risk in older people (1 hour 30 mins)
- Older age and suicide: some facts
- Risk factors
- Protective/resilience factors
- Introduction to levels of risk
- Session summary

Session 3 – Working with older people at risk of suicide (1 hour 30 mins)
- Older people mental health and suicide
- Identifying and responding to older people at risk
- Asking questions about suicide risk
- Session summary

Session 4 – Ongoing care and support of older people (1 hour 30 mins)
- Care and support options
- The referral process
- Exploring case scenarios
- Pulling it all together
- Session summary
What might be some of the underlying mental health concerns related to the following problems that older people may present with?

<table>
<thead>
<tr>
<th>Presenting concerns in older people….</th>
<th>Underlying Mental Health Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness/grief</td>
<td></td>
</tr>
<tr>
<td>Poor sleep</td>
<td></td>
</tr>
<tr>
<td>“Off my food”</td>
<td></td>
</tr>
<tr>
<td>Nothing to live for anymore</td>
<td></td>
</tr>
<tr>
<td>Pain/physical complaints</td>
<td></td>
</tr>
<tr>
<td>Not interested in activities</td>
<td></td>
</tr>
<tr>
<td>Cannot do much</td>
<td></td>
</tr>
<tr>
<td>Memory problems</td>
<td></td>
</tr>
<tr>
<td>‘Euthanasia’ request</td>
<td></td>
</tr>
</tbody>
</table>
Are depression and suicidal ideation a ‘normal’ part of ageing?

Research has shown that many health providers, family members and older people themselves accept depression and suicidal ideation as a normal part of ageing (Pearson & Brown, 2000). This is despite the fact that depression has been shown to decrease in prevalence with increased age. Evidence suggests that emotional wellbeing generally increases with age unless an older person experiences major health problems, disabilities or social disadvantage (Centre for Mental Health, 1998). Also, older people who live in institutional settings have a higher incidence of depression and depressive disorders than older people living in the community (Centre for Mental Health, 2001).

Do older people cope better with grief and loss than younger people?

The experience of the death of a loved one is more common in older adults, but older people experience grief in the same way as other age groups (i.e. as an unexpected and tragic event). The loss may possibly be experienced more deeply because of the length or significance of the relationship (Knight, 1996). Depression may be precipitated by experiences of grief and loss.

Why focus on suicide in older people – isn’t youth suicide more significant?

The rate of suicide for men over 65 years is as high as the rate for young males between 18–25 years (Centre for Mental Health, 2001), however, suicide is a tragedy no matter which age group is affected. Research has shown that physicians and older people in the general population are more tolerant of suicidal behaviour among older people compared to young or middle-aged groups (Pearson, 2000). This finding reflects both stigma related to mental health problems as well as ageism.

Specific advantages noted by Conwell (2001) to focussing on prevention of suicide in older people include:

- Decreasing pain and suffering of older people
- Reducing devastating impact on people bereaved by suicide death
- ‘Ancillary’ benefits to prevention through detecting depression as result of reduced health care costs - Conwell (2001) states that a number of studies
have shown that older people with depression have higher usage of health care services.

Do older people usually disclose sad feelings?
Many older people do not disclose how they are feeling (Conwell, 2001). Reasons proposed include shame related to having mental health problems, or fear of consequences of bringing up issues. Symptoms of depression may be masked by somatic complaints.

Can physical symptoms relate to mental health problems in older people?
Acute and chronic physical health conditions are highly prevalent in later life and therefore medical problems can become the focus of attention in working with an older person (Snowden, 1998). An unfortunate consequence is that physical symptoms may be pursued exhaustively while psychological symptoms are overlooked or ignored (Centre for Mental Health, 2001).

A further challenge to aged care workers is that older people may present their concerns in ways that make the detection of depression challenging. For example, an older person may experience and describe emotional and mental health problems in terms of physical (somatic) symptoms. In addition, if depressive symptoms accompany painful medical conditions, then the depressive symptoms may be perceived as ‘normal’ or ‘understandable’ and therefore not treated.

Do older people who are suicidal seek help?
A significant proportion of people who die by suicide have seen their health care provider in the three months prior to death, however, the visit may not be specifically about suicidal ideation. Suicide risk for vulnerable older people is increased because of the likelihood that they may have fewer people interested in their wellbeing, their social isolation may be greater and the risks may be unnoticed or not raised (Centre for Mental Health, 2001). Importantly, older people do not generally access mental health services, receiving their health care from doctors, community centres, and hospitals (Pearson & Brown, 2000).

What are the implications of attitudes towards older people in terms of detection of suicide risk?
Attitudes about ageing, mental health and suicide mean that depression and suicide risk are often not detected or treated in older people. The attitudes of older people
themselves are important, as older people may not readily discuss sad feelings or mental health concerns. Challenges to detecting depression and possible suicide risk in older people include the possibility that physical symptoms are focussed on to the exclusion of mental health concerns, and the frequent complexity of presenting concerns of older people. An additional challenge is to acknowledge the experience and intensity of the older person’s concerns whilst maintaining and expressing a sense of hope and optimism for the future.

Adapted from:


**Additional readings on processes of ageing:**


Handout 4 – Suicide terminology

The following terms may be encountered in literature and reports related to suicide and suicide prevention. Note that not all of the terms listed will be used during the Suicide Prevention for Older People Workshop.

**Suicidal act**  
Self-inflicted injury with an intention to die from suicide, including self-poisoning, possibly resulting in death or serious injury

**Suicidal ideation**  
Thoughts about suicidal acts

**Suicidal intent**  
The aim or plan/s to inflict non-accidental self-injury in the expectation that this act will result in a fatal outcome

**Suicidal threats**  
Actions suggesting an intention to die from suicide or self-harm

**Suicidal behaviour**  
Suicidal ideation, suicidal threats, or suicidal acts

**Attempted suicide**  
Suicidal act causing injury but not death

**Non-fatal suicidal behaviour**  
Act/s causing injury but not death

**Suicide**  
A suicidal act resulting in death

**Deliberate self-harm**  
Various self-inflicted harmful acts or injuries that do not result in death

**Possible suicidal behaviour**  
Any suicidal or deliberate self-harming behaviour, whether or not the intent was to die

**Accidental death**  
Unintended outcome of deliberate self-harm

**Suicide prevention**  
Activities aimed at reducing the rate of death, disability (mortality and morbidity) resulting from risk factors linked to suicidal acts
<table>
<thead>
<tr>
<th><strong>Risk factor</strong></th>
<th>A risk factor for suicide is a factor which predicts a higher likelihood of the particular adverse outcomes (for example suicide)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Protective factor</strong></td>
<td>A protective factor is a factor which buffers the individual from the effects of risk factors</td>
</tr>
<tr>
<td><strong>Resilience</strong></td>
<td>The process of and the capacity for successful adaptation despite challenging or threatening circumstances</td>
</tr>
<tr>
<td><strong>Suicide rate</strong></td>
<td>Shows how often an event occurs per a larger group of the population, e.g. 5 per 100 000 means that there would be 5 suicide deaths for every 100 000 of the whole population.</td>
</tr>
<tr>
<td><strong>Suicide numbers</strong></td>
<td>The total number of people who have died by suicide.</td>
</tr>
</tbody>
</table>

**Adapted from:**
Centre for Mental Health (1999). *Suicide: We can all make a difference. NSW suicide prevention strategy.* NSW Health Department: Sydney.
Handout 5 - LIFESPAN PERSPECTIVE OF SUICIDE RATES

Suicide Rates (Australia), 5 yr Age Groups, 2000, by sex

Source: developed by Hunter Institute of Mental Health from ABS Suicide Catalogue No. 3309.0 (2000).
Rates are based on year of registration of death.
Handout 6 – Suicide rates for older people in NSW

Trends for older people compared with general population
The numbers of people who die by suicide in all age groups (including older people) in NSW have remained relatively stable over time. In general, the suicide death rates for people 65 years and older have remained high since 1964/65.

Suicide rates in older men
Since the 1960s suicide death rates have remained higher for older men than for the population as a whole, and have been relatively stable since about 1990. The rate of suicide death is as high for older men as younger men. For older men, the rate of suicide increases as age increases, with suicide rates for men over 85 years of age in 1996/97 being the highest of any age group in the population. Note however that the actual number of deaths in this group represent only about 1½% of all male suicide deaths for that period (due to the low numbers of people in the over 85 age group).

The suicide rate for older men is higher than that of older women. The rate of suicide for men over 65, at approximately 30 deaths per 100,000, is almost three times that of women.

Suicide rates in older women
Since the 1960s suicide rates for older women have ranged between 5 and 10 deaths per 100,000. This rate is at or about the same level as that of the general female population. As for all other age groups, older women have a lower rate of suicide death than older men.

Suicide attempts in older people
Older people differ in their levels of suicidal behaviour from other age groups. Unlike other age groups, the number of people hospitalised for a suicide attempt compared with the number of people who die from an attempt is lower in older males and females. This may mean that for older people, a suicide attempt is more likely to result in death than an injury. This has implications for early intervention and prevention in terms of responding and intervening promptly to suicide risk.

The rate of attempted suicide is similar for older men and older women, with men over 65 hospitalised for suicide attempts slightly more than older women. This is
different than for other age groups. In younger age groups, women are hospitalised for attempts more than men are. This difference for older people could provide an opportunity for intervention during hospitalisation after a suicide attempt. However, intervention prior to a suicide attempt is always the priority due to the high lethality of older age suicide attempts.

**Means of suicide**

Understanding the means used for suicide can have an impact on suicide prevention as access to a means for suicide is a significant risk factor for all age groups.

In NSW in 2000, the most common method of suicide in older males is firearms. Other significant means for suicide include carbon-monoxide poisoning from car exhaust and hanging. For females in NSW (in 2000), the most common method is drug overdose. The rate of death from drug overdose has decreased since the 1960s as a result of the restrictions on amounts of barbiturates that can be prescribed.

**Aboriginal and Torres Strait Islander older people**

Aboriginal and Torres Strait Islander people appear to be experiencing a high and increasing rate of suicide. The suicide rate among young Aboriginal and Torres Strait Islander people is estimated to be four times higher than the non-indigenous population. The number of suicides among older indigenous people is low, however, as a smaller number of Aboriginal and Torres Strait Islanders live to old age it is not possible to draw conclusions from this. It is also important to note that the quality and availability of health statistics for Australia’s indigenous population are not as good as for the whole Australian population. Substantial under-identification of indigenous status in death and hospital data collections is likely to result in underestimation of rates of any health event.

When considering suicide risk for older aboriginal people, it is extremely important to acknowledge the devastating impact of past governments’ policies and practices on the lives of aboriginal communities, families and individuals and the impact of this on their mental health. It is also important to be aware of the need for cultural sensitivity, incorporating the holistic concepts of social, emotional, spiritual and physical wellbeing.
Older people from culturally and linguistically diverse backgrounds

There is great diversity in the rate of suicide among immigrants to Australia. Generally both male and female immigrants over 65 years of age have significantly higher rates than the overall suicide rates for people over 65 in NSW. There is evidence of higher suicide rates amongst NSW immigrant populations than for people that remain in their country of origin. However, there are similarities in both the rates of suicide and the methods used between immigrants and their country of birth counterparts. This suggests that suicide is strongly influenced by sociocultural factors associated with country of birth.

Suggested factors contributing to the increase risk of suicide for older immigrants from culturally and linguistically diverse communities include: increased social isolation, poverty, difficulty accessing community support services, breakdown of traditional family support structures, traumatic experiences/prolonged stress prior to or during immigration and poor utilisation of mental health services.

Additionally the process of adapting to a new culture (acculturation) causes acculturative stress. There is greater stress adapting to a culture that has a different language and widely divergent values and beliefs. Many older immigrants and those that arrive in Australia as adults experience substantial difficulties during this process and are at risk of becoming marginalised, where there is neither affiliation to their country of birth or wider Australian culture.

Adapted from:

Centre for Mental Health (1997). NSW Aboriginal Mental Health Policy. A strategy for the delivery of mental health services for aboriginal people in New South Wales. Sydney: NSW Health Department.

Centre for Mental Health (2000). The NSW suicide data report: Suicide in NSW – We need to know more. NSW Health Department, Sydney. (The data for this report is based on the Australian Bureau of Statistics Mortality Date 1964–1997, NSW Inpatient Statistics Collection 1989/90–1995/96 and data from studies and surveys.)

Handout 7 – Issues surrounding suicide in older people

Suicide in older people is characterised by:

- Less warning or explicit cues
- Higher lethality – older people are more likely to die from a suicide attempt than younger people
- Less history of previous attempts
- Greater prevalence of depression and physical illness
- High levels of hopelessness
- Less likelihood of contacting mental health services to seek help

Some of the reasons proposed in the literature in order to understand the characteristics of suicide in older people are listed below:

Older people have a greater susceptibility to potentially lethal attempts as a result of frailty
Greater social isolation means less likelihood of discovery
Greater intent and planning leads to higher lethality (older people may avoid intervention, take precautions against discovery, do not communicate plans to anyone)
Recognition of suicide risk is more complex in older people – many have co-morbid depression and painful medical illnesses, fewer explicit cues are given as to their plans, and older people have less contact with mental health services.

(Baume & Snowden, 1999; Caine & Conwell, 2001; Pearson & Brown, 2000)

Adapted from:


Handout 8 – Resilience and risk factors for suicide in older people

Retrospective studies conducted in the US and UK have identified that up to 70% of older people who die by suicide have visited a primary health care worker in the month prior to suicide death (Conwell, 2001). It is important to note that the visit may not be specifically about suicidal feelings or even about how the person is feeling. No one factor is predictive of suicide, rather it is the combination or culmination of a number of interrelating factors and/or life events.

**Resilience factors**

There is a need for more research into resilience factors, or those factors that protect a person from suicide risk. However, the research that is available and extrapolated information from research into risk indicate that some of the following factors may be significant:

- Connections with family, friends and community
- The presence of a significant other, such as a spouse
- Personal resilience and problem-solving ability
- Economic security in older age
- Good physical and mental health
- Strong spiritual or religious faith or a sense of meaning and purpose of life
- Early identification and treatment of mental health problems
- A belief that suicide is wrong
- Lack of access to guns in the home

(Commonwealth Department of Health and Aged Care, 2000).

**Risk factors**

The presence of risk factors can indicate the possibility that a person may be at risk of suicide, but it does not automatically mean they are thinking of suicide. Generally only a small number of people will attempt or die by suicide. The presence of risk factors enables those working with older people to be alert to the presence of warning signs and assess for the presence of suicidal ideation by asking questions about suicide.
Mental health problems and disorders

Diagnosable mental health problems are present in 90% of all people who die by suicide, with depression accounting for two thirds of suicide death in people over 50 years of age (Conwell, 1997). (In young to middle ages, psychosis and substance abuse are more common.) Other risk factors related to mental health problems and disorders include:

- Untreated mental health problems
- Alcoholism
- Past history of suicide attempts (uncommon in the elderly, but may signify especially high risk).

Personality/coping factors

A number of researchers have attempted to identify personality factors that may be associated with suicide in older people. Personality or ‘coping style’ factors that have been associated with suicidal behaviours by some researchers include:

- A timid or shy and reclusive personality (a person with these traits may not seek help readily)
- A personality characterised by a rigid, fiercely independent style (this may suggest that the person will have difficulty seeking help, or developing coping strategies for difficult situations)
- Tendency to ‘somatisise’ or unconsciously express psychological pain in physical terms (rather than expressing possible feelings and emotions that may be underlying)
- Feelings of hopelessness
- Major difficulty coping with or adjusting to change.

Social circumstances

The social circumstances of older people are important indicators of risk. A number of factors identified by researchers as being of particular significance include:

- Living alone
- Social isolation and loneliness
- Clustering of stressful life events in weeks or months before suicide (commonly physical illnesses and other losses)
- Being widowed
• Grief (loss within the last 6–12 months being the most significant in terms of risk)
• Carer stress.

**Physical illness and functional impairment**

Estimates indicate that physical illness contributes to between 35% and 70% of suicide death in older people (Conwell, 2001). It is important when considering physical illness as a risk factor to be aware of the complex relationships between illness, functional impairment, pain and affective disorders, such as depression. Some specific physical illnesses have been associated with suicide in older men including:

• Cancer
• Disease of the central nervous system
• Peptic ulcer
• Cardiopulmonary complications
• Rheumatoid arthritis
• Urogenital disease.

**Adapted from:**

Centre for Mental Health (2000). *The NSW suicide data report: Suicide in NSW – We need to know more.* NSW Health Department: Sydney.


Centre for Mental Health (1999). *Suicide: We can all make a difference. NSW Suicide prevention strategy.* NSW Health Department: Sydney.

Handout 9 – Depression

Unless otherwise noted, the information on this handout is adapted primarily from Centre for Mental Health (2001). *Consensus guidelines for assessment and management of depression in the elderly.* NSW Health Department: Sydney.

There is a strong link between mental health problems and suicide risk in all age groups. In older people depression is the most significant risk factor for suicide and is estimated to be associated with up to two thirds of suicide deaths.

**What is depression?**
Depression is a common mental illness, significantly different from unhappiness/sadness (depressed mood) that occurs as a normal emotional state. It can be a long-lasting and often recurring illness, as real and debilitating as heart disease. Depression is defined as a persistent lowering of mood over a period of weeks or longer which has a sustained impact on physical, social and psychological functioning.

**Depression and older people**
Whilst the prevalence of depression decreases with age for those older people who live in the community, depression can occur for the first time in older age and is more likely to persist if untreated (Commonwealth Department of Health and Aged Care, 1999). Estimates of depression for older people vary. The 1997 National Survey of Mental Health and Wellbeing (ABS, 1998) found that depressive disorders are experienced by approximately 1% of men and 2% of women over 65 years of age who live in the community.

The prevalence of depression in older age is strongly influenced by where an older person lives. Older people living in residential care such as hostels and nursing homes are more at risk for depression, with estimates indicating that between 15% and 42% of residents experience depressive symptoms (Commonwealth Department of Health and Aged Care, 1999).
Depression in older people needs to be differentiated from delirium, dementia, the signs and symptoms of a medical illness itself, or substance abuse and dependence. It is very important to note, however, that depression can co-exist with any of these conditions.

**Typical signs and symptoms of depression include:**

- Low mood
- Loss of pleasure/interest
- Appetite/sleep disturbance
- Worry/rumination
- Feeling unworthy or helpless
- Difficulty with memory and/or concentration
- Lack of energy
- Thoughts that life is not worth living

An older person with depression may present somewhat differently to younger age groups, and may have both physical and psychological symptoms. Presentations more common in older age include:

- **Somatic symptoms** – a complaint of pain or illness over any of a range of body systems
- **Cognitive impairment** – generally of recent onset, which may be severe
- **Minimal expression of sadness** – older people frequently minimise feelings of sadness, often in an attempt not to burden others
- **Behaviour change** – behaviour changes that are very uncharacteristic of the person
- **Accentuation of negative personality traits** – these may become more pronounced and challenging
- **Agitation/anxiety** – development of anxiety, obsessional traits or hysteria for the first time in an older person may be indicative of depression.

**Range of conditions**

Depression and depressed mood can occur in a number of conditions. It is important to recognise the severity of the mood disorder and the need for assessment and treatment rather than focussing on the specific type of disorder. The types of depressive disorders are listed below:
• **Major Depression** – a persistent lowering of mood over a period of weeks or longer with a significant impact on functioning (may occur in the context of a new medical condition or its treatment)

• **Bipolar Disorder** – characterised by alternating episodes of mania (elevated mood) and depression

• **Dysthymia** – no distinct episodes, but milder symptoms of depression present for a period of two years or more

• **Adjustment disorder** – depressed mood in response to a crisis/stressor but more marked or prolonged than normal reactions (adjustment disorder is less severe and prolonged than major depression)

• **Complicated bereavement** – some grief reactions are complicated by the development of depressive disorders in vulnerable people

• **Anxiety conditions** – symptoms of anxiety and depression may appear together, especially for a person experiencing adjustment disorder or generalised anxiety disorder.

In some instances, depression may have the following features:

• **Psychotic features** – delusions or hallucinations that may or may not be congruent with mood

• **Melancholic features** – loss of pleasure in all or almost all activities, lack of reactivity, worse in the morning, waking in the early hours of the morning, marked psychomotor retardation or agitation, significant anorexia, excessive or inappropriate guilt.

**What causes depression?**

There is no one clear cause for depression, rather it is a result of the interaction of predisposing and precipitating factors. Predisposing factors are long-term background factors that, if present, make it more likely that an individual may develop a particular condition. Predisposing factors for depression include:

• **Genetic susceptibility** – this risk decreases with age

• **Previous psychiatric disorder** – including previous episodes of depression or mania

• **Neurobiological risk factors** – some biological changes in brain chemistry associated with ageing may be similar to changes that occur in depression

• **Personality** – for example, a previous sustained depressive response to life events

• **Personality Disorder** – pronounced traits that limit a person’s ability to function effectively in a number of areas, particularly in interpersonal relationships

• **Past events or traumas** – impact of experiences such as war, migration, suicide in the family, or early childhood experiences
• **Poor physical health** – especially chronic pain and ill health
• **Medication biochemistry** – the side effects of some medication may cause depression.

Precipitating factors are events and incidents that have led to the development of a condition in individuals who have a predisposition.

<table>
<thead>
<tr>
<th>Precipitating risk factors for depression in older people include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New, potentially life-threatening or chronic illness, e.g. cancer, CVA</td>
</tr>
<tr>
<td>Unexplained physical symptoms</td>
</tr>
<tr>
<td>Any disability or handicap</td>
</tr>
<tr>
<td>Recent losses/bereavement (relationships, income, work role, home)</td>
</tr>
<tr>
<td>Being a carer</td>
</tr>
<tr>
<td>In residential care</td>
</tr>
<tr>
<td>Social isolation</td>
</tr>
<tr>
<td>Substance dependence and/or abuse</td>
</tr>
</tbody>
</table>

**Detecting depression in older people**

*The Consensus Guidelines for Assessment and Management of Depression in the Elderly* (Centre for Mental Health, 2001) recommend that depression should be suspected when depressive symptoms are evident or if there has been a recent decline in function or cognition. Persistence of depressive symptoms over two weeks should lead to treatment, and in some instances, such as when a person has suicidal ideas or plans, or is also experiencing psychosis, an urgent referral to a specialist should be made.

**Management of depression**

Management of depression aims to reduce symptoms, improve functioning, increase contact with supportive agencies, maintain current accommodation if desired by older person, decrease suicide risk, improve physical health, and provide support and education to carers of the older person.

Most depressive disorders will be managed with the older person staying in their usual home. In some instances, where safety cannot be assured due to suicide risk or physical health and wellbeing concerns, hospitalisation may be necessary.
The most important features of support for an older person with a depressive disorder are that it is personal, starts early and occurs regularly and predictably. Vital considerations in treating depression in older people are recognising depression in the first instance, and ensuring treatment is continued for long enough to allow for improvement. With appropriate intervention and enlistment of support, at least 50% of older people with depression should recover completely, and a further 25% should make some improvements.

Adapted from:


Handout 10 – Delirium, dementia and depression

The ‘3 Ds’ – depression, dementia and delirium – can create complex clinical presentations. Complexities arise as a result of the overlap between disorders, as well as the possibility of co-existing disorders. It is very important that a correct diagnosis is made so that an appropriate treatment can be trialed. However, it should be noted that investigations of causes of problems can occur in parallel and treatment of a depressive illness should not be delayed if indicated (Centre for Mental Health, 2001).

Delirium

Delirium is an acute confusional state characterised by disorientation and fluctuating level of consciousness. Delirium may present just like depression and should always be considered in the assessment and management process.

<table>
<thead>
<tr>
<th>A person with delirium may experience:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of self-awareness, attention and concentration</td>
</tr>
<tr>
<td>Heightened or decreased level of arousal</td>
</tr>
<tr>
<td>Increased physical activity (usually purposeless)</td>
</tr>
<tr>
<td>Fluctuating mood</td>
</tr>
<tr>
<td>Perceptual disturbances</td>
</tr>
<tr>
<td>Slow and muddled thinking</td>
</tr>
<tr>
<td>Frightening illusions</td>
</tr>
<tr>
<td>Simple hallucinations</td>
</tr>
<tr>
<td>Distortions in visual perception</td>
</tr>
</tbody>
</table>

There are a myriad of causes of delirium, including trauma, infections, toxic reactions to drugs, hypoxia and endocrine and metabolic causes. Due to the wide range of causes, it is crucial to obtain accurate history from a reliable informant.

The symptoms of delirium may be masked in older people with moderate or severe dementia and the clinical picture may only be of a change in behaviour, increased confusion or agitation.
Dementia
A number of symptoms of depression and dementia overlap, including cognitive impairment, and changes in usual patterns of behaviour. The assessment of depressive disorders in older people who already have dementia is challenging. When considering the possibility of depression in an older person with dementia, reviewing recent changes can provide insights.

Consider changes such as:
- A recent change in behaviour
- A recent change in psychomotor function
- A recent deterioration of biological function, such as sleep and appetite
- Development of a depressed affect

Depression in an older person with dementia should be considered if sudden changes occur such as those listed above, and these changes cannot be explained by the development of a new physical illness or discomfort.

Investigate depression in an older person with dementia if the following symptoms occur for more than a week:
- Sudden decline in function
- Dysphoria (feeling terrible)
  - Loss of interest
- Psychomotor change
- Aggression/noisiness
- Refusal to eat or drink adequately
- Emotional lability
- Thoughts of death

If no underlying medical condition, delirium or painful condition can be detected and treated with a positive result, then assessment and treatment for depression should occur.
Some clinical features of delirium, dementia and depression

<table>
<thead>
<tr>
<th></th>
<th>Dementia</th>
<th>Delirium</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in behaviour</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Change &gt; 12 months duration</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change &lt; 12 months duration</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Problems mainly with memory</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems mainly with attention and concentration</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

(Williams, 2000)

Adapted from:
Handout 11 - Anxiety disorders and depression

Anxiety disorders are a significant problem among older people in Australia. A study conducted by the Australian Bureau of Statistics (ABS, 1998) found that 3.5% of males and 5.4% of females over 65 years of age reported anxiety disorders. Anxiety often occurs in association with or prior to the onset of depression in older people, and may also be a presenting symptom of depression (Commonwealth Department of Health and Aged Care, 1999).

What is anxiety?
Anxiety is a normal response to a scary, dangerous or unknown situation. Anxiety involves the physical and psychological reaction that is necessary to prepare a body for either running away or fighting if necessary (the ‘fight or flight response’).

A person experiencing an anxiety disorder has physiological and psychological symptoms caused by an internal intense fear or a more sustained pattern of worrying. The symptoms occur in the absence of or are grossly disproportionate to an actual threat. Symptoms may include fearfulness, social phobias, panic attacks, post traumatic stress disorder or agitation.

Anxiety disorders usually begin in early adulthood and are often triggered by a series of significant life events. It is very common for older people to present with a combination of anxiety and depressive symptoms.

Anxiety signs and symptoms may include:

- Mind becomes alert/racing
- Feeling sick or nauseous
- Increased heart rate, blood pressure and breathing rate
- Trembling, shaking, sweating, butterflies in the stomach
- Tense muscles and startling easily
- Dry mouth, increased thirst
- Frequent urination
- Irritability, feelings of fear or apprehension, feeling out of control, restless or ‘crazy’
- Sleeping difficulties
- Decreased immune response
Mixed presentation of depression and anxiety

Depression is more likely to be associated with anxiety than any other disorder (Commonwealth Department of Health and Aged Care, 1999). Symptoms of depression and anxiety may occur in the context of adjustment disorder. An adjustment disorder occurs in response to changes such as loss of physical health, change in social circumstances or stage of life issues (Centre for Mental Health, 2001). Higher levels of anxiety have also been found to be a feature of depression among older people when compared with the presenting symptoms of younger age groups (Gottfries, 1998).

Responding to anxiety in older people

Treatment of both anxiety and depressive symptoms is important for those older people who experience mixed presentation of disorders. It is important to be aware of the relationship between anxiety and depression, so that appropriate assessment and treatment can occur (Commonwealth Department of Health and Aged Care, 1999).

Handout adapted from:


Psychosis is a term used to describe a range of conditions that lead to distorted perceptions of reality. Psychosis can be experienced as an acute event (for example, as a symptom of depression) or may be recurrent, and experienced over many years of a long-term mental health problem. Working with a person who is experiencing psychosis presents communication challenges as the person’s experience of reality may differ from yours. Understanding psychosis and appropriate mental health assessment and intervention may be crucial to achieving a positive health outcome for an older person.

What is psychosis?
The key feature of psychosis is the misinterpretation of the nature of reality. One example of a psychotic illness is schizophrenia.

**Symptoms of psychosis can include:**

- Hallucinations - Impaired perceptions
- Delusions - False beliefs and interpretations of the environment
- Disorganised thoughts - Disorganised patterns of thinking and speech.

What is schizophrenia?
Schizophrenia is a mental health disorder that is characterised by changes in either the way a person thinks, perceives, behaves and/or the way they emotionally respond to themselves, others and the world around them. It has an enormous impact on nearly every aspect of a person's life. The onset of schizophrenia in older age is a rare occurrence - it is usually a disorder that an older person has had for many years.

The causes of schizophrenia are not fully understood, however, they appear to be a combination of life stress, problems with brain functioning and genetic vulnerability.

The symptoms of schizophrenia can include:
• Thought disorder – difficulty organising thoughts or concentrating
• Delusions – convincing beliefs about things that are in fact not true
• Hallucinations – hearing, seeing, feeling or smelling something which is not there
• Unusual behaviour – the symptoms experienced by a person with schizophrenia may mean they present in an unusual way, in terms of speech, behaviour and appearance
• Loss of drive – not motivated by anything, seeming loss of interest in life and general activities
• Blunted emotions – a person does not show emotions and may have vacant eyes and a toneless voice; the person does not seem to react to events around them appropriately
• Social withdrawal – a person with schizophrenia may isolate themselves from others due to preoccupation with their thoughts and feelings
• Lack of insight – a person with schizophrenia may not believe anything is wrong with them. This may lead to a refusal to accept treatment and distress for family and friends.

Psychosis and depression
Psychosis may be a severe or unusual symptom of depression in older people. If psychotic features such as delusions, hallucinations and disorganised thoughts are evident then assessment by a psychiatrist is recommended (Centre for Mental Health, 2001).

Adapted from:
Handout 13 – Treatment of mental health problems in older people

A number of effective treatments including medication and counselling therapies are available for the treatment of mental health problems in older people. When working with older people, it is also important to consider the positive benefits of intervention for early signs that suggest a person may have a mental health problem. Health promotion activities that promote socialisation, community participation and that address underlying emotional issues can be of crucial importance in preventing the development of serious mental health problems and possible suicidality. Maximising the social, community and health care supports for an older person can increase their chance of recovery. Supports may include talking therapies, practical improvements to physical and social environments, and/or optimising the management of any underlying physical illness or disability.

A number of specific treatments for mental health problems are discussed below.

Psychotherapies

There are a number of different models of psychotherapy that have been shown to be effective in the treatment of different mental health disorders.

Supportive therapy – Central to the treatment of any disorder is a treating professional who engages with the older person and allows for ventilation of the older person's concerns. Supportive therapy must be regular and of predictable duration and allow for openness between the treating professional and the older person. Encouragement, optimism and hope are essential characteristics of providing support to the older person.

Cognitive behavioural therapy – a brief time-limited skill-based treatment proven to be effective for the treatment of major depression.

Different forms of therapy can be conducted in a group setting, and this approach may be very effective for older people as group processes have a supportive component. However, it is very important that the group members have similar issues and needs.
Medication

The aim of drug treatment is to reduce symptoms. The optimal dose is one that produces maximum reduction in symptoms with minimum side effects. The side effects of different classes of medication differ greatly and this may be the basis on which one medication is selected over another.

It is important to note that older people experience more side effects with all medications. This is due to concomitant illnesses and their treatments as well as the effect of age-related changes on drug metabolism. It is important that medication is started at low doses and increased gradually with regular reviews.

**Antidepressants** – the main forms of medication for acute and long-term depression. Antidepressants may have significant side effects and it is important to weigh up the benefits against the risks. The usual first choices for antidepressants (based on the profile of side effects) are:

- Selective serotonin reuptake inhibitors (SSRIs) – citalopram, fluoxetine, fluvoxamine, paroxetine, setraline
- Serotonin-noradrenaline reuptake inhibitors (SNRIs) – venlafaxine
- Monoamine oxidase inhibitors (MAO-Is) – moclobemide
- Nefazadone
- Mianserin
- Mirtazepine

The medications used as a second line are all effective antidepressants, but have the potential to produce more side effects in older people:

- Tricyclic antidepressants – nortryptiline, dothiepin
- MAO – inhibitors – phenelzine

Antidepressant medication may be augmented by medications that stabilise mood or address any psychotic features (anti-psychotic medications are usually used temporarily due to the potential for long term use to cause physical movement disorders).

**Typical and atypical antipsychotics** – the main forms of medication for acute and long-term schizophrenia. Different classes of medication have an impact on different aspects of illness (e.g. atypical antipsychotics have more effect on 'negative symptoms').
Benzodiazepines – are used for acute stress reactions and sleep disorders. They are not suitable for long-term use due to dependence issues.

Electroconvulsive Therapy (ECT)
ECT is sometimes indicated as an adjunct to antidepressant medication or where medication has failed. ECT only occurs as part of hospital management and with the persons consent or under the Mental Health Act (all States in Australia have laws regarding the administration of ECT). ECT is a procedure that is often not well accepted by the community, and may be associated with negative images. However, it is important to note that ECT can be very effective for some older people with depression. ECT has a better safety profile than some medications, and a more rapid onset of action and can be safer for older people when used for the appropriate condition (Centre for Mental Health, 2001).

The NSW Mental Health Act
The NSW Mental Health Act is a law that governs the care and treatment of people in NSW who experience mental health problems or disorders. The main aim of the Act is that ‘mentally ill’ and ‘mentally disordered’ people are to receive the best possible care in the least restrictive environment and that any interference with the person’s rights, dignity and self-respect is kept to a minimum. ‘Mental illness’ and mental disorder’ are specifically defined in the Act. Both categories require specific characteristics to be present for ‘scheduling’ (involuntary admission to hospital) to occur.

The Mental Health Act does not contain any specific provisions for older people. However the Act may need to be used in a number of circumstances, such as for an older person with depression at risk of self harm, or an older person experiencing the recurrence of a persistent condition such as schizophrenia or bipolar affective disorder.

Illnesses causing dementia, such as Alzheimer’s disease, are not recognised as ‘mental illnesses’ as defined by the Mental Health Act. However a person with dementia may experience psychotic symptoms such as hallucinations or delusions, or serious mood disorders such as depression or mania. The provisions of the Mental
Health Act may be able to be used to ensure the care and safety of an older person where such symptoms are present.

Older age is often characterised by the presence of a number of co-existing conditions, such as dementia and another mental illness. This does not preclude the use of the Mental Health Act. The complexity of presenting concerns in older people may mean that urgent admission for comprehensive assessment is required in order to ensure the safety of the older person. Urgent admission may be possible on the basis of a ‘mentally disordered person’ in these circumstances.

Because of the complexity of social and medical factors that are associated with older age, it is very important to ensure a thorough assessment, utilising the expertise of Aged Care Assessment Teams and psychogeriatric services where available.

**Adapted from:**


Handout 14 – Vignette

Beth is a 76-year-old widow who was discharged home from an acute care hospital after a multiple diagnosis of pulmonary oedema and anaemia. She has borderline diabetes and needs her blood sugar level checked twice a week. She also has a large ulcer on her right lower leg that requires second daily dressing. She has impaired mobility and walks with a frame due to osteoarthritis. She and her husband migrated to Australia nearly forty years ago.

Beth has lived alone since the death of her husband ten years ago. She has no children. When you visit she appears tired and eager for you to leave. She answers some of your questions but supplies only short answers. She is very concerned about her decreasing self-care abilities, having too many tablets to take and the side effects of these, such as having to go to the toilet often. She appears anxious and fearful about the possibility of re-location to a nursing home, as she does not want to live in residential care. She is overly appreciative of your help, claiming she is a real burden on you and society at large. She says she is managing to the best of her ability but does not think that is good enough and is not sure if life is worth living.

What are your concerns for Beth?
Handout 15 – Questions for identifying older people at risk of suicide

The following questions are provided as examples of a way to start to gather information when talking to an older person about suicide risk. The questions are not intended as a checklist to be completed with each person, but rather as ideas on approaches to use to explore sensitive issues with older people.

History and intent

- What has been happening to you lately? Has anything sad or awful happened recently?
- Have you been feeling like this for long?
- How have you coped previously with these feelings?
- Do you see that the situation will improve? Do you have hope for the future?
- Having the problem you are describing often makes people think that life is not worth living. Have you ever felt like that?
- When have you been feeling like this? Have you ever had thoughts of harming yourself?
- Have you had these thoughts at other times?
- Have you ever acted on these thoughts?
- What have you done?
- What happened after that? How was the situation resolved?
- Are you feeling like that right now?
- Have you ever thought about harming anyone else (as well as yourself)?

Plans

- Have you ever felt so bad that you have made plans to act on your thoughts (about self harm or harm to others)?
- What have you thought about doing?
- Have you got any plans now about how this may happen and when?
- (If the older person has a plan) Do you have access to the means?
- What have you done about this?
- Do you have access to firearms, or any medication?
- What has kept you from acting on these thoughts in the past? What ways have been useful? Do you think they may work now?
Other

- Have you given away any of your things?
- Have you written any notes to anyone to say goodbye?
- What impact do you think your death may have on your family and friends?
- What has stopped you so far?
- What do you think about staying alive?
- What help would make it easier to cope with your problems?
- How does talking about it make you feel?
- How would you see the future?
- What activities did you enjoy in the past? Do you still enjoy them? Why/why not?

Adapted from:


Role play scenarios:

Wilma is a 76 year old widow. She has recently moved into residential care after she broke her hip and was unable to manage the family home. Her husband of 48 years passed away 5 years ago and since that time she had quite successfully managed to run her family home, even baby sitting her daughters three children every afternoon for two hours after school. After moving into residential care, Wilma feels that she has no purpose in life. She refused to bring any of her family possessions with her – not even the photographs of her grandchildren. She seems very distant and unresponsive when her family visits on weekends and they are concerned that she may do something to harm herself.

Bob is an 85 year old man. He lost his wife to a long battle with cancer only 3 months ago. Since that time, Bob has been very agitated and refuses to let Home Care Services into the house. He only has one son who lives in Queensland and is reluctant to make conversation with him when he phones each Saturday night – sometimes he even refuses to answer the phone. His appearance has become quite dishevelled and it is obvious that he has not showered in quite some time. The local Pharmacist has noticed that Bob has not renewed his blood pressure medication which was due to be renewed last month. When asked why he had not been in to pick up his prescription, Bob replied “I won’t be here long enough to take them”.

Suicide Prevention for Older People - Questions for identifying older people at risk of suicide 2
Handout 16 – Information required by referral agencies

Steps in the referral process:
1. Obtain consent from the older person and involve them as much as possible in the treatment planning process
2. Collect information to make the referral
3. Decide on the appropriate referral agency
4. Make the referral
5. Follow-up to ensure the appointment occurred.

Information usually required by referral agencies:
- Name
- Address
- Phone number
- Date of birth
- Older person’s next of kin or contact person
- Name and contact details of General Practitioner
- Medicare details and information on medical background
- Your relationship with the older person and your contact details
- Current problem and background to this problem.

Information to provide if suicide risk assessment is needed:
- All of the above
- Your concerns and how long you have had these concerns
- Your concerns regarding suicide risk specifically
- Information you have gathered on suicide risk for the older person (e.g. your understanding of risk and protective factors).

If the agency you are calling is not able to provide the help you are seeking, ask for advice on the most appropriate agency to refer to.

Remember:
- Do not keep it all to yourself – seek help and advice
- Always be active in responding to mental health problems and possible suicide risk
- Identify who you will call in your area for assistance.
Handout 17 – Vignettes

1. A woman 79 years of age involved with your service has recently been discharged following an overdose of Mogadon and wine. Her husband had died that week and the funeral was the day of the overdose. It was also the anniversary of the death of her son that week.

2. An 84-year-old woman who has received assistance with daily living activities over the past month says she is not feeling well and has lost interest in going out and involving herself with others. She has no appetite and is not sleeping at night.

3. A man 81 years of age has chronic obstructive airways disease and is currently physically sick and constantly breathless. His wife died 2 years ago and he finds it difficult to get out of the house very often. He often talks about how his mates are all dying around him, but this morning when you visit he seems more preoccupied with death and says that when he woke up in the morning he could not see the point of living.

4. A 95-year-old man, who is frail and going blind, lives at home with his 93-year-old wife who has dementia. He has little insight into his wife’s dementia, and has become increasingly angry towards her, saying that ‘his wife never leaves him alone’. He has also expressed sadness over the loss of his wife as he knew her as her dementia has progressed. Over the past weeks, he has stopped his regular walk of ‘600 paces around the neighbourhood’, has stopped eating and is complaining of pain which when further investigated he denies any pain. He is found in his bedroom trying to strangle himself with his pyjama pants. When help is sought he tells the neighbours that he is upset that they have interfered and that next time he will do it properly. When the ambulance officers arrive he tells them that he is fine and they do not take him to hospital.

Adapted from:

Handout 18 - Understanding policy directions

There are a number of New South Wales and National mental health promotion and suicide prevention policies and strategies. These polices aim to provide health care across the lifespan as well as to address the specific needs of different age groups. Policies on suicide prevention and mental health among older people have been developed using a population health approach and take into account the possible increase in suicide numbers in older people as the population ages, and the concerning rates of suicide in specific groups of older people.

Second National Mental Health Plan - A commonwealth strategy identifying methods to improve mental health care across a range of services. Key strategies include the development of partnerships that increase access to people with mental health problems to mainstream services.

Living is for Everyone (LIFE): a framework for prevention of suicide and self-harm in Australia - This national policy outlines suicide prevention approaches that range from population based strategies (e.g. strategies that target population groups at risk, such as men, people with chronic illness, pain or depression) through to strategies aimed at increasing responsiveness to individuals presenting to health care and related services. Workshops such as this one form an important part of increasing overall responsiveness to suicide risk among groups at risk.

Caring for Older People’s Mental Health - A NSW policy that describes the key issues for mental health care among older people in NSW and identifies strategies for responding and improving health care outcomes.

Suicide: We can all make a difference/NSW suicide prevention strategy whole of government approach - A NSW policy that outlines the NSW whole of government approach to suicide prevention. The policy emphasises the need for collaboration and partnership between the government and the community to address suicide prevention.
Handout 19 - Resources

Policies and reports


- Centre for Mental Health (1999). *Suicide: We can all make a difference. NSW Suicide prevention strategy*. NSW Health Department: Sydney.

- Centre for Mental Health (2000). *The NSW suicide data report: Suicide in NSW – We need to know more*. NSW Health Department: Sydney.


(Copies of NSW Health publications can be obtained by contacting the Better Health Centre on (02) 9816 0452 or through the NSW Health website www.health.nsw.gov.au)

Other suicide prevention training resources


For further information on these training manuals contact your local Area Mental Health Service.

Mental health education

*The NSW Institute of Psychiatry*
Telephone: (02) 9840 3833
Email: institute@nswiop.nsw.edu.au
Website: www.nswiop.nsw.edu.au

Advice on the Mental Health Act

*Centre for Mental Health (NSW Health)*
(02) 9391 9309

*Mental Health Advocacy Service*
(02) 9745 4277

*Mental Health Review Tribunal*
(02) 9816 5955
Toll free 1800 815 511

**Advocacy, advice and support organisations**

*Association of Relatives and Friends of the Mentally Ill (ARAFMI)*
(02) 9887 5897

*Mental Health Coordinating Council*
(02) 9555 8388

*Mental Health Information for Rural and Remote Australia (MHIRRA)*
1300 785 005

*NSW Association for Mental Health Inc.*
(02) 9816 1611

*NSW Consumer Advisory Group*
(02) 9556 9219

*NSW Mental Health Information Service*
(02) 9816 5688
Toll free 1800 674 200

*Schizophrenia Fellowship of NSW*
(02) 9878 2053

**Aboriginal and Torres Strait Islander Services**

*Aboriginal Health and Medical Research Council*
(02) 9698 1099
(Contact details of Local Aboriginal Medical Services are available)

**Culturally and linguistically diverse services**

*Transcultural Mental Health Centre*
(02) 9840 3800
Toll free 1800 648 911

**Websites for more information**

www.beyondblue.org.au
www.menshealth.uws.edu.au
www.health.nsw.gov.au
www.auseinet.com
List of appendices

1. Further notes for educators
2. Description of a needs assessment
3. Example of an attendance list
4. Example of an evaluation questionnaire
5. Example of an attendance certificate
6. Acknowledgments
7. References
Appendix 1 – Further notes for educators

Depending on the location of the workshop and the interests of participants, there are a number of issues that may arise, which are not directly covered within the training manual. Educators may wish to incorporate some of the following material into the training manual, or alternatively, use the following notes to answer questions as they arise. Further notes are provided for:

a. Current suicide statistics
b. The NSW Mental Health Act
c. Aboriginal and Torres Strait Islander older people
d. Older people from culturally and linguistically diverse backgrounds

a. Current suicide statistics

It is the responsibility of educators to be updated on the latest available suicide statistics. The training manual outlines the statistics in the period 1996-2000 (see session 2). The following are some key points from the ABS suicide rates for 2001, released in December 2002:

65-74 year age group

• In 2001, suicide accounted for 160 deaths with a death rate of 12.1 per 100,000
• In 2001, suicide accounted for less than 1% of total male deaths and of total female deaths.
• From 2000 to 2001, the death rates for males increased from 18.9 to 19.9 per 100,000.
• From 2000 to 2001, the death rate for females decreased from 6.0 to 4.8 per 100,000.

75+ year age group

• In 2001, suicide accounted for 145 deaths with a death rate of 13.0 per 100,000.
• In 2001, suicide accounted for less than 1% of the total male deaths and of total female deaths.
• From 2000 to 2001, the death rate for males decreased from 27.2 to 24.4 per 100,000.
• From 2000 to 2001, the death rate for females increased from 4.6 to 5.6 per 100,000.

Adapted from:
b. The NSW Mental Health Act

The NSW Mental Health Act is a law that governs the care and treatment of people in NSW who experience mental health problems or disorders. The main aim of the Act is that ‘mentally ill’ and ‘mentally disordered’ people are to receive the best possible care in the least restrictive environment and that any interference with the person’s rights, dignity and self-respect is kept to a minimum. ‘Mental illness’ and ‘mental disorder’ are specifically defined in the Act. Both categories require specific characteristics to be present for ‘scheduling’ (involuntary admission to hospital) to occur.

The Mental Health Act does not contain any specific provisions for older people. However, the Act may need to be used in a number of circumstances, such as for an older person with depression at risk of self harm, or an older person experiencing the recurrence of a persistent condition such as schizophrenia or bipolar affective disorder.

The complexity of presenting concerns in older people may mean that urgent admission for comprehensive assessment is required in order to ensure the safety of the older person. Urgent admission may be possible on the basis of a ‘mentally disordered person’ in these circumstances.

Because of the complexity of social and medical factors that are associated with older age, it is very important to ensure a thorough assessment, utilising the expertise of Aged Care Assessment Teams and psychogeriatric services where available.

Note – Information on the NSW Mental Health Act has been outlined for participants in Handout 13.

Adapted from:

c. Aboriginal and Torres Strait Islander older people

Aboriginal and Torres Strait Islander people appear to be experiencing a high and increasing rate of suicide. The suicide rate among young Aboriginal and Torres Strait Islander people is estimated to be four times higher than the non-indigenous population. The number of suicides among older indigenous people is low, however, as a smaller number of Aboriginal and Torres Strait Islanders live to old age it is not possible to draw conclusions from this.

When considering risk for older aboriginal people, it is extremely important to acknowledge the devastating impact of past governments’ policies and practices on the lives of aboriginal communities, families and individuals and the impact of this on their mental health. It is also important to be aware of the need for cultural sensitivity, incorporating the holistic concepts of social, emotional, spiritual and physical wellbeing.
d. Older people from culturally and linguistically diverse backgrounds

There is great diversity in the rate of suicide among immigrants to Australia. Generally both male and female immigrants over 65 years of age have significantly higher rates than the overall suicide rates for people over 65 in NSW. McDonald and Steel (1997) reported that the rates for NESB males aged 75 and over were seen to be 65.6% higher than the general community. With NESB females in this age range, the rates were up to 177% higher.

There is evidence of higher suicide rates amongst NSW immigrant populations than for people who remain in their country of origin. However, there are similarities in both the rates of suicide and the methods used between immigrants and their country of birth counterparts. This suggests that suicide is strongly influenced by socioeconomic factors associated with country of birth.

It is important to note that the nature of the coroner’s data means that suicide data on second generation (and beyond) immigrants are not included in the statistics on NESB immigrant populations. Deaths data is only collected on ‘country of birth’, hence there is no data on suicide of the Australian born children of immigrants (Kyrios, 1995).

Immigration is associated with exposure to factors with the potential to increase the risk of suicide. Not all immigrants will be exposed to all or any of these factors, however it is important to note that many older immigrants have higher exposure rates. These increased risk associations include:

- Decrease in socio-economic status
- Lack of recognition of overseas qualifications
- Low levels of English language skills
- Social isolation and lack of support
- Separation from families, friends and culture
- Prejudice and discrimination
- Trauma and stress prior to or during the immigration experience
- Barriers to accessing mental health services
- Breakdown of traditional and family support structures

Equally, consideration must be given to the weight of potential protective factors that may be present. These may be related to the individuals immigration experience or be related to their cultural background. Examples may include internalisation of religious sanctions against suicide or being part of a local ethnic community that support and holds in high esteem it’s elders.
A number of factors should also be considered in relation to risk assessment. These include:

- How is health understood by the individual? Does the person come from a culture that does not have a concept of mental illness?
- What is the meaning of suicide? In cultures where the community is the focus, suicide is both understood and explained in terms of the person's family and community relationships rather than the person's personality, mental health etc.
- Language barriers are complex and go beyond the need for interpreters. Complex local idioms of expression can and do lead to serious misinterpretation by those assessing the risk of suicide by individuals. Language difficulties complicated by cognitive deficits and or hearing loss in the elderly further complicate assessment and management.
- The cultural expression and interpretation of symptoms and emotions argues the case for caution by the clinician working with a client or their family.
- When considering access to means, is the clinician aware of the main means of suicide utilized by the demographic group to which the client belongs in their country of origin. For example, are they more likely to ingest herbicides than overdose on medication.

Note – Some notes on older people from culturally and linguistically diverse backgrounds is provided for participants in Handout 6.

Adapted from:


Appendix 2 – Description of a needs assessment

General target group for the workshop
The Suicide Prevention for Older People Training Manual has been written with a primary target group in mind – workers with clinical and/or assessment and referral responsibilities for older people. Workers may be from a range of fields in health and health-related services, however, they should all have a similar level of responsibility for assessment of older people, and referral and follow-up of problems that arise through the course of assessment and intervention.

Examples of services and agencies included in the primary target group are listed below:
- Generalist community health staff
- Aged Care Assessment Teams
- Care package coordinators, including Home and Community Care (HACC), Homecare and Community Aged Care Packages (CACP)
- Hospital personnel (nurses and allied health) in wards/departments with high proportions of older people
- Hostel/nursing home coordinators
- Dementia care coordinators
- Day care coordinators.

The training package may be suitable for modification (by experienced educators) for a number of secondary groups. Examples include:
- General Practitioners
- Direct care workers (e.g. homecare personnel)
- Aged care mental health teams
- Psychogeriatric services
- Mental health workers.

Any modifications to the package will need to reflect the level of responsibility for suicide detection and management of secondary target groups. Some groups may require more information about ongoing suicide risk assessment and management, while others may require a more general introduction to issues around suicide risk for older people. Modifications to the package may include incorporation of material from other suicide prevention training programmes including:
- 98/31 Suicide risk assessment and management training manual; or
- Introduction to clinical aspects of suicide prevention for young people.

(For further information on these suicide prevention training manuals contact your Area Mental Health Service.)

Customising the workshop
Once you have determined a training need and established a local target audience, you will need to find out about your potential participants. Information needs to be obtained about participants’ needs.
You will need to find out as much as you can about:

- The context of training
- The knowledge potential participants already have about older people and suicide.

This information will help you to provide the appropriate training at the right level for the audience.

**Questions to ask about context**

- Why is the training being requested?
- Who identified the need for training?
- Has organisational support been obtained?

**Questions to ask about potential participants**

- Do potential participants have experience working with older people?
- Have any of the potential participants worked with older people at risk of suicide?
- Has there been work-related exposure to an older person who has died of suicide?
- Will participants know each other?

In preparing for the Suicide Prevention for Older People workshop, there are a number of key points to consider.

1. This workshop provides only basic level training in suicide prevention. More advanced training may be required by some audiences.
2. Suicide prevention training is not a debriefing tool. If training has been requested as a result of a workplace suicide death, ensure appropriate debriefing has taken place.
3. The workshop is not a substitute for personal therapy in those cases where participants have lost love ones by suicide or are affected by suicidal behaviour.
4. It is never possible to accommodate all participants’ needs in one workshop. Educators need to be prepared to answer questions on a wide variety of suicide-related topics and refer participants to reading material.
Appendix 3 – Example of an attendance list
Suicide Prevention for Older People Workshop

Place ____________________________________________

Date ____________________________________________

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Contact details (job title, address, phone number)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 – Example of an evaluation questionnaire
Suicide Prevention for Older People - EVALUATION

We would like your comments on the workshop that you attended today. Please tick the relevant option that describes your thoughts about the workshop, and fill out the open parts of the questionnaire as honestly as possible.

1. How would you rate the quality of the workshop you attended today?
   
   Excellent  
   Very good  
   Good  
   Fair  
   Poor  

2. Was the material presented in an organised way?
   
   Yes, definitely  
   Somewhat  
   No, not at all  

3. Did the educators present the material in an interesting way?
   
   Yes, definitely  
   Somewhat  
   No, not at all  

4. Was the material relevant to your needs?
   
   Yes, definitely  
   Somewhat  
   No, not at all  

5. How much did you learn from the workshop?
   
   A great deal  
   A moderate amount  
   Very little  

6. Name three things you liked best about the workshop.
   
   __________________________________________
   __________________________________________
   __________________________________________

7. Name three aspects of the workshop that are in most need of improvement.
   
   __________________________________________
   __________________________________________
   __________________________________________
Appendix 5 – Example of an attendance certificate
This is to certify that

____________________________________________________

has attended a one-day workshop

SUICIDE PREVENTION FOR OLDER PEOPLE

Covering early intervention, assessment and referral options for older people who may be at risk of suicide

conducted at

________________________________________

on

________________________________________

Signed

________________________________________

Educator
Appendix 6 – Acknowledgments

The Suicide Prevention for Older People training manual was initially developed by the South Western Sydney Area Health Service (SWSAHS), and the Elderly Suicide Prevention Network - ESPN (NSW) in collaboration with the Centre for Mental Health. Ms Karen Cornish (Consultant) compiled the manual in consultation with a steering committee with representatives from the three key organisations. A number of independent reviewers have also contributed to the initial development of this training manual (listed below).

In a second phase of development, the Hunter Institute of Mental Health conducted seven pilot workshops across four Area Health Services in NSW to further refine and enhance the package. Based on observations from the seven workshops, input from trainers and feedback from workshop participants, some final changes were made to the module. These changes were reviewed and accepted by a working group comprising representatives from the Centre for Mental Health, the ESPN (NSW) and the Hunter Institute of Mental Health (see list below). We would like to acknowledge the Central Sydney, Central Coast, Illawarra and Greater Murray Area Health Services who piloted this one-day workshop and contributed to its further development.

The content of the training manual has been based on a number of resources and education packages previously developed by the members of ESPN (NSW). We would like to acknowledge and thank the many people who provided feedback during the first and second phase of development.

Committee Members – Phase One

Dr Scott Clark
Area Director for Mental Health, South Western Sydney Area Health Service

Ms Bernadette Dagg
Senior Policy Analyst, Centre for Mental Health, NSW Health

Ms Kym Scanlon
Manager, Prevention Unit, Centre for Mental Health, NSW Health

Mr Matthew Dougherty
Chairperson, Elderly Suicide Prevention Network (NSW), Suicide Prevention Coordinator (older people) Psychogeriatric Service, Hunter Mental Health Service

Mr Troy Speirs
Area Suicide Prevention Coordinator, Western Sydney Area Mental Health Service

Ms Margaret Dalmau
Aged Suicide and Depression Prevention Worker, Greater Murray Area Health Service

Ms Olutoyin Oluwoye
CNC, Aged Care Psychiatry, Braeside Hospital

Ms Ruth Ofner
Social Worker, Liverpool/Fairfield Aged Care Assessment Team
Mr Edward Thomas  Coordinator, South Western Sydney Carer Respite Centre
Ms Gladiss Warda  Depression & Suicide Prevention for Older People, South Western Sydney Area Health Service
Ms Ruth Ferrington  Area Suicide Prevention Coordinator, South Western Sydney Area Health Service
Ms Trish Wynne  Elderly Suicide Prevention Network, Central Coast Health

Independent Reviewers

Dr Rod McKay  Psychogeriatrician & Director, Aged Care Psychiatry, Braeside Hospital
Ms Sue Willis  Area Mental Health Education Coordinator, South Western Sydney Area Health Service. Member of the Mental Health Education Network (NSW)
Dr David Kitching  Chairperson, Faculty of Psychiatry on Old Age
Mr Trevor Hazell  Projects Manager, Hunter Institute of Mental Health
Mr Edward Webb  Welfare Worker, Legacy Macarthur
Mr Neil Tucker  Executive Director, Council on the Ageing (NSW)
Dr Ray King  Psychologist, Greater Murray Area Health Service
Dr Thomas Brent  Psychogeriatrician, Western Sydney Area Health Service
Mr Brian McMinn  Clinical Nurse Consultant, Psychogeriatric Service, Hunter Mental Health Service
Ms Catherine Heal  Suicide Prevention Coordinator, Transcultural Mental Health Centre

Working Group – Phase Two

Ms Bernadette Dagg  A/ Manager, Prevention Unit, Centre for Mental Health, NSW Health
Ms Monica Warby  A/ Senior Policy Analyst, Suicide Prevention, Centre for Mental Health, NSW Health
Mr Trevor Hazell  Deputy Director & Projects Manager, Hunter Institute of Mental Health
Ms Lisa Reardon  Project Officer, Hunter Institute of Mental Health
Ms Jaelea Skehan  Project Officer, Hunter Institute of Mental Health
Mr Matthew Dougherty  Chairperson, ESPN (NSW), Hunter Area Health Service
Ms Trish Wynne  ESPN (NSW), Central Coast Area Health Service
Mr Cerdic Hall  ESPN (NSW), Central Sydney Area Health Service
Trainers involved in the pilot workshops

Mr Cerdic Hall  Suicide Prevention Officer for Older people, Central Sydney Area Health Service
Ms Amelia Merriman-Renu  Clinical Nurse Consultant, Psychogeriatric Services, Rozelle Hospital
Ms Raichel Green  Social Worker, Aged Care Mental Health, Central Coast Mental Health Service
Mr Peter Kerle  Social Worker, Gosford Acute Care Team, Central Coast Mental Health Service
Ms Susan Lampe  Quality Manager, Illawarra Mental Health Service
Ms Maree Vukovic  Clinical Nurse Consultant, Inpatient Services, Illawarra Mental Health Service
Mr Norbert Pereira  Acting Education and Research Coordinator, Illawarra Mental Health Service
Ms Jenny Kempster  Clinical Nurse Consultant, Aged and Extended Care Services, Illawarra Health Service
Mr Tim Kent  Clinical Nurse Consultant, Shoalhaven Community Mental Health Team, Illawarra Mental Health Service
Mr Steven Maron  MHIP Coordinator, Illawarra Mental Health Service
Ms Margaret Dalmau  Aged Suicide and Depression Prevention Worker, Greater Murray Area Health Service
Ms Kerrie Ormond  Registered Nurse, Aged Care Coordinator, Corowa
Ms Gail Stevens  Clinical Nurse Consultant, Community Mental Health, Wagga Wagga
Ms Jan Scott  Clinical Nurse Consultant, Aged Care, Wagga Wagga
Appendix 7 – References


Byrne, G. (1994). *The recognition and management of mental disorders in older people.* NHMRC.


Centre for Mental Health (1997). *NSW Aboriginal Mental Health Policy. A strategy for the delivery of mental health services for aboriginal people in New South Wales.* Sydney: NSW Health Department.


Centre for Mental Health (1999). *Suicide: We can all make a difference. NSW Suicide prevention strategy.* NSW Health Department: Sydney.

Centre for Mental Health (2000). *The NSW suicide data report: Suicide in NSW – We need to know more.* NSW Health Department: Sydney.


