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Invited Perspective

Is Suicide the End Point of Ageism and Human Rights Violations?

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ARTICLE INFO

Article history:
Received May, 7 2021
Revised May, 26 2021
Accepted May, 28 2021

Key Words:
Suicide
human rights
ageism

ABSTRACT

Ageism and human rights violations may pervade each of the potential factors underlying suicidal ideation or behavior in older persons, including physical and mental health, disability, relationships, and social factors. We outline how infringements of human rights and ageism may create or exacerbate risk factors associated with suicide in older persons. Strategies to address these issues are discussed, including tackling ageism, psychosocial interventions and education. A United Nations convention on the rights of older persons would create a uniform standard of accountability across health and social systems. Future studies are needed to evaluate the effects of alleviating ageism and human rights violations on suicide. (Am J Geriatr Psychiatry 2021; ■■:■■–■■)

INTRODUCTION

The contributing factors to suicide in older persons are well known, but potential nexus with ageism and human rights violations have not been explored. Risk factors associated with suicide in older persons include male gender and advanced age 85+,[1] medical illness,[2] mental health conditions,[3] psychosocial disability,[2,4] and accommodation transition into care settings.[5] Qualitative research has given meaning to risk factors of loneliness, social disconnection,[6-9] and perceptions of burdensomeness,[7,8] loss of meaning,[6,9,10] family and healthcare provider invalidation, hopelessness and rejection.[9-11] Using the UN Convention on Rights of Persons with Disabilities (CRPD)[12] as a framework, these risk factors may be viewed in terms of human rights violations. Equally, they may represent downstream effects of ageism.[13] The aims of this paper are to explore the nexus

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https://doi.org/10.1016/j.jagp.2021.05.025

between human rights violations, ageism and suicide in older persons, and posit solutions.

Beginning with the 1948 Universal Declaration of Human Rights, followed by the UN Principles for Older Persons (1991) and the Madrid International Plan of Action on Ageing (2002), a series of human rights instruments have articulated the rights of older persons. The CRPD addressed the rights of persons with disabilities more generally.[12] However, due to systemic inertia, ageism and ignoring specific needs of older people, these treaties have failed to actualize the rights of older people, particularly those with mental health conditions and psychosocial disabilities.[14] The aforementioned risk factors for suicide are considered through the lens of resultant human rights violations, using the CRPD as a framework. Box 1 highlights the human rights relevant to late life suicide.

Older persons with medical illness and disability are at risk of suicide,[2] particularly when they do not enjoy equal access to quality healthcare. This is often a downstream effect of ageism in health, manifested by ageist communication styles, clinical decision-making with less diagnostic and treatment zeal, self-directed ageism and a range of macro-level (institutional or structural) processes that impede access.[15] It is unsurprising that older persons who have self-harmed report hopelessness, and invalidation and dismissal of symptoms by their clinicians,[9] consistent with these long-established empirical observations of ageism in health.[16]

Similarly, older persons do not enjoy equal standards of mental health care in relation to identification and treatment. Ageist biases lead to dismissal of depression[17] and suicidal ideation[11,18] as understandable or expected. Healthcare professionals may lack specialist training in the different presentations of mental health conditions in older persons.[19] Lack of training in primary care regarding management of depression, particularly with comorbid cognitive impairment, may fuel therapeutic nihilism.[20] Healthcare provider hopelessness may amplify patient hopelessness and potentially, suicidal behaviours.[20] Therapeutic nihilism, ageist dismissal of distress as normative, and ageist assumptions of ineffectiveness[19] may also account for less use of psychological treatments, despite their efficacy.[21] Conversely, there is overuse of psychotropic medication, especially in care settings[22] and for people with dementia.[23] This misses opportunities to address psychosocial risk factors including bereavement, perceptions of loneliness, not belonging and disconnection,[9,10] and loss of meaning.[6,9,10] These risk factors represent violations of rights to inclusive living and provision of meaningful social activity that utilizes strengths and potential most prominent in care settings.[24] The loss of meaning some people experience in retirement, especially men,[25] may heighten suicide risk.[6,10] Failure to give meaning and purpose, and to recognize contributions of older people to society[22]- including as carers, volunteers and grandparents- fuels internalized ageism and perceptions of burdensomeness, known risk factors for suicide.[11,18] In people with dementia, human rights violations may underpin changed behaviors (including suicidal behaviors), through dismissal of wishes and preferences, biopsychosocial needs, social connection[26] and participation in gainful activities.

The human right to respect for family and relationships is salient to late life suicide. Negative perceptions of relationships may underly suicidal behaviors in older persons[6,8-11]; most notably perceptions of burdensomeness may have their origins in

Box 1 Articles of the CRPD[12] most pertinent to older persons at risk of suicide

CRPD Article	Key tenets
12	Equal recognition before the law: equal right to legal capacity and support to achieve this; safeguarding to respect rights, will and preferences without abuse and undue influence.
14	Liberty and security of the person (right to freedom).
19	Living independently and being included in the community: including the right to choose where one lives and access to community supports to enable living and inclusion in the community and prevent isolation or segregation.
22	Respect for privacy: including of personal and health information.
23	Respect for home and the family, and relationships.
25	Health: the right to the enjoyment of the highest attainable standard of health without discrimination (including affordable healthcare, prevention, early detection and intervention against further disability, and promotion of autonomy).
26	Habilitation and rehabilitation: enabling attainment of maximal independence, physical, mental, social and vocational ability, and full participation and inclusion.
30	Participation in cultural life, recreation, leisure and sport.

relationships with carers.[27] Carer support and relief of burden is key to enjoyment of the right to respect for relationships. These issues are most relevant to requests for Voluntary Assisted Dying (VAD)- perceived by some as a legitimized alternative to suicide.[28] Older people whose relationships are characterized by dependency, disability, and internalized perceptions of burden, may experience undue influence to end their lives from family carers burdened by caregiving,[29-31] fuelled by the perceived helplessness of family and clinicians.[9] Older persons, especially those who are depressed, may accede to this influence perceiving that carers are better off without them.[32] Deficits in service provision can expose these vulnerabilities, and even lead the older person to feel duty-bound to request VAD.[31]

Maintaining community tenure and independence are important for many older persons, with strong preferences to avoid moving into nursing homes and heightened risk of suicide proximal to moving into care.[5] Fear of placement may drive suicidal behaviours,[9,11,28] but also be an unintended outcome of self-harm in an older person amplifying perceptions of rejection and abandonment.[11] Placement into nursing homes against a person's wishes in this situation, although intended to provide safety and supervision, may violate the right respect for home. The latter may contravene the rights to live independently, community inclusion, and freedom. Forced moves into nursing homes may be a consequence of systemic failures to provide timely aged care packages, which would enable living at home longer.[22] People with dementia may be especially vulnerable to human rights abuses in nursing homes,[33,34] where segregation creates new risk factors for suicide including depression,[35] and loss of control/autonomy through chemical and physical restraint.[36]

SOLUTIONS

Strategies to counter the human rights violations which may contribute to suicide in older persons include addressing widespread ageism at societal and clinical levels, psychosocial interventions, older-adult specific education, and incorporating a rights-based framework into service provision.

Ageing needs to be reframed positively to target ageism as a risk factor for suicide. This must start with governments providing adequate funding for health and social support services for older persons, policy and law addressing discrimination accompanied by education through the media, equity in resource allocation, and inclusion of older adult voices.[37] Addressing ageism may also be positioned within a public health response to ensure healthcare professionals practice without stigma and discrimination, and receive education about its importance.[37] This involves dispelling societal misconceptions about ageing and emphasising positive aspects of growth, enjoyment and continued activity.[15,38] For example, retirement can be promoted positively, through symposia which demonstrate positive models of retirement and debunk ageist myths about this phase of life.[16]

Older people must have a public voice. Initiatives such as AGE Platform Europe promote the voices of older persons and the realization of their human rights (https://www.age-platform.eu/). Governmental support for initiatives is also crucial. For example, the Mona Lisa project in France is a national commitment to suicide prevention in older persons, using empowerment of older persons and solidarity with civil and public stakeholder engagement to seek meaningful inclusion and integration in society (https://www.monalisa-asso.fr/).

Interventions which target the older person's underlying contributing factors for suicide make intuitive sense. However, clinicians must first identify the spectrum of risk factors for suicide and address them assertively,[11] recognizing the benefit and cost-effectiveness of addressing factors such as loneliness[18,39] and depression.[21] Social Engage Psychotherapy which specifically addresses quality of life, depression, suicidal ideation and social disconnection is one promising example.[40]

Community-based services should be available in a timely manner to address rights to inclusive living and enjoyment of quality healthcare without discrimination. This means having timely, affordable community aged care packages to assist older persons in their homes and avoid premature admissions to nursing homes.[22] There must also be recognition and support for carers, especially carers of older persons who have had suicidal ideation[41] or behaviours.[27]

Education for primary care must include the importance of listening carefully, validation, taking

into account life context, values and needs, and conveying hope.[9,11] The specific biopsychosocial factors relevant to suicidal behaviors in older persons must be highlighted.[9,37] Guidelines for the assessment and management of late life suicide in primary care, including appropriate specialist referral processes,[37] will address both equitable access to care for patients and reduce therapeutic nihilism in primary care.

We echo calls for consideration of an international charter of rights specifically for older persons.[22,26,42] Specialist older persons' mental health clinicians are well-placed to advocate for the human rights of older people,[26] with integration of human rights frameworks into healthcare systems relevant to older persons. This should include highlighting how ageism and other human rights violations may adversely affect physical and mental health care of older persons, including specifically suicide prevention and management.[31] In healthcare settings, human rights should inform clinician decision-making and advocacy,[26] and accountability of services and institutions.[14,22]

We use our posited solutions as a starting point to suggest some testable hypotheses examining the relationship between ageism, human rights violations and suicide, for example:

- That the introduction of a greater number of community aged care support packages reduces premature nursing home placements.
- That ageism in healthcare professionals can be addressed as part of an education package.
- That psychoeducation to family carers can reduce perceptions of burden.

CONCLUSIONS

Ageism and human rights violations are pervasive and may fuel suicide risk in older persons. This potential nexus should be empirically examined in future research. When older persons feel their needs are ignored or dismissed as 'normal for ageing' and their rights to healthcare, community living and relationships are denied, they may consider suicide. Similarly, suicidal ideation may arise out of feelings of being a burden to family and society. There must be systemic changes within healthcare services and society more broadly with goals of eradicating ageism and promoting the enjoyment of human rights by older persons. Education is needed as part of a public health approach and specifically for all clinicians and must be founded upon empirical evidence derived from older persons. Simply extrapolating the issues underlying suicide in younger adults to older persons constitutes another form of abuse by denying older persons their unique identities and needs. A UN convention on the rights of older persons would create a uniform standard of accountability across health and social systems and provide a meaningful holistic approach to suicide prevention.

AUTHOR CONTRIBUTION

All authors developed the concepts discussed in the manuscript. A/Prof Wand drafted the initial manuscript. Professor Peisah, as senior author, finalized the content of the manuscript. All authors contributed to revising the article and approved the final submitted version.

ACKNOWLEDGMENT

The authors have no conflicts of interest to declare.

DISCLOSURES

The data and content of this paper has not been presented at any meetings or conferences.

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