Suicide and the Human Rights of Older Persons. Country Report: Sweden

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Suicide and Human Rights among Older Persons:

A Comparative Study of Australia, South Korea, and Sweden

AGAC 아셈노인인권정책센터
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Titti Mattsson, PhD, is a Professor of Public Law at Lund University in Sweden, with a specialization in Health Law, Social Welfare Law – including child law and elder law – and Human Rights Law. Her research adopts a cross-disciplinary approach, and is frequently conducted within both national and international research collaborations. The central theme of her work concerns the governance of welfare state issues, which she explores from both national and transnational perspectives. Her studies focus on legal structures and their impacts on vulnerable populations, including children, older adults, and individuals reliant on social welfare systems, aiming to strengthen legal protections and promote human rights within welfare frameworks.

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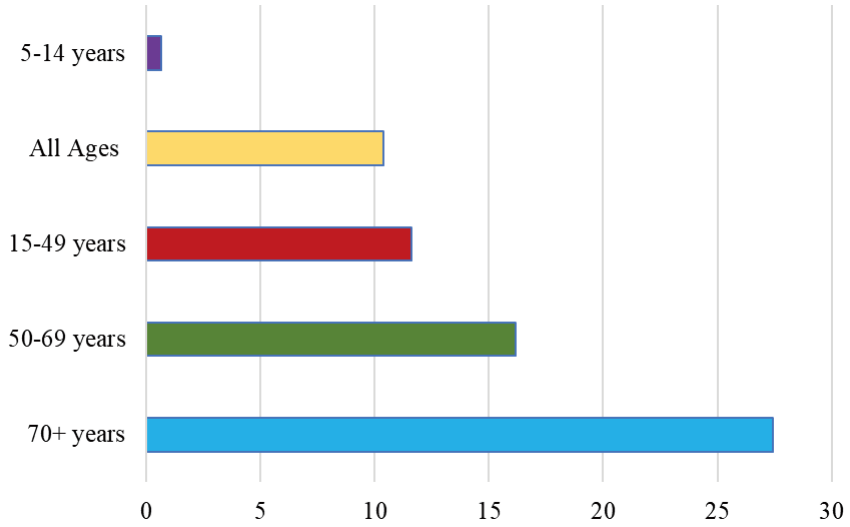
INTRODUCTION

Suicide is a leading cause of mortality among older adults and remains a critical public health and human rights issue, despite global advancements in healthcare and quality of life. In 2017, suicide rates across the world for individuals aged 50–69 reached 16.2 per 100,000, increasing sharply to 27.45 per 100,000 for those aged 70 and older (Dhole et al., 2023). These alarming statistics underscore systemic failures in safeguarding older adults' rights to life, health, dignity, and societal participation.

Suicide Rate by Age



**Suicide Rates are the number of deaths per suicide measured per 100,000 individuals in a given demographic.

Source: IHME, Global Burden of Disease Study: World Rates of Suicide, 2017

Contributing factors to this crisis include chronic health conditions, loss of independence, bereavement, social isolation, age discrimination, and inadequate mental health care systems. From a human rights perspective, these challenges highlight a failure to uphold the United Nations Principles for Older Adults, which emphasize dignity, independence, participation, care, and self-fulfillment. In particular, De Leo points out that that the erosion of dignity – a cornerstone of these principles – is closely tied to rising late life suicide rates (Diego De Leo, 2022).

Despite the significant rate of suicide among older adults, comprehensive research using a human rights framework remains limited. This policy research project conducts a comparative study of South Korea, Sweden, and Australia. These countries were chosen for their distinctive demographic trends, cultural contexts, and policy frameworks, offering valuable perspectives on addressing suicide among older adults. South Korea, with one of the highest global suicide rates among older adults, serves as a crucial case for examining systemic and cultural risk factors and evaluating efforts to protect the mental health of this demographic. Sweden, despite its strong social welfare policies, continues to face challenges with suicide among older adults, warranting an exploration of strategies to strengthen preventive systems. Australia, recognizing concerns about the effectiveness of its mental health and suicide prevention services, introduced the Fifth National Mental Health and Suicide Prevention Plan in 2017. However, further analysis is needed to assess how these strategies can be tailored specifically for older adults. This study aims to uncover key individual, community, and systemic factors influencing suicide rates among older adults through a comparative analysis. The findings contribute to evidence-based policies and interventions that uphold older adults' rights to life, health, and dignity, ensuring their inclusion and well-being. This research is guided by the following critical questions:

1. What are the current suicide rates among older adults, and what individual, community, or societal factors drive these trends? How do these factors, and the resulting suicide rates, infringe on older adults' human rights, particularly in relation to the five United Nations principles: independence, participation, care, self-fulfillment, and dignity?

2. To what degree have nations made advancements in creating systems for suicide prevention? What approaches are being adopted to improve these systems specifically to benefit older adults from a human rights perspective? Are there any specific examples of countries that have been successful in expanding their suicide prevention policies or systems for older persons?

3. How well does the suicide prevention program in the specified country integrate a human rights-based approach for older adults? Does it sufficiently address their rights to independence, participation, care, self-fulfillment, and dignity?

4. What are the strengths and weaknesses of suicide prevention policies in the country under discussion, specifically regarding older adults? How can these policies be refined to leverage their advantages and address any shortcomings effectively?

Anne Wand examines the complex factors contributing to suicide among older adults in Australia, emphasizing the intersection of health, psychological, social, and systemic issues, compounded by ageism and human rights violations. Using the United Nations Principles for Older Persons and the Convention on the Rights of Persons with Disabilities as guiding frameworks, she highlights the critical role of independence, dignity, and social inclusion in effective suicide prevention. Australia's

suicide prevention efforts have advanced through systems-based approaches, such as the Fifth National Mental Health and Suicide Prevention Plan (2017), which aligns with WHO guidelines promoting integrated and collaborative community strategies. The establishment of the National Suicide Prevention Office (NSPO) in 2022 further strengthened these efforts by integrating human rights-based strategies and addressing the broader determinants of suicide. Innovative initiatives such as New South Wales' Older Persons' Aftercare Service Delivery Model and gatekeeper training programs underscore the value of person-centered, rapid-response care tailored to older adults, aligning with international principles of inclusivity and anti-ageism. However, Wand points out that older adults remain underrepresented in national frameworks, and suicide prevention programs targeting their unique needs are fragmented and geographically limited. Systemic barriers such as siloed healthcare services, insufficient engagement from the aged care sector, and a generalized focus on well-being rather than targeted suicide prevention, impede progress. Ageism, inadequate training for healthcare providers, and delays in accessing care further undermine the effectiveness of interventions. Wand emphasizes the urgent need for a cohesive national strategy explicitly prioritizing older adults. This strategy must address stigma, provide equitable access to tailored mental health and social services, and focus on vulnerable groups like older men, who face disproportionately high suicide risks. She concludes that by adopting a more inclusive, human rights-driven framework, Australia can better support the mental health and well-being of its ageing population and make meaningful strides in reducing suicide rates.

In the case of Korea, Yujin Kim describes the significant challenges that South Korea faces: the highest suicide rate among older adults in the OECD, and a growing issue of lonely deaths. She discusses the Specialized Service, established in 2020 as part of the Individualized Support Services for Older Adults program, to address suicide and loneliness among socially isolated and depressed seniors. The program provides multidimensional care, including case management, mental health interventions, and community resource linkage, targeting older adults in severe isolation or with depression and suicidal ideation. It has shown positive outcomes – reduced loneliness, depression, and suicidal thoughts – but faces challenges that include difficulties in reaching high-risk individuals, limited aftercare, and systemic barriers in community cooperation. Service providers also report heavy workloads and job insecurity. From a human rights perspective, the program underscores the need for broader societal respect for older adults and their well-being. Kim's recommendations include enhancing recruitment strategies, improving mental health awareness, providing sustainable aftercare, and redefining evaluation metrics to focus on qualitative outcomes like self-esteem and social connections. While it is impactful, Kim argues the program requires systemic improvements and cultural shifts to ensure its long-term effectiveness.

In the case of Sweden, Titti Mattsson focuses on prevention systems and their alignment with human rights standards. The suicide rate in Sweden peaked in the 1970s; in the last fifteen years, however, it declined by about 20 percent, and currently hovers around the EU average. Research indicates that mental illness, such as depression and anxiety, is a significant factor in suicidal behavior, with a

large number of suicide attempts linked to mental health issues. Mattsson discusses Sweden's 2008 national suicide prevention program, which is based on WHO guidelines, focuses on nine strategic areas, and addresses both individual and societal factors such as improving life opportunities, reducing stigma, enhancing support systems, and training key personnel. The program emphasizes human rights such as dignity and care. While no specific studies on older adults exist, national goals apply to all age groups. Research on older persons' rights is growing, with the Institute of Human Rights focusing on this issue in 2024, highlighting the need for a national study on suicide risk and older people's rights. Sweden has made progress in suicide prevention with a strong national strategy, but challenges remain, particularly for older adults who often live alone and face isolation. The "ageing-in-place" policy, while promoting independence, may increase suicide risk. National policies lack age-specific focus, with few interventions targeting older adults. Mattsson suggests that to improve, Sweden needs to prioritize older persons in suicide prevention efforts and ensure policies align with human rights principles, particularly in the areas of dignity and participation.

This collection of papers examines the prevalence of suicide among older adults and its risk factors, highlighting the strong link between mental health issues that may stem from human rights violations, particularly in the areas of social participation and self-fulfillment across different cultural and national contexts. The findings consistently emphasize the need for age-sensitive, specialized mental health strategies at the national level to address rising suicide rates within this demographic. By offering diverse perspectives and approaches, this international comparative literature aims to support the development of effective systems that safeguard the mental health and fundamental human rights of older adults. It seeks to inform and inspire policy improvements among ASEM partners and the global community, promoting a collaborative, rights-based approach to ensuring the dignity, inclusion, and well-being of ageing populations worldwide.

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AUSTRALIA'S APPROACH TO PREVENTING SUICIDE AMONG OLDER PERSONS FROM A HUMAN RIGHTS PERSPECTIVE

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I . Background

Suicide in older people is associated with myriad factors spanning health, psychological, and social issues, and broader systemic spheres. Many of these underlying contributing factors to suicide may be derived from or exacerbated by infringements on human rights and ageism (Wand et al., 2021). Also influential is the way in which society recognizes and responds to the needs of older people, through prevailing attitudes, government policy, and the availability and types of services and community support for older people, which may give rise to stigma, ageism and discrimination.

The United Nations (UN) Principles for Older Persons (United Nations, 1991) and the UN Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006) provide frameworks with which to consider the risk factors for suicide in older people through a lens of infringements on human rights. More recently, Dainius Pūras, UN Special Rapporteur on the right to health, emphasized that suicide prevention must address the causes of distress arising from within power imbalances, psychosocial adversity and trauma, economic disparity and other structural factors which make "lives unlivable". He recommended States adopting suicide prevention measures with a rights-based approach which promotes autonomy and resilience through "social connection, tolerance, justice and healthy relationships" and avoids excessive medicalization of suicide (Pūras, 2019).

Although over 30 years old, the UN Principles for Older Persons remain relevant, categorizing

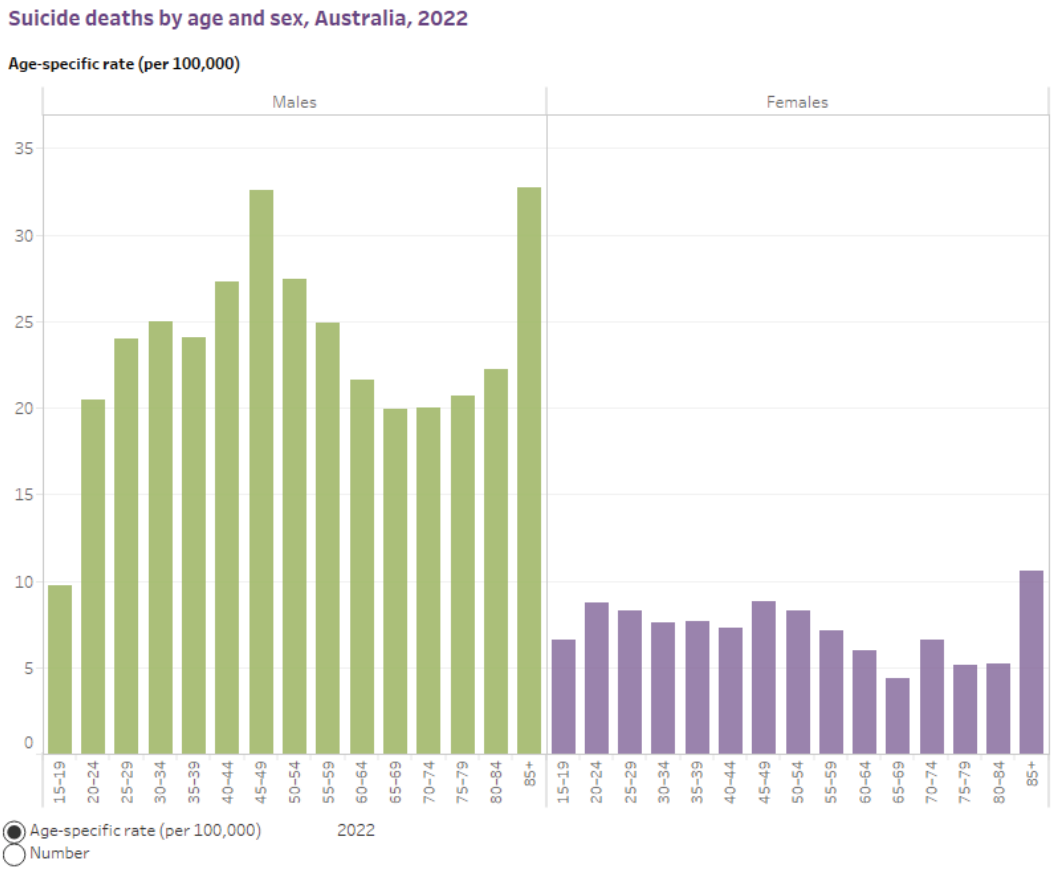
the rights of older people under the headings of independence, participation (inclusion), care, self-fulfillment and dignity, each of which incorporates factors important for suicide prevention. The CRPD, although pertaining more specifically to people with disabilities, is also relevant, especially for older people with physical and psychosocial disabilities and mental health conditions (Peisah et al., 2022). For example, violations of Articles 19- Living independently and being included in the community; 23- Respect for home and the family; 25- Right to the highest standard of health; 26- Habilitation and rehabilitation; and 30- Participation in cultural life, recreation and leisure, directly intersect with known risk factors for suicide in older people (Wand et al., 2021).

This case study will explore the factors contributing to suicide in older people living in Australia from a human rights perspective. It will consider the governmental policies and systems relevant to suicide prevention in older adults as well as dedicated suicide prevention strategies in Australia. The intersection between these individual, community, and societal risk factors for suicide will be explored with reference to human rights.

II. The epidemiology of suicide in older adults in Australia

The Australian Government's Prioritising Mental Health Package included a National Suicide and Self-harm Monitoring Project (Department of Health and Aged Care, 2023). As part of this, the Australian Institute of Health and Welfare developed and implemented a suicide and self-harm monitoring system (https://www.aihw.gov.au/suicide-self-harm-monitoring/about/overview). Since the early 1900s, age-specific suicide rates have been higher in men than women in Australia (Australian Institute of Health and Welfare, 2023). In the most recently reported data, 24.5% of suicide deaths were in people aged 60 or more, compared to 54.6% in people aged 30-59 (Australian Bureau of Statistics, 2023). However, the highest age-specific suicide rates were in men (32.7 deaths/100,000) and women (10.6 deaths/100,000) aged 85 or over (see Figure 1). These highest suicide rates in men aged 85 or more have been observed since 2008. To put the data in perspective, the absolute numbers of deaths by suicide in those aged 85 or more are low compared to midlife (age 30-59 years), where the population is much larger (Australian Institute of Health and Welfare, 2023).

Figure 1. Suicide deaths in Australia by age and sex



Note: This figure is reproduced from the Australian Institute of Health and Welfare, 2023

• Interface between risk factors for suicide and human rights

The factors associated with suicide in older adults may be considered at individual (micro), community (meso), and societal (macro) levels. While these factors are reasonably well known, there has been little reflection on their implications for human rights (Wand et al., 2021).

Demographic characteristics such as advanced age (≥85 years) and male gender are well-recognized risk factors for suicide. The literature has mixed findings regarding whether marital status, living arrangements (i.e. living alone or not), and frequency of social contact are associated with suicide (Fassberg et al., 2012). Instead, the perceived quality of relationships, loneliness, and social connectedness/belonging (Fassberg et al., 2012; Kim, 2014; Wand et al., 2018d), and receiving less emotional support from family and friends than the older person needed (De Leo et al., 2013), appear to be more influential. When unavailable for those with a disability, the latter factors may be considered violations of the rights to meaningful social activity and inclusive living in the

community articulated by the CRPD (Articles 19, 26 and 30), (United Nations, 2006). Bereavement is more common with ageing and associated with higher risk of suicide in general (Mogensen et al., 2016), but especially so in very old men (aged 80+) in the first year after loss of a spouse (Erlangsen et al., 2004).

Several mental health conditions conferring disability are associated with suicide in older adults, highlighting the relevance of the CRPD, specifically Article 25 and the right to the highest standard of health, including mental health (Wand et al., 2021). Major depression in older adults is associated with the spectrum of suicidal behaviors, from ideation to attempts and suicide deaths, and is the most prevalent mental illness in older people who die by suicide (Obuobi-Donkor et al., 2021). However, provision of the highest standard of health may be denied through underdiagnosis and undertreatment of depression in older adults (Allan et al., 2014; Pfaff & Almeida, 2005). These violations of human rights may be fueled by ageism in health (Chang et al., 2020), manifested in the ageist attitudes that depression is "understandable" in late life (Burroughs et al., 2006) or a normal part of ageing (Wuthrich & Frei, 2015), therefore not worthy of treatment, and by generally less rigorous clinical decision-making and treatment in this population (Wyman et al., 2018). This attitude and behavior may reflect inadequate training of clinicians in older adult mental health (Bodner et al., 2018). Australian research has shown that a multifaceted personalized approach to general practitioner (GP) education, comprising practice audit and feedback, and written educational materials and educational newsletters, has reduced prevalence rates of depression and self-harming behavior in older adults treated by GPs in the intervention group compared to control physicians (Almeida et al., 2012). Qualitative research from Australia has indicated that therapeutic nihilism in general practitioners and lack of support from specialist psychiatric services in managing older adults with self-harm may also be contributory (Wand et al., 2018a; Wand et al., 2019a). Anxiety disorders are often comorbid with depression in older adults and associated with suicide (Voshaar et al., 2015). Bipolar disorder, schizophrenia and post-traumatic stress disorder are also associated with suicide in late life (Ilgen et al., 2010).

The relationship between cognitive impairment and suicide is complicated. In a Danish longitudinal study, people with dementia aged 50-69 had 8-10 times greater risk of suicide than those without dementia, and people with dementia aged over 70 had a lower risk of suicide (Erlangsen et al., 2008). Suicidal behaviors are associated with previous self-harm, depression, greater frailty and mild dementia (Hedna et al., 2024). There is an elevated risk of suicide around the time dementia is diagnosed, especially within the first year after diagnosis (Choi et al., 2021), pointing to a key area for intervention. It is not known whether this risk may be mediated by improved post-diagnostic support for people with dementia, but an Australian study found all-cause mortality was less for people with dementia and self-harm who were seen by outpatient mental health services (Walker et al., 2024), suggesting benefits from dedicated clinical support for those with mental health issues. However, access to post-diagnostic support may vary, and is not routinely offered through aged care services in Australia.

Alcohol use disorders are also associated with both suicide attempts (Morin et al., 2013) and suicide in older adults (Sadek et al., 2024). The contribution of alcohol to suicide in late life relates to the disinhibiting effects of intoxication as well as the interplay between alcohol and depression. Alcohol consumption is especially prevalent in Australia: a fifth of people aged 65-74 reported drinking more than 10 standard drinks in the last week (Australian Bureau of Statistics, 2022). This amount exceeds the Australian Adult Alcohol Guidelines (National Health and Medical Research Council, 2020). Despite this, as with depression, alcohol use disorders in older adults are under-recognized or overlooked, and therefore untreated (Yarnell , 2020). A cross-sectional study undertaken in older persons' care settings (mental health and geriatric wards) in Australia, which screened participants for alcohol, smoking, and substance use, reported that prior recognition of participants' alcohol use was poor, and only 14% of those screening positive had a management plan (Draper et al., 2015). Clinician referrals of older adults for substance use programs are low compared to younger adults, and few treatment programs are designed for older adults (Lin et al., 2023), infringing their right to quality healthcare. This disparity in access to healthcare is exacerbated by the higher likelihood of limited mobility, transport barriers, financial hardship and social isolation in older adults (Lin et al., 2023). There is also an increased risk of depression in people with alcohol use disorders (Sadek et al., 2024), which may compound suicide risk.

Physical illness and functional disability are important contributing factors to suicide in older adults. Certain physical conditions have been associated with suicidal behaviors, including liver disease, chronic obstructive pulmonary disease, chronic pain, malignancy, neurological disorders, arthritis and male genital disorders (Fassberg et al., 2016). Healthcare professionals may not recognize and understand the specific needs of older adults due to ageism (Chang et al., 2020). Access to healthcare services and treatment may be affected by systemic bias against ageing (Jeyasingam et al., 2023; Wyman et al., 2018), violating older people's right to the highest standards of health, as articulated in Article 25 (United Nations, 2006).

While it is important to identify and optimize physical health factors which may predispose to suicide, such comorbidity is common in older adults, most of whom do not have suicidal behaviors (Fassberg et al., 2016; Wand et al., 2018c). Qualitative research has shed light on how these identified risk factors may be interpreted by individuals and predispose to suicidal behaviors. For example, feelings of hopelessness, being a burden on others, loss of control, perceived invalidation by clinicians (when presenting with physical symptoms), and helplessness, may mediate pathways to self-harm and suicide (Bonnewyn et al., 2014; Rurup et al., 2011; Van Orden et al., 2015; Wand et al., 2019a; Wand et al., 2018d). The loss of independence that may derive from physical disability may affect perceptions of self-worth and act as a practical barrier to accessing healthcare (Fassberg et al., 2016). While community support can and should be available to meet these care needs and ensure older people enjoy the right to inclusive living (Article 19, CRPD) (Byrnes, 2020; United Nations, 2006; Wand et al., 2021), in Australia there may be considerable delays in accessing such services that support preferences to stay living at home (Royal Commission into Aged Care Quality

and Safety, 2021). Those assessed and approved for aged care services but awaiting care, who live alone and do not have a s, have been identified as at higher risk of suicide (Cations et al., 2023). Some older adults may prematurely enter residential aged care facilities due to unmet support needs (Byrnes, 2020), violating rights articulated by Article 25 of the CRPD (United Nations, 2006), with fear of placement in a residential aged care facility cited as a contributing reason for suicidal behaviors (Wand et al., 2018d) and risk of suicide highest in the early months after placement (Murphy et al., 2018).

There are other community-level factors which may contribute to suicide in older adults and which intersect with many of the individual factors discussed above. In addition to barriers to older people accessing community-based and affordable disability support (e.g. for activities of daily living), there may be inequitable access to healthcare (physical and mental health), including after suicidal behaviors (aftercare), and the availability and inclusiveness of social activities. Ageism has been identified as a barrier to aftercare (Wand et al., 2023). This may be manifest through the invisibility and neglect of suicide in older people as an issue and downplaying the seriousness of self-harm in this cohort, lack of inclusion of older people with lived experience of suicidal behaviors in service planning, and the lack of specialized clinical positions or training with older people (Wand et al., 2023). Compared to younger adults, less dedicated funding and older person-specific suicide prevention initiatives and training may represent further evidence of ageism and discrimination that impede equal rights to healthcare (Wand et al., 2023). For example, in an Australian study implementing the Towards Zero Suicide approach through aftercare, older adults comprised only 3% of those included in the suicide prevention pathway (Turner et al., 2020). Postulated reasons for this near-absence of older people in the suicide prevention initiative included lack of clinician training regarding the specific needs of older people, barriers to access, possible ageism regarding the presumed relevance of the program to older people, and lack of linkage with primary care (Wand & McKay, 2021).

Another community-level factor, while not a formally recognized risk factor but relevant here, is the increasing accessibility of voluntary assisted dying in Australia (De Leo, 2022). Specifically, cases have been described of older adults who attempted suicide because they could not legally access voluntary assisted dying (Wand et al., 2016). Furthermore, older adults may be especially vulnerable to abuse under legislation for voluntary assisted dying, given their interpersonal contexts, including comparatively greater healthcare needs, frequent dependent relationships, and other psychosocial factors such as perceived burdensomeness, which may affect their decision-making (Wand et al., 2018b). Studies of older people who self-harmed (Van Orden et al., 2015; Wand et al., 2019a; Wand et al., 2018d) and older people who died by suicide (Van Orden et al., 2016) highlight how perceived burdensomeness to society or family may contribute to suicide. These perceptions of burdensomeness may be amplified by carer stress and helplessness (Wand et al., 2019a; Wand et al., 2019b), culminating in older people experiencing undue influence to end their lives from family members burdened by caregiving (Wand et al., 2021). Carer burden may be amplified by therapeutic

nihilism in healthcare professionals (Wand et al., 2018a). Combined with delays accessing or unavailable services, the older person may feel obliged to request voluntary assisted dying (Wand et al., 2021). In this way the relational context of older adults, both in their personal and healthcare spheres, may contribute to requests for voluntary assisted dying (Wand et al., 2018b).

There are clear links between violations of the UN Principles for Older Persons of participation and self-fulfillment (United Nations, 1991) and suicidal behaviors. Qualitative studies of older adults following suicide attempts and self-harm have highlighted lack of meaning and purpose as contributory (Bonnewyn et al., 2014; Kim, 2014; Wand et al., 2018d). Men in particular may struggle to find meaningful roles following retirement (Oliffe et al., 2011). In Australia, organizations such as the Men's Shed (https://mensshed.org/) may provide opportunities for social connectedness and meaningful activity among older men, while the MATES intervention targets men working in construction and industry (https://mates.org.au/). Feelings of not belonging and disconnection from community have also been associated with suicidal behaviors in older people (Van Orden & Deming, 2018), and may reflect lack of inclusion and participation – core human rights. Related factors such as social isolation and loneliness may predict premature all-cause mortality (National Academies of Sciences, Engineering and Medicine, 2020), and have been associated with suicide (Niu et al., 2020).

Ageism and the relative invisibility of older adults at a societal level may compound risk factors for suicide. Despite older adults having the highest age-specific suicide rates, there is a lack of public awareness about this issue. Stigma may undermine the UN's principle of dignity for older people, with harmful negative media representations of older people depicted as helpless, fragile or in states of physical and psychological decline (De Leo, 2022). Furthermore, discrimination per se has been associated with a two-fold increase in suicidal ideation (Conwell, 2018; Li et al., 2018). The important societal roles played by older adults in society in education, mentorship, and as grandparents may be under-valued and under-recognized (Byrnes, 2020; Wand et al., 2021), but could be promoted to counter negative societal portrayals of older people.

Ⅲ. Australian suicide prevention: Beyond risk factors to action

• Government and policy

The raft of risk factors described above provides fertile ground for intervention through suicide prevention, the enactment of such on a national level being contingent upon the establishment of national frameworks for suicide prevention. In 2017, the Fifth National Mental Health and Suicide Prevention Plan (NMHSPP) was released in Australia, representing the first time that the national suicide prevention plan had been included with the national mental health plan (Department of Health, 2017). Suicide prevention is a priority area in the plan, with three actions, consistent with

the WHO's "Preventing suicide: A global imperative", committing all Australian governments to a systems-based approach (World Health Organisation, 2014). These included the establishment of a subcommittee of the national Mental Health Drug and Alcohol Principal Committee to set future directions for planning and investment, the development of a National Suicide Prevention Implementation Strategy to operationalize the elements of the systems-based approach with a particular focus on the health system, and government support for primary health networks (PHN) or Local Health Districts (LHD) to develop integrated whole-of-community approaches to suicide prevention.

However, notwithstanding these generic initiatives, despite the recognition that men aged 85 years and older have the highest suicide rates, and that older people often experience a complex combination of physical and mental disorders that might be best addressed through integrated services, older people are not specifically targeted in the NMHSPP (Department of Health, 2017).

In 2019 the Australian Prime Minister, Scott Morrison, appointed Christine Morgan as the first National Suicide Prevention Adviser She released three complementary reports over 18 months: "Compassion First" (National Suicide Prevention Adviser, 2020a), "Connected and Compassionate" (National Suicide Prevention Adviser, 2020b), and "Shifting the Focus" (National Suicide Prevention Adviser, 2020c). Four key enablers to suicide prevention were identified – leadership and governance for a whole-of-government approach, lived experience knowledge and insight, data and evidence to drive outcomes, and workforce and community capability. These required four key shifts in suicide prevention activities – responding earlier to distress, connecting people to compassionate services and supports, targeting groups that are disproportionately affected by suicide, and delivering policy responses that improve security and safety. While older people were not excluded from broad recommendations, they were not identified as a group disproportionately affected by suicide. One brief section discussed risk factors in late life, and lack of aged care services for suicidal older people was mentioned, but other than the Commonwealth government having lead responsibility in this area, no specific actions for older people were recommended in the ten listed opportunities for change.

Meanwhile, a National Suicide Prevention Strategy for Australia's Health System for 2020-2023 was developed by the Mental Health Principal Committee (National Suicide Prevention Project Reference Group, 2020). Based largely on the National Suicide Adviser's reports, there is very little specifically on older people. One vignette is of a 74-year-old woman who became suicidal in the context of proximal and distal traumas, but the vignette is used to demonstrate trauma-focused therapy rather than anything related to old age. It is elsewhere noted that large-scale public education campaigns are strengthened when coupled with populations at high risk, and older people are included in the list. Aged care workers are mentioned as one of many "community connectors" and frontline "safety nets" in community suicide prevention.

Based on recommendations of the National Suicide Prevention Advice and the earlier Productivity Commission Inquiry into Mental Health, a National Suicide Prevention Office (NSPO) was established in 2022. The NSPO is responsible for developing a National Suicide Prevention Strategy, ii) leading the development of a national outcomes framework for suicide prevention, iii) working with all jurisdictions to set priorities for suicide prevention research and knowledge sharing, and iv) leading the development of a National Suicide Prevention Workforce Strategy in collaboration with all jurisdictions and stakeholders. The NSPO has a 14-person Lived Experience Partnership group with representatives from each jurisdiction as well as a diverse range of sociodemographic backgrounds that includes two older people. There is also a 17-person Advisory Board, with the expertise of each member listed on the NSPO website. While no one is listed as being an expert in older people, several have done research in aged care, although not necessarily in suicide-related issues (National Mental Health Commission, 2024). The recently released Advice on the National Suicide Prevention Strategy provides guidance for long-term, coordinated actions for suicide prevention in Australia (National Suicide Prevention Office, 2024). Older people are identified as a population experiencing disproportionate impacts of suicide. The Advice broadens current suicide prevention efforts to incorporate the health, technology, social and economic factors contributing to suicide/suicidal distress. It describes actions required for reducing the prevalence of suicidal distress and improving access to high-quality effective support for people experiencing suicidal distress. A human rights approach to suicide prevention policy and programs is explicitly identified, facilitated by strengthening the role of the Australian Human Rights Commission in reviewing and advising regarding suicide prevention (p. 14). The rights to physical and mental healthcare, social inclusion, safety and security and respectful relationships are highlighted.

In collaboration with the Australian Institute of Health and Welfare, the NSPO established the first National Suicide and Self Harm Monitoring System (NSSHMS). So far, none of the reports from the NSSHMS has had a specific focus on older people, although age effects have featured in several reports, including ones on the impact of the COVID pandemic (Clapperton et al., 2021), individual income effects (Biddle et al., 2022), and an overview of suicide trends between 1964 and 2018 (Australian Institute of Health and Welfare et al., 2020). In each case, old age was characterized in a single group (65 years and over) and was noted to offer some protection. The known disproportionate suicide rate in those aged 85 years and over was not examined.

Each Australian State and Territory has its own suicide prevention strategy/ framework. New South Wales (NSW) is the only jurisdiction with a comprehensive array of initiatives that focus on older people, and while they are in part associated with the NSW Premier's Priority "Towards Zero Suicides" projects (NSW Health, 2023b), most have been sponsored through the Older Persons' Mental Health Policy Unit. Initiatives include the development of an aftercare service delivery model for older people (Wand & Peisah, 2021), a pilot project of one aspect of the model, an older people's suicide prevention pathway (NSW Health, 2023a), and gatekeeper training programs. The other States and Territories of Australia have tended to identify the same priority groups as those

mentioned by the National Suicide Prevention Advice and thus have little that is specific to older people. Of note, South Australia is the only jurisdiction that has a Suicide Prevention Act that has a legislative mechanism to reduce the incidence of suicide (South Australia Suicide Prevention Act, 2021). Key features of the Act include the establishment of the Suicide Prevention Council and the prescription of requirements for the State Suicide Prevention Plan. The Act requires the experience and expertise of the Council's membership to be representative of priority population groups, which are specified but do not include older people. A consultation process is currently underway in NSW to shape the development of the NSW Suicide Prevention Act, described as a "whole-of-government and whole-of-community approach to suicide prevention to ensure collective responsibility, accountability, and action towards suicide prevention across government" (available at: https://www.nsw.gov.au/have-your-say/nsw-suicide-prevention-legislation).

Suicide Prevention Australia, the peak non-government organization in this field, has four key pillars in its National Policy Platform which are consistent with the National Suicide Prevention Advisory. There is no specific strategic initiative that focuses on older people, who are not regarded as a priority population (Suicide Prevention Australia, 2024).

• Implementation of a systems-based approach

The final evaluation of a three-year National Suicide Prevention Trial (NSPT) was released in December 2020. The main objective of the trial was to determine how a systems-based approach to suicide prevention might be best undertaken in an Australian context, and to provide evidence of what strategies are effective at a local level and in at-risk populations. These populations were specified as people who have attempted suicide or are considered at risk of suicide: Aboriginal and Torres Strait Islander peoples, young adult and middle-aged men, young people, and ex-Australian Defence Force members, and lesbian, gay, bisexual, transgender and intersex people (Flego et al., 2022), but not older adults.

There were twelve trial sites across Australia managed by eleven PHNs. Older people were a focus of only one site (Tasmania), as this site identified them as a local priority group. The overall outcome in which trial PHNs were compared with control PHNs found no significant differences in the rates of self-harm and suicide, but noted the timeframe for implementation and evaluation was too short to detect change in outcomes for system-level initiatives. No conclusions could be made about essential aspects of successful strategies in older people due to a lack of information. The main strategies employed were awareness-raising and engagement rather than suicide prevention more directly, with one implied critique in the evaluation being that activities focused on social isolation and well-being rather than suicide and mental health. Capacity building was another strategy (Flego et al, 2022).

Despite the limited focus on older people, some important challenges were identified. The main challenge was the inability to achieve substantive buy-in from stakeholders to implement NSPT activities (Flego et al., 2022). The aged care sector did not see suicide prevention as core business,

limiting their engagement in the multicomponent strategy, and stakeholders preferred to focus on well-being and social isolation rather than specific suicide prevention. Such attitudes may reflect the siloing of healthcare services, limiting more holistic and opportunistic opportunities for suicide prevention (Wand et al., 2023). Competition between service providers was also a barrier to building partnerships. Key health sector stakeholders including GPs, hospital staff and aged care workers lacked time to participate in the NSPT. There were also difficulties in direct engagement with older people, particularly those who were not in contact with aged care services. This was amplified by the COVID pandemic that emerged during the NSPT. The NSPT did not examine the approach of reaching older people through their families (Flego et al., 2022).

Although there was no aftercare service that focused on older people in the NSPT, 10.8% of the general aftercare services evaluated in the project were for people aged 60 years and over, with 6.7% aged 65 years and over. No age-related outcomes were provided regarding activities and referrals, but it is perhaps noteworthy that there was no mention of aged care services (Flego et al., 2022).

IV. The strengths and shortfalls of Australia's approach to suicide prevention

Aftercare is an important systemic suicide prevention measure (Wand & Peisah, 2021; Wand et al., 2022), given the risk of prior self-harm for subsequent suicide, especially so in older adults (Troya et al., 2019) and the low ratio of self-harm to suicide in older people (Chiles et al., 2019). The Mental Health Branch of the NSW Ministry of Health commissioned studies of current approaches to older persons' aftercare, in order to inform a service delivery model. A co-design consultation with Roses in the Ocean (a lived experience organization), intended to involve older people with lived experience of suicide in adapting redirection from emergency departments (Safe Havens) and Suicide Prevention Outreach Teams projects to meet the needs of older people, had to modify its consultation to include phone interviews, site visits, online workshops, and written submissions due to difficulties in engaging the target group (Roses in the Ocean, 2020). Key findings included the need for older adult specific suicide prevention services developed using co-design, a focus on non-clinical suicide prevention services which champion the social connectedness and autonomy of older adults, flexibility in service provision, normalizing (or destigmatizing) older peoples' mental health, suicidal crises and help-seeking, and addressing the short-fall in services supporting mental health and well-being for residents of aged care facilities (Roses in the Ocean, 2020).

A systematic review of the evidence base for older persons' aftercare was commissioned by NSW Health (Wand et al., 2022). Few studies were identified, mostly of low-level evidence and variable quality. There was some evidence for older adult specific multifaceted assertive follow-up paired with systemic change, although the need for further study was outlined. The lack of older person specific guidelines for responding to self-harm or imperatives for community mental health follow-

up were noted (Wand et al., 2022). The review highlighted a need for studies comparing screening to needs assessment and evaluating interventions for safety planning and psychotherapy with older people (Wand et al., 2022). The importance of aftercare was reinforced by another Australian study, which found all-cause mortality was less for people with dementia and self-harm who were seen by outpatient mental health services (Walker et al., 2024), suggesting benefits from dedicated clinical support for those with mental health issues.

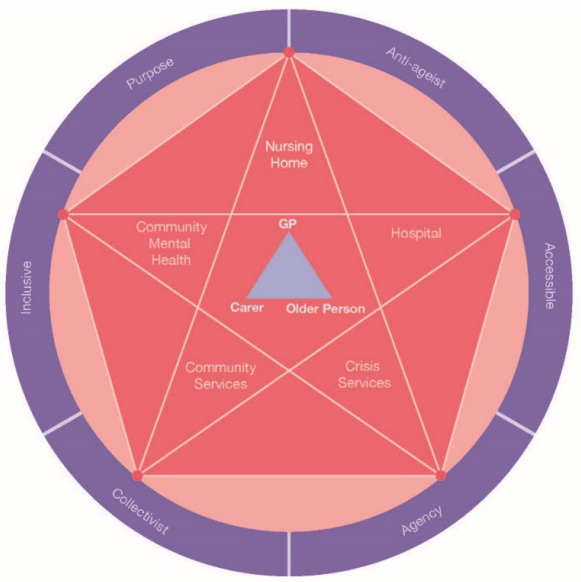
Following on from the systematic review, and recognizing the value of experiential knowledge of consumer needs, key stakeholders were interviewed to qualitatively examine the perceived strengths and limitations of older persons' aftercare in Australia (Wand et al., 2023). Key stakeholders comprised older people with lived experience, older people's mental health clinicians, GPs, Emergency Department clinicians and suicide prevention researchers. The strengths of current approaches to aftercare included person-centered holistic care matched to the individual's needs/goals, validation of and hearing the older person, and aspects of delivery of aftercare (home visits, follow-up with a trusted GP, care coordinators) (Wand et al., 2023). These identified strengths align with the UN Principles for Older Persons, particularly regarding access to healthcare, social services, self-fulfillment and dignity (United Nations, 1991).

Several gaps were identified in the current provision of aftercare for older people in Australia (Wand et al., 2023); many could be considered counter to human rights. Chief among these was ageism, reflected by the invisibility and neglect of older persons' suicide as a public health issue, downplaying the seriousness of mental illness and suicide in older people, the absence of older people with lived experience from planning and evaluation of aftercare services, and the lack of specialist clinicians and dedicated training for working with older people (Wand et al., 2023). The fragmentation and siloing of aftercare services, especially discriminating against people with dementia and older people living in residential aged care facilities, were other perceived limitations. This fragmentation goes against rights to equality and non-discrimination, accessibility, inclusion in the community, and the highest standards of healthcare for people with disabilities (United Nations, 2006). Poor communication and handover between healthcare professionals, especially across transitions in care (e.g., from hospital to home), were also noted (Wand et al., 2023). As discussed above, participants identified delays accessing care packages and home support services as limitations in aftercare, acknowledging that such unmet needs may be contributing factors to suicide for some older adults. Older people with lived experience emphasized that aftercare service delivery could be traumatizing, especially when clinicians' responses to suicidal ideation or self-harm were characterized by excessive focus on risk, involuntary hospitalization and treatment without first engaging with the older person about their situation and supports (Wand et al., 2023). The latter directly contravenes the right of older people to make decisions about their healthcare, and their right to autonomy and independence (United Nations, 1991). A lack of services to support older men and the families of older people with suicidal behaviors was identified. Workforce limitations, including inadequate numbers of clinicians, lack of specialist training, and lack of funding for the

important liaison and communication processes needed to deliver comprehensive aftercare for older people, were also raised (Wand et al., 2023).

The literature, including these dedicated Australian studies of older person aftercare supported by the NSW Ministry of Health, was used to develop an evidence-informed Older Persons' Aftercare Service Delivery Model (Wand & Peisah, 2021). The model was reviewed and refined by key stakeholders with lived experience, and carers, clinicians and representatives from organizations involved in suicide prevention, mental health, health education, clinical innovation and policy development (Wand & Peisah, 2021). The identified core principles of older persons' aftercare service delivery – accessible, giving agency, inclusive (addressing loneliness and feelings of not belonging), collectivist (coordinated care and good communication), giving purpose and meaning in life, and anti-ageist (Figure 2) – align closely with the UN Principles for Older Persons (United Nations, 1991), highlighting the importance of human rights in suicide prevention.

Figure 2. Core principles of older persons' aftercare service delivery (from Wand & Peisah, 2021)



To date, two recommendations outlined in the Service Delivery Model have been pilot-tested and evaluated. The Older People's Suicide Prevention Pathway Project (NSW Health, 2023a) involved four local health districts in NSW developing local pathways to care for older people with suicidal distress, informed by the Aftercare Service Delivery Model (Wand & Peisah, 2021). Outcomes included pathways for responding to older people with suicidal distress, more rapid access to specialist older persons mental health follow-up (from 1-2 weeks to 1-2 days), and greater emphasis on identifying the contributing factors to suicidal distress (NSW Health, 2023a). Challenges included delays and slow governance processes in health districts, lack of leadership support, tension around change (including through ageism and knowledge gaps about older persons' suicide), staff concerns

about workload, and workforce shortages. The other initiatives involved gatekeeper training, which targets non-mental health clinicians or the general population, provides education about suicide in older adults, and teaches how to identify and support an older person at risk of suicide. A Suicide Prevention for Seniors Program delivered by Anglicare aims to train staff working in residential aged care facilities, retirement villages and community aged care services; General Practitioners supporting older people; and Aged Care assessors across NSW (Anglicare, 2024). The Older Persons' Gatekeeper Training Workshops (HETI, 2023) aimed to upskill non-mental health and non-clinical staff to recognize, assess and support (through referral and linkage) older people at risk of suicide. There were three pilot sites and 220 participants in the 45-minute hybrid workshop. The response rate to the evaluation was low (20%). Most participants indicated they would recommend the training to colleagues, valued the content, and felt it aligned with their roles (HETI, 2023).

What is missing? While the Advice on the National Suicide Prevention Strategy (National Suicide Prevention Office, 2024) represents a major opportunity to improve Australia's approach to suicide prevention for all by considering the contributing factors to suicidal distress within a human rights framework, Australia does not have a national approach and policy focus on suicide prevention in older adults. This is needed, to raise community awareness of the issue (De Leo, 2022; de Mendonca Lima et al., 2021) and address prevalent stigma and ageism (Wand et al., 2021), but also to ensure that other government initiatives and policies across the country, especially those affecting psychosocial factors contributing to suicide, are consistent, and are appraised within the lens of suicide prevention (National Suicide Prevention Office, 2024). Ensuring adequate government funding for healthcare, social and support services for older people and equitable access to such, is one practical example of addressing the upstream factors which may underlie suicide in this population (National Suicide Prevention Office, 2024; Wand et al., 2021). This would also address older persons' rights to healthcare without discrimination and inclusive living (Wand et al., 2021), articulated in the CRPD (United Nations, 2006), and potentially reduce premature placement in residential aged care facilities – placement being a risk factor for suicide (Murphy et al., 2018). Qualitative work has identified some of the contributing factors to suicide in older men, including the effect of masculine norms on coping with ageing and dependency (King et al., 2020). Gender disparity has been reported regarding men's access to treatment for depression, and how emotional states are perceived and reported, with men being more likely to conceal or minimize suicidal thoughts and plans due to feelings of shame and stigma (Hinton et al., 2006). Dedicated evidence-based interventions to address the disproportionate risk of suicide in older men are needed, and have been proposed, but require implementation and evaluation (Pathmanathan et al., 2023).

V. Conclusions

In the Australian context, while some States have led the way in terms of policy and implementation of evidence-based strategies for suicide prevention in older adults, there is no consistent national approach, and most jurisdictions have not considered the needs of older people specifically – perhaps reflecting prevailing ageism. Given the breadth of risk factors for suicide in older adults, and their frequent intersection with human rights violations, as outlined here, discussions about whole-of-government and whole-of-community approaches to suicide prevention make sense. An approach derived from mental health alone cannot address the many contributing factors to suicide in older people, since they also encompass social factors (both general and personal), community, society, and general health. Human rights must be at the center of such a collaborative, multilevel strategy, so that policy and programs are viewed within that lens and do not inadvertently cause harm and contribute to suicide in older people through human rights violations, including discrimination or ageism.

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A CASE STUDY ON LATE-LIFE SUICIDE AND LONELY DEATH PREVENTION IN SOUTH KOREA: THE SPECIALIZED SERVICE PROGRAM WITHIN THE STATE PROGRAM OF INDIVIDUALIZED SUPPORT SERVICES FOR OLDER ADULTS

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The suicide rate among older people in Korea is consistently the highest among OECD countries in the 21st century (Ministry of Health and Welfare, 2023), and the issue of lonely deaths is also serious. Given the urgent need for preventive interventions for socially isolated and depressed older adults, a mental health care initiative called the Specialized Service in the Individualized Support Service for Older Adults (hereinafter referred to as "the Specialized Service") was established in 2020. This study aims to summarize the background to the emergence of the Specialized Service, outline its purpose and objectives, and examine how it has been implemented in practice. Additionally, we will discuss its implications from a human rights perspective, and the areas for improvement. To achieve this, I have examined the reasons for the necessity of such interventions, detailed the specific components and characteristics of the Specialized Service, and reviewed three empirical studies. Based on the findings from this case study, I propose several measures to prevent suicide and loneliness among older people, as well as improvements to mental health interventions for older adults.

I. Introduction: Background of the Specialized Service

1. The Need for Mental Health Interventions for Older Adults at Risk of Suicide and Loneliness

Older adults in South Korea face significant hardships due to a combination of rapid demographic change, shifting attitudes toward caring for older people, and increasing socioeconomic inequality and ageism. With 40% living in poverty, the rate among older households far exceeds the OECD

average of 14.2%. Factors such as poverty, illness, and loneliness have led many older adults to make extreme choices or to be found dead alone. Over the past five years, the annual suicide rate among those aged 65 and older averaged around 3,500, or 39.9 per 100,000, which is 2.7 times higher than the OECD average. The rate escalates with age; for those 80 and older, it was 60.6 per 100,000. Moreover, the number of deaths attributed to loneliness has nearly doubled in the past five years. A lonely death is a death that is discovered after a certain period of time, when a person who has been living in isolation, cut off from family and without other people around him or her, dies of suicide, illness, or other causes (Act on the Prevention and Management of Lonely Deaths, Chapter 1, Article 2). In 2021, individuals aged 60 and older accounted for 47.7% of the 3,378 lonely deaths.

2. Despite Various Social Interventions, Access to and Sufficiency of Services is an Issue

As suicide and loneliness among older adults have emerged as serious social problems, various interventions are being implemented in both the private and public sectors, led by central government. This is because the problems of social isolation and suicide prevention are both a health issue and a community issue that require collective societal responses (Lubben et al., 2015). A multilayered system of intervention has been established, ranging from work projects for older people to promote social relationships and supplement income, to intensive management of groups at high risk for suicide and lonely death. However, these responses have faced criticism for being inadequate due to their fragmented nature, often delivered in a provider-centered manner. Policies and projects are carried out according to the laws and regulations of each relevant government ministry (Son & Park, 2018). In the field of practice, interventions are also fragmented according to the characteristics of each sector. Social welfare initiatives typically focus on low-income households (Seok et al., 2018), neglecting older adults with diverse care needs, especially those with mental health needs. Conversely, mental health interventions often prioritize symptom management without adequately considering age-specific characteristics (Jeon et al., 2020). As a result, the accessibility and the sufficiency of mental health services for older adults continue to be issues (Son & Park, 2018).

Recognizing the need for integrated interventions, the government has emphasized inter-ministerial collaboration. In 2018, as suicide prevention initiatives were unified under a national plan, the project to support older people living alone and the project to promote mental health by life cycle were coordinated. In accordance with the National Action Plan for Suicide Prevention, coordination was established between mental health centers and welfare service providers to identify and manage older people at high risk of suicide; life managers were trained as suicide prevention gatekeepers to detect high-risk groups (Joint Ministry of Related Ministries, 2019). As a result of a 2019 pilot project, approximately 320,000 people, including the older population, were screened for depression, and 13,000 high-risk individuals were referred to local mental health centers (Statistics Korea, 2019). However, there is little information on progress after referral. This highlights the lack of continuity and comprehensiveness of services (Kim, 2020).

To address suicide and loneliness among older adults effectively, a multidimensional and integrated approach that is based on an understanding of mental health in later life and includes service delivery systems that are accessible to older adults is essential (Feldman & Fredenthal, 2006; Joe & Niedermeier, 2008). The phenomenon of suicide and loneliness in old age is not caused by any single factor, but is a complex issue that is often the result of multiple challenges, including poverty, illness, and the breakdown of social relationships. Against this backdrop, the Specialized Service has emerged as an intensive mental health care project targeting socially isolated and depressed older individuals.

II. Overview of the Specialized Service as a Mental Health Care Resource for Older Adults Experiencing Depression and Social Isolation

1. The Purpose and Goals of the Specialized Service

As part of social care for older people, a program called "Individualized Support Services for Older Adults" was introduced in 2020. This program, which integrates similar care projects, aims to delay the need for long-term care while supporting healthy aging-in-place (Ministry of Health, Labor and Welfare, 2024). Individualized Support Services for Older Adults aim to respect the residual functions of older people and provide personalized care according to their needs to support self-care as much as possible. As of 2023, approximately 520,000 older people were receiving services through 665 organizations nationwide. Within this project, a project named "the Specialized Service" has been developed as an intensive intervention for older people experiencing severe social isolation and depression (Ministry of Health, Labor and Welfare, 2024).

The Specialized Service builds upon the Social Relationship Activation Project for the Elderly Living Alone (also known as the Friendship Project for the Elderly Living Alone), which was piloted from 2014 to 2019. It provides case management, including mental health interventions, to identify older people who are at high risk of isolation, depression, and suicidal thoughts, with the aim of preventing lonely deaths and suicides (Ministry of Health and Welfare, 2024). As a social intervention, the Specialized Service supports the following hypotheses: If high-risk older adults with depression, suicidal ideation, and isolation are provided with case management services, including mental health support and opportunities to build social networks, their quality of life will improve. It believes that caring for mental health and strengthening social support systems are critical to improving quality of life for older people.

Understanding older persons' suicide and loneliness as complex issues stemming from poverty, illness, and social isolation, the project aims to identify at-risk seniors and support them to live with strength (Kim, 2020). This is different from existing IoT enabled care services and traditional suicide prevention programs in Korea, which primarily focus on detecting risks or prescribing medication.

2. The Characteristics of the Specialized Service

The Specialized Service operates within the care delivery system with the intention of enhancing access to mental health services for older adults (Kim, 2020). In collaboration with local public and private organizations, welfare institutions for older people—such as senior welfare centers and home-based support centers—actively seek out seniors struggling with mental health issues due to isolation, stigma, and misunderstanding of or ignorance about mental health, and then provide services according to the characteristics of the older person, as summarized in Table 1. Individuals prone to social disconnection and self-neglect are classified as reclusive subjects and receive case-managed interventions aimed at restoring their social connections and meeting their basic needs for survival. On the other hand, those experiencing severe depression, including suicide attempt survivors, are identified as depression-type subjects. Only those with depression, suicidal thoughts, and loneliness scale scores above a certain level and severe enough to be diagnosed as depressed are selected for this category. They receive medication management, individual counseling, group activities, and resource linkage services, all aimed at reducing depression and suicide risk while improving social relationships (Ministry of Health and Welfare, 2024).

Table 1. Intervention Methods for the Specialized Service

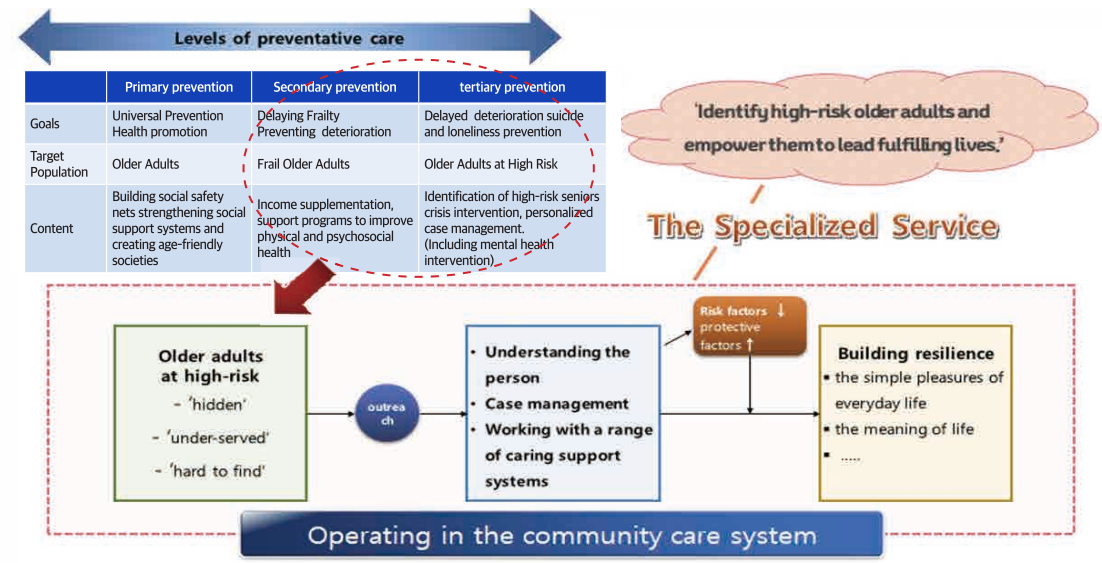
	Group 1: Older Adults in Severe Isolation	Group 2: Older Adults with Depression, Sucidal Thoughts
Target Group	Individuals aged 65 and older who are isolated from family and neighbors, and do not utilize public or private services beyond the National Basic Livelihood Security System	Older individuals at high risk of suicide or lonely death due to mental health issues, difficulties with daily activities, or diminished social connections
Goals	Restore broken social relationships Meet basic survival needs	Reduce the risk of depression and suicide by increasing mental health awareness and enhancing coping skills Improve social connections
Approach	Individual case management	Individual and group counseling
	Crisis intervention support Referral to community resources	Depression assessment and medication management Group activities (including therapy, counseling, programs, and self-help groups) Referral to community resources

The older people targeted by the Specialized Service are closely related to welfare blind spots. This is because older people who are socially isolated are less likely to use healthcare or social services than those who are not (Kobayashi, Cloutier-Fisher & Roth, 2009). In addition, those who view depression and loneliness as natural aspects of aging or hold stigma against mental illness are less inclined to seek help for non-physical symptoms (Chew-Graham et al., 2012; McInnis-Dittrich, 2014; Qiu et al., 2010).

Therefore, it is very important for the Specialized Service to identify high-risk older people so a support system can be organized around them. This outreach model is an effective way to improve access to services and improve mental health and quality of life for underserved older adults (van Citters & Bartels, 2004). The Specialized Service emphasizes multidimensional service in terms of intervention content. This is because many older people in high-risk situations not only have mental health problems (such as dementia and other mental illnesses in addition to depression), but also have chronic co-morbidities (alcohol and substance misuse problems), and often live in unstable housing with significant isolation (Kim, 2018; Theeke, 2010). Since these challenges cannot be addressed by a single expert or organization, establishing a service linkage system is essential. To this end, the Specialized Service aims to create a detection system for people at risk of lonely death, using local public and private networks; it also aims to enhance community resource linkages, and develop a sustainable mutual care system (Ministry of Health and Welfare, 2024).

The Specialized Service can be viewed as a secondary or tertiary preventive care initiative, focused on bolstering the resilience of older people by mitigating risk factors such as depression, loneliness, and isolation while enhancing protective factors at both personal and social levels. If primary prevention involves universal community-level interventions that create social environments that reduce older people's vulnerability to risk situations (such as poverty, poor health, and isolation), secondary and tertiary prevention focuses on helping high-risk seniors transition out of risk situations and build resilience (Lubben et al., 2015). As illustrated in Figure 1, secondary prevention includes counseling, case management, and group activities that promote social relationships, whereas tertiary interventions provide crisis support for older individuals at very high risk of suicide or lonely death (Lubben et al., 2015).

Figure 1. The Characteristics of the Specialized Service as Preventive Care (Source: Kim et al. (2020). p.30)



The Specialized Service is a project funded by central government subsidies and is significant in that it identifies high-risk older people through the establishment of a community older persons care service system. By focusing on the mental health support needs of older people rather than limiting care to physical or cognitive needs, it represents a significant social intervention. This innovative service model combines older person care and mental health services, which have traditionally been offered separately in Korea. Furthermore, it addresses major issues that have emerged in Korea's social welfare delivery system in recent years, in that it is aimed at strengthening the community care system (Kim, 2020).

3. The Characteristics of Older Adults Using the Specialized Service

As of December 2023, 8,348 older individuals were utilizing the service across 190 institutions nationwide. The primary users of the Specialized Service are women suffering from depression; in 2021, 95.8% of service users were in the depressed group, and 97.1% of them were female. The average age of these clients is 77.6 years. Pre-service assessments revealed average scores of 12.1 on the Korean Elderly Depression Scale (out of 15), 17.7 on Beck's Suicidal Ideation Scale (out of 38), and 57.3 on the Korean version of the UCLA Loneliness Scale (out of 80). Notably, 46.1% of clients had a history of at least one suicide attempt (Support Center for the Elderly Living Alone, 2021).

The Specialized Service targets mental health vulnerability rather than economic status, resulting in a high proportion of clients who are not economically disadvantaged. Specifically, 49.5% of depressed clients come from ordinary households, with 33.8% at the basic subsistence level and 12.1% at the secondary level. The reclusive population, which comprises 4.2% of all users, differs from the depressed group in several key areas. For instance, reclusive clients are more likely to be male (40.8%), have a lower average age (76.1 years), be unmarried (10.5% compared to 3.9% for depressed clients), and receive a basic living allowance (63.2%) (Support Center for the Elderly Living Alone, 2021).

A study comparing the characteristics of users of the Specialized Service with those receiving non-specialized older person care services found that Specialized Service users exhibited significantly higher levels of depression, suicidal ideation, and loneliness, along with notably lower levels of subjective health, hopelessness, and social support networks compared to their counterparts (Kim & Noh, 2021).

III. Reviews of Research on the Process of the Specialized Service, and Outcome Evaluation

Several studies have examined the process and outcomes of the Specialized Service. The first study measured changes in users, using standardized scales. The second study employed the RE-AIM model to assess the process and outcomes related to participant identification and service provision, and can be seen as an evaluation of the process from the service provider's perspective. The third study utilized qualitative research methods to explore user experiences.

1. The Study on Service Effectiveness with Pre- and Post-Measures

The Ministry of Health and Welfare, which operates and manages the project, conducts an annual evaluation of the project's effectiveness through its affiliated organization. The evaluation primarily focuses on the number of older individuals identified and using the service, but also examines pre- and post-change characteristics of older people participating in the project through standardized measurement tools (Ministry of Health and Welfare, 2024). A paired sample t-test is performed to evaluate mean differences between pre-test and post-test scores on key items such as loneliness, depression, suicidal thoughts, hopelessness, and number of friends.

For the evaluation, the project uses the Korean version of the Geriatric Depression Scale (GDS), adapted from Yesavage et al. (1983) and revised by Ki (1996), the Korean version of the UCLA Loneliness Scale, standardized by Kim et al. (1989), and the Suicidal Ideation Scale, adapted by Kim et al. (2008). In response to feedback from the field that the number of pre- and post-scale questions was too many, a shortened scale feasibility study was conducted to reduce the workload on service providers while strengthening accountability and ethics of practice (Kim & Noh, 2021). Since 2022, the shortened scale has been used instead of the original scale.

This article reviews the most recent evaluation data from 2023. As of late November 2023, 2,762 older users who completed the service and participated in the post-survey were evaluated for effectiveness. As shown in Table 2, scores for loneliness, depression, suicidal thoughts, and hopelessness, which are the main targets of the Specialized Service project, showed a statistically significant decrease in the post-test from the pre-test. Additionally, there was a significant increase in the number of friends reported. For the sake of space, the results of in-depth analyses are briefly described as follows: among depressed subjects, those receiving both individual counseling and group activities experienced greater reductions in depression and loneliness, as well as an increase in the number of friends, compared to those receiving only individual counseling. The magnitude of change also varied depending on the number of sessions attended, with more substantial improvements observed among those who met the recommended number of sessions.

Table 2. Validation of Pre-Post Mean Differences by Key Variables

key variables		mean	SD	t
loneliness (9)	pre	6.88	1.453	22.679***
	post	6.05	1.856	
depression (27)	pre	15.05	4.240	20.863***
	post	13.11	4.878	
suicidal ideation (18)	pre	9.77	2.418	29.542***
	post	7.99	2.810	
hopelessness (12)	pre	8.60	2.131	17.911***
	post	7.78	2.437	
number of friends	pre	0.85	1.184	-6.686***
	post	1.01	1.344	

*** p<.001

2. The Implementation Process and Outcomes of the Specialized Service Using the RE-AIM Model

Despite its low internal validity, it is problematic to draw conclusions about the effectiveness of an intervention based solely on measuring change from pre- to post-program participation in older adults. For instance, what does it signify when an older person's depression score decreases from 15 to 13? A more nuanced analysis is essential to comprehend the context of these score changes and to determine which aspects of the intervention contributed to the observed effects. Evaluations of interventions like the Specialized Service need to look not only at the changes that the intervention brings about for older people, but also at how the intervention is implemented and institutionalized in practice.

To address this need, the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) model was utilized to examine the implementation process and outcomes of the Specialized Service project. The study examined all five domains of the RE-AIM model, with a particular focus on the Reach, Adoption, and Implementation domains, i.e. the process and outcomes of identifying and selecting beneficiaries and delivering services (Kim, 2022).

Table 3. Issues and Achievements in Identifying and Selecting Participants and Providing Services

Research questions	Evaluation contents	Results
1. How are clients recruited, identified, and selected for the service? Are the outcomes aligned with the objectives of the Specialized Service project?	① Evaluation of the Implementing Organization and Setting (A): - Assess the number and proportion of organizations involved. - Understand the motivation behind each organization's participation and how well it aligns with the project's objectives. ② Willingness and Capacity to Operate the Service (I): - Examine the organization's proactivity in establishing a community care system. - Evaluate the level of support for collaboration within the organization. ③ Appropriateness and Fairness of Recruitment Methods (R): - Analyze the efforts made by local governments and organizations in recruiting participants. - Identify challenges faced during the recruitment process. - Consider the referral pathways and the demographics of clients using the service compared to control groups.	Recruitment appears half-hearted in a community that lacks engagement in supporting high-risk older adults, leading to a focus on merely filling quotas. Underserved older populations who do not meet selection criteria represent a significant gap in addressing loneliness and preventing suicide.
2. How effectively and seamlessly are specialized service projects delivering evidence-based interventions, and in what contexts does user change take place?	① Adequacy and Sufficiency of Service Provision (I): - Evaluate adherence to evidence-based action plans and project guidelines. - Assess the implementation of service delivery procedures and the number of services provided. - Review the percentage of completed services and analyze contextual factors affecting success or challenges at each stage. ② Willingness and Capacity of the Organization (A): - Measure the level of support for cooperation within the agency. ③ Service Provider Characteristics (A, I): - Examine providers' understanding of their roles and their competence. - Assess overall job satisfaction regarding work content and intensity. - Gather feedback on project progress, difficulties encountered, and areas for improvement. ④ Context of User Changes (E, I, M): - Gather service providers' perceptions of user changes. - Consider stakeholder feedback on performance evaluation.	Ongoing efforts are needed to increase accountability for projects that are well-intentioned but perceived as difficult to execute due to the interlocking nature of the issues. Achieving meaningful, lasting changes in the lives of older adults requires significant time, patience, and commitment.

The first finding highlights that our society struggles to care for high-risk older adults who are lonely and at risk of suicide (see Table 3). Although there is a high level of understanding and interest in loneliness and suicide prevention initiatives, many areas lack commitment to supporting these vulnerable populations. In some regions, local authorities do not view loneliness and suicide prevention as part of their responsibilities. Furthermore, because the project is administered in a performance-driven work environment, there can be competition to see who can find more older adults at risk; this means municipalities can be prompted to act simply to enhance their performance-based evaluations rather than in the long-term interests of high-rick clients. Since isolation and depression in later life are influenced more by community factors than individual ones (Park, 2013), the success of intervention depends on community cooperation (Windle et al., 2011), which has proven to be very difficult.

Loneliness and suicide prevention work is about identifying older people who are at risk of falling through the cracks and supporting them to live independently, but the need to avoid duplication of services and to consider equity in services can mean that even the most at-risk older people are excluded from loneliness and suicide prevention work. The second finding of the study illustrates this situation. For older people with complex and chronic physical, psychosocial, and mental health needs, the program is a last resort service, but the selection criteria prevent them from being eligible. Even if they are selected, their care needs are often not met. This is because there are many cases where depression coexists with other mental illnesses, such as severe cognitive decline, personality disorders, and delusions, and referrals to other organizations or projects do not lead to service use. Even if there are relevant organizations in the community, the barriers to accessing services are still high for older people. There is still a long way to go in terms of developing the capacity of local organizations to not only identify at-risk older people but also to support them to live independently.

The study's third finding demonstrates how difficult it is for evidence-based loneliness and suicide prevention programs to be implemented as intended, and how they need to be accompanied by ongoing monitoring and support to ensure accountability and viability. For the implementing organizations and the staff, this is a well-intentioned but very difficult project to implement. There is a lack of societal interest in caring for high-risk older people, and there are fights not only between related organizations but also between them and local governments over who gets credit for supplying care to the beneficiaries. And, the project is being carried out as a contracted project without job security for service providers such as social workers. Moreover, this is a business that involves a large workload, high intensity work alone, and dealing with elderly people with mental health difficulties such as suicidal thoughts and depression on a daily basis. Workers deal with mood swings and suicide attempts, and often come across deaths. However, the evaluation of the project is centered on quantitative figures such as the number of people served and the number of services provided. Due to the nature of the target population, no matter how hard the dedicated staff tries, identification of the target population may not lead to their using the service, or older people may not participate in group activities due to changes in their health or mood.

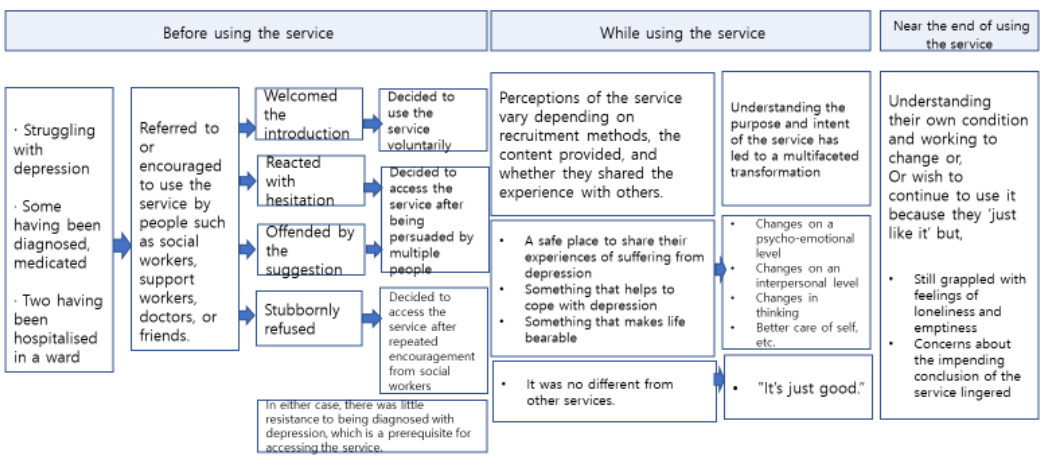
The fourth outcome pertains to participant changes in these challenging circumstances. As shown in the impact evaluation data above, there are statistically significant reductions in depression, suicidal ideation, loneliness, and hopelessness scores from pre to post-service. These positive changes are primarily attributed to the dedicated staff who work closely with older people. However, there was skepticism about the extent to which changes in the participants were sustained. At the end of the service, participants often reverted to previous behaviors. In some cases, despite the staff's best efforts, older adults who have lived in isolation for years struggle to develop social support systems beyond their interactions with social workers.

3. Older Adults' Experience of Using the Service

While the previous study examined the process and outcomes of the project from the perspective of service providers, the third study focused on the experiences of service users. Using Pescosolido's model (2011) as a theoretical foundation, this research explored the experiences of older individuals with depression who used the Specialized Service. It aimed to explore the experiences of older people who were known to have negative attitudes towards mental health care, focusing on how they came to use the service, what they experienced while doing so, and how they changed as a result (Kim, 2024).

Using a purposive sampling method, interviews were conducted with 19 older adults, and the field notes were analyzed using qualitative content analysis. Nine participants were taking antidepressants or tranquilizers prior to accessing the service, including two who had been hospitalized for severe depression, and three had a history of suicide attempts. As illustrated in Figure 2, this study explored the experiences of older adults with severe depression at each stage of their service use, from before they decided to access services, to while they were using services, to when they were on a break or nearing the end of their service use.

Figure 2. Older adults' experience of using the Specialized Service (Source: Kim. (2024). p.11)



According to the results, many older adults who initially resisted or outright refused to use services ultimately decided to do so after persistent encouragement from friends and social workers. Second, perceptions of the service varied depending on the recruitment method and service content. Third, older adults who understood the purpose and objectives of the service reported concrete changes resulting from their service use. Finally, many still expressed feelings of loneliness and emptiness, worrying about the end of service usage.

The results provide an in-depth look at the dynamic nature of service utilization. Not only do older adults become aware of services and decide to access them, but they also interact with multiple systems throughout the process, which shapes their perceptions and enables them to experience various changes. As Polacsek et al. (2020) have demonstrated, an individual's life history and the functioning of their support system can significantly influence their experience of depression and their access to services.

Several points are worth noting from the first set of findings, which deal with the process of older people's decision to use services. Firstly, it is clear that the Individualized Support Services for Older Adults is an important social safety net for older people. Participants in the study often lacked a support system of family, friends and neighbors, and often did not recognize their problems in terms of mental health. This highlights the importance of publicly- funded support workers for older people in these situations.

Secondly, even taking into account that the study participants were from a large metropolitan area and that the interviews were with older people who were favorable enough to the idea of services to be referred by their social workers, a notable change in perceptions regarding depression was observed. Although this may be the experience of a small number of older adults it is nonetheless contrary to previous research which suggests that older adults are reluctant to be diagnosed with depression. Older adults in this study actively sought out this diagnosis, and voluntarily used hospitals and clinics to treat depressive symptoms (Lim, 2016; Nair et al., 2020).

Thirdly, it appears that older adults who were initially skeptical about or reluctant to use the service changed their minds due to the challenges of depression and continuous encouragement from social workers and life support workers. From a service utilization pathway perspective, it is evident that once older people are aware of the existence of a service, they continue to need encouragement and support from their networks before they decide to engage. This finding suggests that it is important for staff to remain engaged after referral or linkage to services, and to pay attention to whether the referral or linkage leads to actual service use.

The study's findings revealed variability in older adults' perceptions of the service. Some participants had a clear understanding of the purpose of the Specialized Service, while others accessed it without fully grasping its intent. While the specifics of how older people perceive the service is an important finding, it is worth noting the impact of the network on older people's perceptions of the service. The manner in which older adults were referred and guided to the service, the content of the programs

they accessed, and their ability to share experiences with peers and social workers significantly influenced their perceptions.

This is related to the third part of the findings: older people's perceptions of the service are also linked to their experiences of change as a result of using the service. Older adults who entered the Specialized Service with a clearer understanding of its purpose were more likely to articulate the changes they experienced.

The third set of findings focused on the nature of changes experienced by older adults as a result of using the service. Understanding these changes is crucial, as they highlight what factors contribute to positive outcomes. Appropriate medication, engaging activities, and a supportive relationship that expresses genuine care and concern contribute to older people experiencing change. Their desire to continue using the service is closely linked to the content and quality of the Specialized Service. Many of the study participants had been diagnosed with depression or were taking medication prior to accessing the service; they either continued to take medication or stopped taking medication that was having adverse side effects. Others were diagnosed with depression and started medication when they started using the Specialized Service. Social workers play an important role in this process, accompanying older clients to medical appointments, participating in diagnosis, and monitoring medication adherence. Depending on participants' financial situation, the costs associated with diagnosis and medication are often covered. Group therapy, counseling, and other programs are provided free of charge, and transportation services are also available for seniors who are hesitant to use the services due to physical limitations or physical mobility issues. These elements were found to foster a supportive environment where older adults could exchange information, advice, and emotional support, recognize changes in themselves and others, and reflect on their experiences. In many ways, we can see that the Specialized Service is able to increase access to mental health services for older people who are under-represented.

The fourth finding of the study indicated that despite experiencing various positive changes, participants still complained of loneliness. Some reported feeling even lonelier after returning home from group activities. This suggests that while social relationships may develop through these activities, underlying feelings of loneliness can persist. It may also indicate that even the best programs cannot fully address deep-seated feelings of sadness and regret, particularly for those facing significant depression. This highlights the challenge of sustaining the effectiveness of interventions and ensuring that the changes participants experience are maintained over time.

IV. Conclusion: The Meaning of the Specialized Service from a Human Rights Perspective, and Ways to Improve the Service

The research studies on the Specialized Service, particularly the second and third studies discussed above, highlight both the significance and the limitations, through a human rights lens, of initiatives aimed at preventing older people's suicide and loneliness. A common point made by interviewees was that while using the service, "there was something I could look forward to". With constant encouragement from social workers, many people who initially resisted the service now spend the week looking forward to their activities. Even if it's only once a week, being with people in a small, safe group where they can share their struggles has revitalized their lives. Genuine attention, a sense of belonging, and activities that engage them in a distraction from their troubles have led to changes in older adults with severe depression and suicidal ideation, such as smiling more, taking better care of themselves, and greeting their neighbors instead of avoiding them. It was the power of small, happy moments and relationships that brought hope back into the lives of older people who suffered from severe depression, anxiety, or suicidal thoughts for various reasons. This raises a very fundamental question. If we were a society that valued people and their small moments of happiness in the first place, wouldn't there be much less depression and loneliness in old age, and fewer suicide attempts?

This society has gone through a period of highly compressed economic modernization and globalization; single-person households are becoming more the norm than the nuclear family; and changes in consciousness are progressing much faster than the overhaul of social policies and institutions. The lack of values and ethics, the rise of populism, intergenerational conflicts, and ageism are also increasing. In these circumstances, many older people, who more than ever need compassionate care, are living like shrimp in a whale fight. The phenomenon of older person suicide and lonely death is a social and structural problem that needs to be approached from a human rights perspective.

It is necessary to rethink the perception of care in our society. The need for social care continues to increase as the population ages, and social care is a human activity, but the environment in which people such as social workers work overemphasizes "effectiveness", "efficiency", and "objective performance", their employment is unstable and working conditions are poor. In addition, our society has a dual attitude toward caring. Although we emphasize community care, people do not see caring as their job. In such an environment, how can service providers like social workers realize simple happiness, the power of relationships, and people-respecting interventions?

The Specialized Service is a challenging project in that it integrates elderly care services and mental health services, which have usually been conducted separately, and aims to provide services centered on identifying elderly people in crisis, with high-density case management (Kim, 2020). Given the

complex nature of suicide and loneliness in old age, suicide and loneliness prevention is one of the most sensitive and complex areas of caring. Based on the results of three empirical studies examined in this study, I would like to propose fundamental measures to prevent suicide and loneliness among older people, and ways to improve mental health care projects for them.

First, there is an urgent need to create a culture of respect for life, along with a social safety net that can substantially improve quality of life for older people. It is also necessary to foster a positive discourse about old age throughout society. Preventing suicide and loneliness among older people can only be done well if it is based on social and community reflection and behavior.

Second, as recommended by the International Labour Organization, the value of caring work needs to be socially recognized. And the job security and working environment of care providers need to be improved. According to the research discussed above, there is a direct and close relationship between the job security of service providers and changes in older service users. Improving the treatment and employment security of providers will improve service quality and change in older users.

Third, we need to think about how to evaluate projects such as the Specialized Service. How do we measure the outcomes of community-based high-risk elder care interventions? Quantitative indicators such as the number of users, and scoring pre- and post-change on standardized scales such as that for depression, are one-dimensional. We need to think carefully about what performance measures can reflect the unique nature of caring for high-risk older adults. Based on the research reviewed in this study, I suggest that the goal of a mental health care program should be to improve the quality of life of older people. When evaluating the performance of any program, consider using indicators such as increased happiness, increased self-esteem, and improved self-care instead of reducing depression and suicidal thoughts.

Mental health care programs should be able to function as a formal care network that identifies older adults with mental health challenges and provides them with instrumental, emotional, and informational support. In addition, the following considerations should be taken into account to improve a program such as the Specialized Service. First, to make the service more accessible, it is necessary to examine the challenges and difficulties of current recruitment methods and explore ways to increase the participation of older adults in high-risk situations. Although the proportion of depressed older women is higher than that of older men, problems such as suicide are more severe among older men. In particular, the suicide rate for older men is more than five times higher than that for women in the same age group (Ministry of Health and Welfare, 2023). The fact that most of the users of the Specialized Service are women indicates that the problem of access to mental health services by men in old age remains serious.

Second, it is necessary to ensure that older adults understand the purpose and intent of the service. The extent to which service providers understand the purpose and content of the Specialized Service, and how they introduce and explain the purpose and content of their work to older adults,

will determine potential users' engagement with the service. In order for older people to be able to make informed decisions about services, there is a need to improve understanding of mental health not only among users but also among organizations and service providers.

The final suggestion relates to improving the content of services. For changes resulting from interventions to be sustained, older adults need to have something to do or somewhere to go after the program has ended, and they need to have a support system. Interventions during gaps in services need to be structured to ensure that changes are sustained or that depression does not recur, and aftercare at the end of services is also very important. Through individual counseling and group activities, it is essential to help older adults reflect more deeply on their experiences, build on that understanding to cope with their illnesses, and use that understanding in the recovery process (Nunstedt et al., 2012).

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SUICIDE AND THE HUMAN RIGHTS OF OLDER PERSONS. COUNTRY REPORT: SWEDEN

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I . Introduction

1. Aim of the study

This report aims to address the phenomenon of suicide among older adults in Sweden, and suicide prevention systems. In a larger context the study, which this report is part of, aims to promote mental health broadly and evaluate how measures used in Sweden comply with human rights standards. The report also aims to analyze suicide rates among older adults in Sweden and their connection to a human-rights-based framework. Further, the report will examine the group of persons who commit suicide and have a history of mental illness, where it is likely that there is a causal link between the death and the mental state. However, the study will not encompass people who use assisted suicide in any form with the help of healthcare/palliative care at hospitals.[1] Such actions are not allowed according to current legislation in Sweden.[2]

2. Outline of the study

The chapter is structured in the following way. First, some general information about suicide in Sweden will be presented, including the prevalence of suicide, population groups, legislation etcetera (2). Thereafter, some key results of research used in Sweden concerning the possible reasons why suicide occurs, including factors that influence the number of suicides in a country, will be introduced (3). The next section will examine what progress Sweden has made in developing and implementing suicide prevention systems (4). The chapter will end with some concluding remarks (5).

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1 These people may also have mental illness, although it is a requirement that the person is capable of making a decision for this type of dying to be possible in a country where assisted suicide is permitted.

2 It is worth noting though that assisted dying is a topical issue in several European countries and some countries are starting to allow this type of assisted suicide.

II. The general situation concerning suicide in Sweden, and the prevalence of suicide among older persons in Sweden due to mental illness

1. General situation

Suicide is often defined as an intentional self-destructive act that leads to death. Although criminal law still has a significant national identity and may vary from country to country, views on suicide have changed historically in many European countries. Nevertheless, we see that in the past in many countries, criminalization of suicide was more prevalent than it is today. In Sweden, such action by the individual towards him- or herself is not a criminalized act. As a consequence, assisting suicide is not a crime either. However, a new offence that has a connection to such action – the offence of *incitement to suicide* – was introduced in Chapter 4, Section 7a of the Criminal Code in July 2021. According to this regulation, a criminal offence to encourage or otherwise influence a person to take their own life is forbidden. Such incitement occurs, for example, via the internet.[3]

2. Some facts

Approximately 1,200-1,300 persons commit suicide each year in Sweden. In 2023, 1,328 people died from confirmed suicide in the country. Of these, 943 were men and 385 women, 10 were children under the age of 15. A further 289 cases were registered where suicide was suspected but the intention could not be proven (The Public Health Agency of Sweden, 2024). The population in Sweden is around 9 million people. Internationally, Sweden's suicide rate is around the EU average.

It is more common for men than for women to commit suicide in Sweden. Two-thirds of those who died by suicide in 2023 were men. In the population aged 15 years or older, the suicide rate (number of suicides per 100,000 inhabitants) was 22 for men and 9 for women. The combined suicide rate for men and women was 15. (The Public Health Agency of Sweden, 2024).

Further, statistics show that for men, the risk of suicide increases gradually with age. In 2018, suicide was three times more common for men over 85 than in younger men aged 15-29. For women, the link to age is much weaker. However, most suicides among women occurred in the 45-64 age group.

Historically, suicide rates in Sweden peaked in the 1970s and have since declined. In recent years, however, the decline has slowed. Over the past 15 years, the suicide rate in Sweden has reduced by around 20 per cent. Internationally, Sweden's suicide rate is around the EU average. However, this positive trend in Sweden does not apply to children and young adults in the 15–24 age group,

3 The regulation includes two offences. The offence of incitement to suicide can lead to imprisonment for up to two years. The offence of recklessly encouraging suicide can lead to a fine or imprisonment for up to six months.

where suicide has remained at the same level for many years. During the COVID-19 pandemic, many feared that suicide rates would increase, but fewer suicides were recorded than in the years before. However, since the pandemic, suicide rates have increased slightly and are now at about the same level as in the years before the pandemic broke out. Over the past 20 years, the suicide rate (number of suicides per 100,000 inhabitants) in the population has decreased in most age groups, except among young people. At the same time, differences in suicide rates between age groups have become smaller (The Public Health Agency of Sweden, 2024).

Most suicides in Sweden are committed by hanging or poisoning. However, the methods differ between women and men. The method most commonly used by men is hanging, followed by poisoning and shooting. Among women, on the other hand, both poisoning and hanging are common methods, while shooting hardly occurs at all. Other methods that occur less frequently include jumping from a height and jumping in front of a moving object. Every year, around 130 suicides occur in the Swedish transport system, most of them in railways and metros (The Public Health Agency of Sweden, 2024).

Ⅲ. Studies focusing on reasons why suicide occurs and what factors influence the number of suicides

1. Introduction

The question of what influences a country's national suicide rates does not have an easy answer. For Swedish agencies working in the field, the recurrent question is what individual behaviors, community support systems, or broader societal issues contribute or not, and if they do, in what way. Like other such agencies in Sweden, their practice needs to be evidence-based, and therefore they follow the findings of national and international research.

From the research that grounds such evidence-based practice, there are certain results that are taken into account in national recommendations. The following section presents the relevant results.

2. Some of the research on which national recommendations in Sweden are based

It is general knowledge that an act of suicide is often a consequence of great suffering. Suffering can be caused by severe illness (both mental and physical) or by various traumas and stressful life events. A significant proportion of suicide attempters have been found in various studies to suffer from depression, anxiety disorders, schizophrenia or other mental health problems (Nock et al., 2009). Somatic conditions that we know can cause significant suffering that may result in suicidal acts include diabetes (Pompili et al., 2014), malignant tumors (Hem et al., 2004), and chronic pain (Tang & Crane, 2006). Impaired decision-making is another cause of suicide and a condition that many older persons experience (Hadlaczky et al., 2018).

The complexity of suicide actions is demonstrated by research. Being suicidal in itself does not necessarily mean that a person will carry out a suicidal act even if the risk exists. The difficulty is that it is not possible to reliably distinguish those who will take their lives from those who will not (Belsher et al., 2019; Large et al., 2016). For example, many suicidal acts are impulsive and occur in the context of a distressing life event that triggers an acute crisis; it can sometimes be difficult for outsiders to recognize the impact of the event and its consequences.

A national program, RESPI (Recommendations for Suicide Prevention Intervention), regularly brings together information on evidence-based population-based interventions in Sweden in an effort to reduce suicidal behavior (RESPI, n.d.). Population-based interventions include any approach where interventions are delivered at the community level and to populations known to be at risk. The information aims to support regions, municipalities, and other relevant government bodies in Sweden charged with deciding on the basis of the latest available research, which suicide prevention interventions should be implemented in the relevant sectors. The purpose of this part of the presentation is to highlight what research forms the basis for current preventive interventions in Sweden and how it relates to the situation in the country.

Twenty per cent of people over 75 in Sweden are currently prescribed antidepressants. At the same time, many older people who take their own lives have not been on any antidepressant medication at all, even though it can be seen afterward that there were clear signs of depression. There is clear evidence in research of a causal link between mental illness and suicide (Abdoli et al., 2022). Several studies show that a significant proportion of suicide attempters have been found to suffer from depression, anxiety disorders, schizophrenia, or other mental health problems. For example, Nock et al. found in their 2009 study that a wide range of mental disorders specifically increased the risk of experiencing suicidal identification. The study also found that mental disorders tend to generate suicidal behavior in similar ways in both developed and developing countries. Another study from 2010 found that about 80 per cent of suicide attempters in the United States had a history of a temporary mental disorder (Nock et al., 2010). Anxiety, mood disorders, impulse control, and various forms of substance abuse were found to significantly predict subsequent suicide attempts. In high-income countries, according to a WHO study, mental disorders are present in up to 90 per cent of people who die by suicide (World Health Organization [WHO], 2019). Suicide risk varies by type of disorder, with the most common disorders associated with suicidal behavior being depression and alcohol abuse. Evidence from the same study also suggests that the risk of suicidal behavior tends to increase with comorbidity. That means that individuals with more than one mental disorder are at significantly higher risk of exhibiting suicidal behavior.

A general conclusion from the research conducted by RESPI is that late-life depression is a common and disabling disorder in Sweden as well as many other countries, and it is associated with an increased risk of suicide as well as with increased all-cause mortality. One way to prevent suicide is to try to reduce suffering by treating the illnesses that cause it. In this endeavor, healthcare seems

to be the most important arena, and a major responsibility for suicide prevention therefore rests with psychiatric care. However, behind suicidal behavior, there are complex problems and a wide range of risk factors. There is a lack of reliable methods today for predicting future suicides and a lack of evidence-based psychiatric treatments for suicidality (Karolinska Institutet, 2014).

IV. Progress that Sweden has made in developing and implementing suicide prevention systems.

This section presents an overview of how much progress Sweden has made in creating suicide prevention systems.

In 2008 a national action program was adopted, with nine strategic areas for developing and implementing prevention systems for reducing the number of suicides in Sweden for the whole population (Public Health Agency of Sweden, 2016). The overall vision of this program is that no one should have to end up in a situation of such vulnerability that suicide is considered to be the only way out. There are no specific recommendations concerning older persons, as the policy work is done broadly and without age limits. However, older persons are a prioritized group in this regard, together with young persons. Both groups seem to have particular vulnerabilities.

The global framework that this national program is based on emanates from the World Health Organization (WHO), which in 2013 declared that suicide numbers in member countries should be reduced by a minimum of 10 per cent by 2020 (World Health Organization, 2014). The global framework program later delivered a report of the results from many countries. All 194 member states of the World Health Organization, including Sweden, have signed the Comprehensive Mental Health Action Plan 2013–2030, which tasks governments with implementing evidence-based interventions in community settings to prevent suicide at all stages of life.

Since 2015, the Public Health Agency of Sweden has been charged with coordinating preventative work at the national level (Public Health Agency of Sweden, n.d.). The national action program for suicide prevention includes nine areas of action to help those who work in suicide prevention or are developing prevention initiatives in a municipality, region, or some other type of organization in Sweden. The action program derives from the government bill mentioned above, “A renewed public health policy”.

The national action program’s nine areas of action for preventing suicide focus both on individuals and on a population-wide perspective. The action areas are considered to be dependent on each other and to complement each other to create an effective program (National Board of Health and Welfare, 2006). The individual-oriented work is carried out mainly within healthcare services, whereas the population-oriented work encompasses many different societal stakeholders. This work aims to create supportive environments where people are less exposed to risk, and to promote the human

rights of the population at risk. It involves increasing people's awareness of the suicide problem and attempting to remove the taboos surrounding suicide among the population in order to be able to highlight and discuss the issues (Eriksson & Bremberg, 2007).

The national program's nine goals generally concern different human rights, among which the right to life is central. However, there are many other rights based on shared values like dignity, fairness, equality, respect and independence that are relevant in the context of work to prevent suicide.

The first goal is to promote good life opportunities and human rights for less privileged groups. This goal is based on the knowledge that living conditions have a clear link to the incidence of suicide. For example, according to Swedish statistics, being unemployed increases the risk of suicide (Public Health Agency of Sweden, 2014). Examples of initiatives to reach this goal are policies of promoting life opportunities for less privileged groups, including work to create good conditions for succeeding in school, and encouraging preventative measures in pre-school, school, and after-school recreation facilities, in order to reduce the risk of young people being affected by mental illness, both at a young age and as they get older.

The second goal is to reduce alcohol consumption in the population and in groups at high risk of suicide. Research shows that in many countries there is a link between alcohol consumption and the incidence of suicide, primarily among young men (Ramstedt, 2001). At an individual level there is also scientific support for the notion that high consumption of alcohol increases the risk of suicide (Wilcox, Conner, & Caine, 2004). Initiatives to reduce access to alcohol and harmful drinking habits include national strategies such as regulating the retail price of alcohol, sales bans, and the monitoring of these bans. Preventative work also involves regulating opening hours for points of sale and age restrictions for purchasing in Sweden. The idea is that measures need to focus on both the availability of alcohol and drinking norms.

The third goal is to reduce access to means and ways of committing suicide. The idea is that it should be difficult to commit suicide and – if the person tries it anyway – methods which decrease the risk of succeeding should be more available. Examples of methods to reduce access to the means of suicide include gun control legislation, restrictions on access to pesticides, restrictions on the prescription and sale of sleeping pills, and use of new, less toxic antidepressants. Another method is to construct protective barriers at high bridges and other exposed places, such as railway and underground tracks, and to change exposed environments where there could be attachment points

The fourth goal is to assess suicide as a psychological mistake or accident, i.e. as the consequence of mental and physical strains, in a similar way to a physical accident. When it is no longer possible to overcome the strains, the incident happens. This perspective lifts the focus from the individual to the environments and systems they are living in. This is intended to help reduce the shame and stigmatization of suicide that often occurs in society. Examples of how this goal is realized illustrate that there are really two different types of initiative here. Individual-oriented initiatives, on the one hand, concentrate on people's ability to solve their problems and handle negative feelings (including

suicidal thoughts) without being overwhelmed by the problems they see. Initiatives targeting the environment, on the other hand, concern the physical factors around people in their daily life, and can range from redesigning medication packs to having safety railings on high bridges and along railway station platforms. These initiatives can also concern how people in society treat those with mental illness, a factor that is significant for a person's psychosocial environment. On the local level, there are often groups that work on managing risks to prevent injuries from accidents, for example. In such accident-prevention work, risk prevention is central to effective implementation. Preventative work in relation to suicide focuses on reducing risks linked to both the environment and to people's behavior.

The fifth goal concerns the importance of improving medical, psychological and psychosocial initiatives among the population at large, and particularly at-risk groups. Suicide is often preceded by some form of mental illness; research findings show this applies to as much as 90 per cent of all those who take their own lives (Lönnqvist, 2009). Preventative measures within the scope of the healthcare services are therefore a high priority and include talking about suicide with healthcare staff (Bremberg, Beskow, Åsberg, & Nyberg, 2015). The care of persons (emergency care, primary care, and specialist somatic care, as well as psychiatry, student healthcare, elderly care, and social services) must include evidence-based knowledge of suicidal behavior in relation to preventative work, primary care, and psychiatry, medication and counselling of patients, etcetera. Different types of support can be offered, depending on knowledge of the individual's ability to manage stress and negative life events. This type of support can be in the form of personal meetings, distance meetings via telephone or the internet, or on the homepages of various groups.

The sixth goal concerns the importance of distributing knowledge in society in general and to different professions about evidence-based methods for reducing suicide. It is important to make it easier for all parties to get hold of the best available information, but particularly for decision-makers and professionals. They need up-to-date knowledge of suicide and suicide prevention strategies and methods. Such knowledge may cover risk and protective factors for preventing suicide, preventative measures and approaches, and the follow-up and reporting of developments and action taken. The effects of various suicide prevention initiatives have not been investigated adequately up to today; there is a need for more research. The idea with this goal is that important knowledge needs to be distributed in order to have a practical effect in society. There are several ways of distributing knowledge, including courses, conferences, seminars and online meetings involving many authorities; these can also encourage cooperation between different authorities, care providers and other stakeholders

Goal number seven concerns the importance of raising skill levels among staff and other key individuals in the care services by regularly offering training initiatives. There is a variety of knowledge that is needed, such as preventing mental illness and increasing services. Not only staff in the healthcare system need to learn these skills, however. Training should also include other

professional groups that through their work come into direct contact with suicidal individuals: priests, pharmacy staff, elder care staff, personnel administrators and staff within the police, the emergency services, schools, the prison service and the defense forces.

Goal number eight concerns the importance of performing "root cause" event analyses after a suicide has occurred. This needs to be done in order to investigate how and why a suicide occurred, and what action may be taken to prevent further such incidents. In Sweden, such an event analysis is performed if the individual who committed suicide had had contact with the health services in the four weeks prior to death. The main reason for this standard procedure is that in 2006, a mandatory reporting requirement for such suicides was introduced in Sweden. Many who commit suicide have, however, not been in contact with healthcare services prior to their suicide, so many suicides are never investigated, and important lessons may be lost. There is therefore a need for event analyses that cover more than just the health and medical care field. For example, health services can work to ensure that all suicides that occur during ongoing care or within four weeks of contact with the care services are investigated and that action is taken to improve patient safety. Municipalities can also play an important role in increasing the number of event analyses of suicides, since it is likely that the individual who committed suicide had been in contact with one of the municipality's various departments, such as social services, a hospital or a school.

Goal number nine concerns support to voluntary organizations. This goal is based on the knowledge that the initiatives of the non-profit-making sector are very important. The role of these organizations is often to strengthen and complement the initiatives of the state, county councils and municipalities via their work in education, information, opinion-forming, and various forms of support work. Often these organizations can raise other perspectives on an issue more easily and quickly than public bodies are able to do.

Since the implementation of the national plan on suicide prevention in Sweden, much work is done in relation to different age groups and has been evaluated. In 2022, the Swedish National Audit Office examined the government's work on suicide prevention (Riksdagen, 2024), and said that although much had been accomplished, work on suicide prevention had not been sufficiently effective in relation to all the goals. More could be done, it said, to reach the goals, including for older persons. The National Audit Office delivered recommendations to the government and the authorities for what actions should be taken in the years to come.

One of the recommendations is to initiate national uniform handling of emergency calls via 112 concerning threats of suicide and suicide incidents. This is to make it easier for the ambulance, police and emergency services to make decisions when they are called out. In response, the Swedish parliament recently decided to recommend adoption of this proposal to the government (Riksdagen, 2022).

V. Strategies that have been effective in enhancing systems for the betterment of older persons.

An important question is how effectively Sweden incorporates a human-rights-based approach for older adults in its suicide prevention work. Key human rights approaches involve adequately addressing an individual's rights to independence, participation, care, self-fulfillment, and dignity. In practice, realisation of the exercise of fundamental rights takes place at national, regional, and municipal levels across Sweden, in interaction with the various levels of government, and in many ways.

The national program's nine goals for combatting suicide in Sweden generally concern different human rights, where the right to life is the central right in the context of suicidal behavior. However, there are many other rights, based on shared values like dignity, fairness, equality, respect, and independence, that are relevant in the context of preventing suicide. These are frequently addressed in the national program.

There are no studies that focus solely on older persons' human rights in this regard in Sweden. Instead, policy work by the government and regional and local authorities in Sweden is mainly done using the national goals (described in the section above), which cover all age groups. As a consequence, this report provides information concerning the situation for several age groups, with older persons one group among others.

It should be noted that the living situation of older persons and their human rights is a research field that is generally expanding in Sweden. The Swedish government is increasingly addressing the rights of this group in various contexts. The Institute of Human Rights, a new government body that investigates human rights in Sweden, has a particular focus on older persons' rights in 2024. So far it has published a report about human rights issues for older people who live in special housing (MR-institute, 2024). The report concludes that human rights are invisible and unfamiliar to many of the duty bearers and the rights holders interviewed in relation to special accommodation. Further, the Institute argues that there is a need to concretize what human rights mean in the context of being old in Sweden today. As a consequence, there seems to be a need for a national study on the risk of suicide from the perspective of older people's human rights.

VI. Ways that Sweden has succeeded in expanding suicide prevention policies or systems tailored to older persons, especially in terms of improving system accessibility and affordability.

It is a crucial task to find and highlight the strengths and weaknesses of suicide prevention policies for older adults in each country in order to develop effective systems nationally as well as locally. Generally, Sweden's work on developing and expanding its suicide prevention policies seems pretty satisfying. There is a well-thought-out national organisation, and a strategy and tools for implementation. There are also protocols for local as well as national evaluations, and resources to enable long-term action.

At the same time, some of the challenges in combatting suicide among older persons in Sweden need to be highlighted. One problem is that many older persons in this country live alone. Only a small number live in residential care and are able to access services such as meals, safety alarms, daily care, medicine, basic healthcare, personal services, and transportation to the hospital (which are the responsibility of the municipality to provide). This ageing-in-place policy that Sweden developed very well during the past few decades is very advanced, and is in many ways attractive. The system is based on the idea that public services should be offered to the older person in his or her private home and that the old person should not have to leave home if this is not attractive to the individual. This ageing-in-place policy is also in accordance with the human rights movement, which proclaims the right of people to stay at home if they want to and feel comfortable doing so. However, one negative aspect of this policy is that many older persons can find themselves very much alone and not as active and social as they may have been if they lived in an older persons' home. From this perspective, ageing-in-place may constitute a risk, since the statistics show that the majority of older people who attempted suicide in Sweden were living alone (De Leo et al., 2001).

Another challenge is the lack of age-related practice in national policy work. The study mentioned above used data from suicide prevention policy documents from the 21 counties in Sweden, but most of the suicide prevention interventions did not prioritize any specific age group (Roos & Fjellfeldt, 2023). When particular age groups were targeted, there was some emphasis on children and adolescents, not older persons.

The question remains to be answered: what has Sweden accomplished so far in the field of combatting suicide by older persons? Related to this: how can national policies be improved to build on strengths and address weaknesses from a human rights perspective? According to recent research, most of the suicide prevention interventions at all prevention levels in Sweden do not prioritize any specific age group (Roos & Fjellfeldt, 2023). This may be a problem from a human rights perspective as well as from an implementation perspective. Researchers conclude

that there is a need to improve national suicide prevention interventions in Sweden by focusing more on those age-groups that have high suicide rates. With a more evidence-based perspective in recommendations and policies, the situation for older persons may be improved, and come more into line with a human rights perspective. In order to live up to the United Nations Principles for Older Persons – independence, participation, care, self-fulfillment, and dignity – there is most probably a need to develop suicide prevention systems further with such aspects in mind. The national action program, with its nine strategic areas of action for developing and implementing prevention systems for reducing the number of suicides in Sweden for the whole population, is not taking age aspects into consideration to the extent that it needs to. There need to be more specific recommendations concerning specifically older people, in addition to broad policy work across all ages.

The global framework that this national program emanates from is that of the WHO, which in 2013 declared that the number of suicides in member countries should be reduced by a minimum of 10 per cent by 2020. The global framework program later delivered a report of the results from many countries.

Since 2015, the Public Health Agency of Sweden has been charged with coordinating the preventative work at national level. There is a national action program for suicide prevention that includes nine areas of action. This national action strategy is a great accomplishment for national policy work in the field. It aims to create supportive environments that are less exposed to risk and to promote human rights for the population at risk. It involves increasing people's awareness of the suicide problem and attempting to remove the taboos surrounding suicide among the population in order to be able to highlight and discuss the issues.

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The Center is dedicated to addressing various challenges faced by ASEM partners in safeguarding the human rights of older persons. Its ultimate goal is to promote and protect these rights through policy research, international cooperation, awareness-raising and educational initiatives, and the dissemination of information.

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