# Older adult mental health

## Older adult mental health

### Australia's ageing population

In 2017, approximately 3.8 million people (15% of Australia's population) were aged 65 and over; the specific age breakdown includes 57% aged 65-74, 33% aged 75-84 and 13% aged 85 years or older (Australian Institute of Health and Welfare, 2018c).

### Prevalence of mental health problems in older adults

Good mental health is an important factor associated with healthy ageing and most older adults report good mental health (World Health Organization, 2017). The 2007 National Survey of Mental Health and Wellbeing of Australian adults (ages 16–85 years) indicates that the prevalence of mental disorders is highest in younger age groups and declines in older age (Burgess et al., 2009; Trollor, Anderson, Sachdev, Brodaty, & Andrews, 2007). It has been estimated that approximately 15% of adults aged 60 years or older have a mental disorder (World Health Organization, 2017) and that the prevalence of mental disorders decreases to 6% in the 75-85 year old age group living in the community (ABS, 2008)[1]. Prevalence estimates for specific mental disorders in the general population are as follows.

- 7-15% of adults 60 years and older experience depression (Haralambous et al., 2009; National Ageing Research Institute, 2009; World Health Organization, 2017)
- 10% of adults 65 years and older and 30% of those aged 85 years and older have dementia (National Centre for Social and Economic Modelling, 2016)
- 4-10% of adults 60 years and older experience anxiety (Haralambous et al., 2009; National Ageing Research Institute, 2009; World Health Organization, 2017)
- 1% of adults 60 years and older have a substance use problem (World Health Organization, 2017)

Prevalence estimates for mental health disorders are estimated to be much higher in older adults living in residential aged care.

- 49% of older adults were diagnosed with depression (Australian Institute of Health and Welfare, 2018d)
- 52% of older adults were diagnosed with dementia (Australian Institute of Health and Welfare, 2018d)
- 86% of older adults were diagnosed with a mental health or behavioural condition (Australian Institute of Health and Welfare, 2018d).

As the Australian population ages, there will be more individuals living longer with mental health concerns.

### Anxiety and depression in older adults

### Symptoms of anxiety in older adults

- Behavioural
  - Avoiding objects/situations which cause anxiety
  - Urges to perform certain rituals to relieve anxiety
  - Not being assertive
  - Difficulty making decisions
  - Being startled easily.
- Feelings
  - Overwhelmed
  - Fear (particularly when facing certain situations or events)
  - Worried about physical symptoms (e.g. Fearing there is an undiagnosed medical problem)
  - Dread
  - Constantly tense or nervous
  - Uncontrollable or overwhelming panic.
- Thoughts
  - 'I'm going crazy'
  - 'I can't control myself'
  - 'I'm going to die'
  - 'People are judging me'
  - Having upsetting dreams or flashbacks of a traumatic event
  - Finding it hard to stop worrying, unwanted or intrusive thoughts.

[1] ABS Australian Bureau of Statistics

- Physical symptoms
  - Increased heart rate, racing heart
  - Vomiting, nausea or pain in the stomach
  - Muscle tension and pain
  - Feeling detached from physical self or surroundings
  - Having trouble sleeping
  - Sweating, shaking
  - Feeling dizzy, lightheaded or faint
  - Numbness or tingling
  - Hot or cold flushes.

(Beyond Blue, n.d.)

## Symptoms of depression in older adults

An older person with depression is more likely to present with physical symptoms (e.g. difficulty sleeping) compared with the other symptoms (e.g. low mood) (Tan & Cheung, 2019). Different language may also be used when discussing their symptoms of depression, for example, instead of describing 'sadness', they may talk about 'their nerves'.

- Behavioural
  - General slowing down or restlessness
  - Neglect of responsibilities and self-care
  - Withdrawing from family and friends
  - Decline in day-to-day ability to function, being confused, worried and agitated
  - Inability to find pleasure in any activity
  - Difficulty getting motivated in the morning
  - Behaving out of character
  - Denial of depressive feelings as a defence mechanism.
- Thoughts
  - Indecisiveness
  - Loss of self-esteem
  - Persistent suicidal thoughts
  - Negative comments like 'I'm a failure, 'it's my fault' or 'life is not worth living'
  - Excessive concerns about financial situation.
- Feelings
  - Moodiness or irritability, which may present as angry or aggressive
  - Sadness, hopelessness or emptiness
  - Overwhelmed
  - Feeling worthless or guilty.
- Physical symptoms
  - Sleeping more or less than usual
  - Feeling tired all the time
  - Slowed movement
  - Memory problems
  - Unexplained headaches, backache, pain or similar complaints
  - Digestive upsets, nausea, changes in bowel habits
  - Agitation, hand wringing, pacing
  - Loss or change of appetite
  - Significant weight loss (or gain).

(Beyond Blue, n.d.)

## Suicide in older adults

In 2017, males aged 85 years and older had the highest rate of suicide of any age group (ABS, 2017a). Older adults were more likely to have a chronic health condition present at death than younger individuals. For example, approximately 25% of males aged over 85 years who died by suicide had cancer. This is in contrast to the 25-44 year age group, where the most common cooccurrence with suicide was drug/alcohol use disorders or acute intoxication (42%), followed by mood disorder (26%) (ABS, 2017a).

## Self-harm in older adults

Self-harm is a major risk factor for suicide in older adults (aged 65 years or older) and older adults report greater suicidal intent than any other age group who self-harm (Morgan et al., 2018). Older adults may be particularly vulnerable because as well as experiencing mental illness, they are more likely to experience bereavement, social isolation, physical illness and decline in functional ability than young or middle-age cohorts (Cheung et al., 2017; Erlangsen, Stenager, & Conwell, 2015; Fassberg et al., 2016; Hawton & Harriss, 2006; Mitchell, Draper, Harvey, Brodaty, & Close, 2017; Morgan et al., 2018). Overdose has been reported as the most common method (68.7%) of self-harm in older adults (Cheung et al., 2017). Around 25% of deaths from self-harm are among people aged 60 or above (World Health Organization, 2017). A recent study conducted in England indicates that older adults were infrequently referred to mental health specialists, and instead were more likely to be prescribed tricyclic antidepressants, which can be toxic (Morgan et al., 2018).

## Risk factors for poor mental health in older adults

Older adults may experience stressors that are common to all age groups. Additionally, they may experience stressors which occur more frequently with older age and increase the risk of poor mental health including:

- Significant decline in functional ability (e.g. decreased mobility, chronic pain, frailty).
- An increase in physical health problems (e.g. heart disease, Alzheimer's disease).
- Cognitive and psychological changes – tasks can take longer to complete or become more difficult than previously, which can impact on sense of self and well-being and heighten feelings of uncertainty, worthlessness and loss.
- Bereavement (especially the death of a life partner).
- Social isolation and loneliness.
- Reduction of income due to retirement/financial stress.
- Loss of ability to live independently.
- Being treated with less respect and being deemed less capable, which can result in a reduction in autonomy and dignity and feelings of hurt, shock, grief and loss.
- Symptoms of depression can occur as a side effect of many prescribed drugs and the risk is greater for older adults who are typically taking multiple medications and are more sensitive to side effects because ability to efficiently metabolise and process drugs decreases with age.

(Rickwood, 2005; Robinson, Smith, & Segal, 2018; Tribe, 2017; World Health Organization, 2013, 2017)

Older adults are also vulnerable to elder abuse, which can include physical, psychological, financial and sexual abuse and neglect/abandonment. Current evidence indicates that 16% of adults aged 60 years and older living in community settings are subjected to some form of abuse; this is likely to be an underestimate, since cases of elder abuse are often not reported (Yon, Mikton, Gassoumis, & Wilber, 2017). The most commonly reported type of abuse is psychological abuse (11.6%) (Yon et al., 2017). Elder abuse in institutional settings has been estimated to be much higher (Yon, Ramiro-Gonzalez, Mikton, Huber, & Sethi, 2018). Elder abuse can lead to serious physical injuries and mental health problems (World Health Organization, 2017).

## Barriers to treatment of mental health problems in older adults

In Australia and globally, 75- to 85-year-old adults with mental health needs have reported low rates of mental health service use compared with other age groups (Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009; Wuthrich & Frei, 2015). Barriers to treating mental health problems in older adults include the following:

- Mental health problems are under-identified by health-care professionals and older people themselves (e.g. symptoms of depression, such as difficulty with sleeping, memory or concentration and changes in mood and activity levels are dismissed as a normal part of ageing) (Tan & Cheung, 2019; World Health Organization, 2017).
- Mental health problems are perceived as a normal part of the ageing process (Sarkisian, Lee-Henderson, & Mangione, 2003; Wuthrich & Frei, 2015).
- Physical health care is prioritised over mental health care (McCabe, Davison, Mellor, & George, 2009).
- The stigma surrounding mental health makes people reluctant to seek help – older adults grew up in an era when talking about psychological issues was frowned upon, so this can make it more difficult to seek help (McCabe et al., 2009; Stargatt et al., 2017; World Health Organization, 2017).
- Knowledge deficits regarding recognition of mental health concerns, management and prevention in older adults (Wuthrich & Frei, 2015).
- A lack of services for older adult mental health in rural areas (Muir-Cochrane, O'Kane, Barkway, Oster, & Fuller, 2014).

## Vulnerable groups within the older adult population

While the prevalence of mental health disorders tends to reduce in older age (ABS, 2008), research indicates that there are certain sub-groups within the older population that are at higher risk of experiencing poor mental health, including those:

- from Aboriginal and Torres Strait Islander communities

- from culturally and linguistically diverse backgrounds
- who are veterans of the Australian Defence Force (or the spouse/widow(er) of a veteran)
- who live in rural or remote areas
- who are homeless or at risk of becoming homeless
- who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI).

## Aboriginal and Torres Strait Islander older adult mental health

In 2016, 5% of the Indigenous population were aged 65 years or older, compared with 16% of the non-Indigenous population (ABS, 2017b). A recent study indicates that the prevalence of depression in Indigenous adults aged 60 years and over was 18% (Shen et al., 2018). Gubhaju et al. (2013) found there was a significantly higher lifetime prevalence of depression (23%) and anxiety (14%) in Aboriginal Australians who were 45 years or older, in comparison with the same-aged general population (13% and 8%, respectively). It is estimated that 30% of Indigenous individuals aged 55 years and older have a mental health condition (ABS, 2016) and this contributes to suicide risk and high rates of smoking, alcohol and substance abuse. Aboriginal and Torres Strait Islanders have three to five times the risk of developing dementia than non-Indigenous individuals (National Centre for Social and Economic Modelling, 2016).

Older people are an integral part of Aboriginal and Torres Strait Islander communities. In Indigenous communities, it is paramount that older adults can mentor and provide positive role models for younger Indigenous people, in order to pass on knowledge and wisdom across generations (Benevolent Society, 2013). Therefore, an older adult developing dementia can be particularly distressing for Indigenous communities, because of the role of Elders in passing on cultural knowledge to younger generations via spoken word, which relies on memory (Benevolent Society, 2013).

### Additional considerations

- Aboriginal and Torres Strait Islander people generally prefer the term ‘social and emotional well-being’ to ‘mental health’ (NSW Department of Health, 2010).
- Being an older Indigenous adult does not necessarily mean that person is an Elder. An Elder is chosen and acknowledged by a community based on contribution and status (Benevolent Society, 2013).
- Older Aboriginal adults frequently have caring roles that involve looking after grandchildren and great-grandchildren and may regard this role as more important than their own health (Benevolent Society, 2013).
- Several individuals may share the role of carer for an older person, thus the concept of ‘primary carer’ may not apply.

## Culturally and linguistically diverse older adult mental health

It has been estimated that 23% of Australians aged 65 years and older are of culturally and linguistically diverse (CALD) background, and that this proportion will increase across the next 10 years (Federation of Ethnic Communities’ Councils of Australia, 2011). Australia’s older CALD population is diverse and their individual needs vary greatly. Older individuals from CALD backgrounds may be more vulnerable to mental health issues than their non-CALD counterparts because they are more likely to have:

- significant histories of trauma/torture
- issues of identity loss and a sense of being disconnected (e.g. from homeland, culture, community, family)
- higher levels of isolation
- lower socioeconomic status.

(Federation of Ethnic Communities’ Councils of Australia, 2011; Minas, Klimidis, Ranieri, & Stuart, 2008; Nimri, 2007; Orb, 2002; Social Policy Research Centre, 2010; Zogalis, 2008).

Research indicates that individuals from CALD backgrounds living in Australia have higher levels of psychological morbidity than their non-CALD counterparts (Federation of Ethnic Communities’ Councils of Australia, 2011; Minas et al., 2008; Stanaway et al., 2010). Despite the greater risk of mental illness, older CALD Australians underuse mental health services by (Trauer, 1995). Many CALD individuals face barriers in accessing mental health services (Australian Institute of Health and Welfare, 2018c).

Barriers to use of mental health services include:

- lack of awareness of available mental health services or how to access these services
- communication difficulties due to limited English language skills
- concerns about confidentiality, for example, with regards to using interpreter services
- a lack of cultural competence/culturally appropriate services
- lack of information and resources in some languages (small and emerging communities)
- a lack of services for small and emerging communities in remote areas.

(Federation of Ethnic Communities' Councils of Australia, 2015; Social Policy Research Centre, 2010; Tribe, 2017).

The following strategies are recommended to create mental health services that are culturally appropriate.

- develop staff cultural competence
- cultivate a service environment which is tolerant and does not tolerate discrimination
- recognise diversity between and within different cultural groups
- utilise a strengths-based approach
- provide culturally appropriate information (in an individual's preferred language) to improve communication
- work in partnership with relevant organisations that support CALD individuals.

(Warburton, Bartlett, & Rao, 2009).

## Older veterans' mental health

Individuals who served in the Australian Defence Force (ADF), or an allied defence force, form an important minority of older Australians who can have a different experience of ageing due to factors associated with service (Australian Institute of Health and Welfare, 2018c). The Department of Veteran Affairs (DVA) also recognises the sacrifice made by war widow(er)s and the effects this can have on their mental health.

Men aged 55 to 64 who have served have higher rates of mental and behavioural problems (1.8 times) than the non-serving population (ABS, 2015; Australian Institute of Health and Welfare, 2018b). The most common conditions are generalised anxiety disorder, depression, posttraumatic stress disorder (PTSD), alcohol dependence and dementia (Department of Veterans' Affairs, 2013; McFarlane, 2010; Qureshi et al., 2010; Yaffe et al., 2010).

Risk factors for veterans developing mental health concerns include:

- chronic physical health conditions
- decreased mobility and loss of independence
- housing and financial uncertainty
- reduced social supports
- the cumulative effect of multiple exposures to trauma over a lifetime.

(Department of Veterans' Affairs, 2013).

The '*Veteran Mental Health Strategy, 2013 – 2023'* has been developed by the Australian Government, with the aim of preventing and supporting veteran mental health problems. The DVA currently funds treatment of PTSD, anxiety, depression and alcohol or substance misuse disorders for veterans with operational service or with more than three years of peacetime service, even if the condition is not service-related and no injury claim has been lodged.

### Websites for consumers

Information for veteran community on mental health, general wellbeing and counselling. https://www.openarms.gov.au/living-wel

Information on eligibility for rehabilitation assistance from the DVA: https://www.dva.gov.au/health-and-wellbeing/rehabilitation/rehabilitation-eligibility

## The mental health of older adults living in regional and remote communities.

Australia can be classified into major cities (e.g. Brisbane), inner regional (e.g. Bundaberg), outer regional (e.g. Bowen), remote (e.g. Mount Isa) and very remote (e.g. Karumba) areas. Regional and remote areas have higher proportions of older persons than major cities (Australian Institute of Health and Welfare, 2018c).

Multiple risk factors exist for older adults living in regional and remote areas.

- Increased likelihood of having a chronic disease and/or pain or disability (National Rural Health Alliance Inc, 2016).
- Increased likelihood of social isolation (Inder, Lewin, & Kelly, 2012; National Rural Health Alliance Inc, 2016).
- Lack of access to services to assist with mental and physical health problems (National Rural Health Alliance Inc, 2016).
- There are disproportionately few residential aged care places available in remote and very remote areas, with 38% of facilities in remote areas and 75% in very remote areas having fewer than 20 places (Australian Institute of Health and Welfare, 2018a).

Some research reports worse mental health outcomes, including higher suicide rates for older males living in rural areas as compared with major cities (National Rural Health Alliance Inc, 2016). However, there are also protective factors associated with living in a rural area: (1) greater social connection if living in a close-knit community and (2) more open spaces and a slower pace of life that can be supportive of mental health, as compared with the overstimulating and busy urban environment (Rickwood, 2005).

## The mental health of older adults experiencing homelessness

On Census night in 2016, 16% of all homeless people were aged 55 or older (ABS, 2018). Homelessness is a growing concern for older adults in Australia, and rates of homelessness in this population will likely continue to increase due to an ageing population and reduced rates of home ownership in this group. In the past 10 years, the largest increase in rates of homelessness for a specific age group was for those aged 55 to 74 years (ABS, 2018). For many older adults, physical and mental health declines may result in them needing some type of assisted living arrangement. This can result in them having to live somewhere that is unsatisfactory or removes them from their local community and supports, which negatively impacts mental health (Mission Australia, 2017). Those who are homeless are also at increased risk of substance misuse (as a precursor or response), which negatively impacts health and can induce premature ageing (Cheng & Lee, 2016). Older adults who are discharged from residential treatment facilities for mental health and/or substance misuse are at increased risk of homelessness and transition planning should ensure suitable living arrangements are available for these individuals (Mission Australia, 2017).

## Lesbian, gay, bisexual, trans, and/or intersex (LGBTI) older adults' mental health

Older adults who identify at LGBTI have lived through a period of cultural transition. Many have endured the negative effects of stigma, discrimination, rejection and social isolation (Department of Social Services, 2012). The rights of people who identify at LGBTI have improved considerably over the past few decades. However, the history of negativity experienced by this group can be a source of anxiety in disclosing sexual orientation, with 34% of people who identify at LGBTI reporting they hide their sexuality or gender identity when accessing services (Australian Human Rights Commission, 2015).

A study assessing the well-being of LGBT Australians found that 33% of LGBT individuals aged 45-59 and 19% aged 60 to 89 years reported being diagnosed or treated for a mental disorder in the past three years (Leonard, Lyons, & Bariola, 2015), which is a higher prevalence rate than in the general population of similar-aged individuals (ABS, 2008; World Health Organization, 2017). Consistent with this, an Australian study assessing individuals who are 45 years and older showed that older adults who identify as being homosexual or bisexual are approximately twice as likely to be diagnosed with depression or anxiety than heterosexuals (Byles, 2013 as cited in ACON, 2013). Finally, 50- to 70-year-old lesbian, gay and bisexual adults generally have higher levels of mental health service use as compared with the same-aged general population (Wallace, Cochran, Durazo, & Ford, 2011). The LGBTI population is diverse and individual needs vary substantially. Consult with the individual and where possible, ensure that their wishes and needs are central to service delivery. Avoid stereotyping and consider culture appropriately (Tribe, 2017).

## Queensland Health: Older Persons Mental Health Service

Most Hospital and Health Services (HHS) in Queensland have an Older Persons Mental Health Service. Referrals for specialist mental health services for persons aged 65 years and over (or 50 years and older for Indigenous individuals) who have a mental illness, complicated by conditions of age-related illnesses, are received by the Older Persons Mental Health Service (OPMHS). Check with your HHS and local hospital regarding the procedure for referral to this unit. For some HHSs the referral must be from a health practitioner, whereas in other HHSs self or carer referrals are appropriate. Some services require direct referral to the OPMHS, others require it indirectly via the Acute Care Team. Additionally, some hospitals have specialised inpatient units for older adults (e.g. Princess Alexandra Hospital).

## Websites for consumers and clinicians

Caring for older people with mental health issues Queensland Health Factsheet
Queensland Health Older Persons Mental Health Services
https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-pathways/residential-aged-care-clinical-pathways/hospital-and-health-service-contact-information/older-persons-mental-health-service
Check your local Hospital and Health Service webpage for information on your local service.

## References


ABS. (2008). *National survey of mental health and wellbeing 2007: Summary of results*. ABS Cat. No. 4326.0. Canberra: ABS.

ABS. (2015). *National health survey: First results, 2014–15 - Australia*. ABS cat. no. 4364.0. Canberra: ABS.

ABS. (2016). *National Aboriginal and Torres Strait Islander social survey, 2014-15*. ABS cat.no. 4714.0. Canberra: ABS.

ABS. (2017a). *Causes of death, Australia, 2017*. ABS cat. no. 3303.0. Canberra: ABS.

ABS. (2017b). *Census of population and housing: Reflecting Australia - stories from the census, 2016. Aboriginal and Torres Strait Islander population, 2016*. ABS cat.no. 2071.0. Canberra: ABS.

ABS. (2018). *Census of population and housing: Estimating homelessness, 2016*. ABS cat.no. 2049.0. Canberra: ABS.

ACON. (2013). *Health outcomes strategy 2013-2018: Mental health and wellbeing*. Sydney: Author.

Australian Human Rights Commission. (2015). *Resilient individuals: Sexual orientation, gender identity and intersex rights 2015*. Sydney: AHRC.

Australian Institute of Health and Welfare. (2018a). National aged care data clearinghouse: AIHW analysis of unpublished data.

Australian Institute of Health and Welfare. (2018b). *Australia's health 2018*. Australia's health series no. 16. AUS 221. Canberra: AIHW.

Australian Institute of Health and Welfare. (2018c). *Older Australia at a glance*. Retrieved from https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/summary

Australian Institute of Health and Welfare. (2018d). *People's care needs in aged care*. Retrieved from https://gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care

Benevolent Society. (2013). *Working with older Aboriginal and Torres Strait Islander people*. Retrieved from https://www.cmsa.org.au/documents/item/63

Beyond Blue. (n.d.). Older people. Retrieved from https://www.beyondblue.org.au/who-does-it-affect/older-people

Burgess, P. M., Pirkis, J. E., Slade, T. N., Johnston, A. K., Meadows, G. N., & Gunn, J. M. (2009). Service use for mental health problems: Findings from the 2007 National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry, 43*(7), 615-623. doi:10.1080/00048670902970858

Cheng, G. L. F., & Lee, T. M. C. (2016). Accelerated aging in heroin abusers: Readdressing a clinical anecdote using telomerase and neuroimaging. In V. R. Preedy (Ed.), *Neuropathology of drug addictions and substance misuse* (pp. 1012-1022). San Diego: Academic Press.
Cheung, G., Foster, G., de Beer, W., Gee, S., Hawkes, T., Rimkeit, S., . . . Sundram, F. (2017). Predictors for repeat self-harm and suicide among older people within 12 months of a self-harm presentation. *International Psychogeriatrics, 29*(8), 1237-1245. doi:10.1017/s1041610217000308
Department of Social Services. (2012). *National lesbian, gay, bisexual, transgender and intersex (LGBTI) ageing and aged care strategy*. Canberra: Author.
Department of Veterans' Affairs. (2013). *Veteran mental health strategy: A ten year framework 2013-2023*. Canberra: Author.
Erlangsen, A., Stenager, E., & Conwell, Y. (2015). Physical diseases as predictors of suicide in older adults: A nationwide, register-based cohort study. *Social Psychiatry and Psychiatric Epidemiology, 50*(9), 1427-1439. doi:10.1007/s00127-015-1051-0
Fassberg, M. M., Cheung, G., Canetto, S. S., Erlangsen, A., Lapierre, S., Lindner, R., . . . Waern, M. (2016). A systematic review of physical illness, functional disability, and suicidal behaviour among older adults. *Aging and Mental Health, 20*(2), 166-194. doi:10.1080/13607863.2015.1083945
Federation of Ethnic Communities' Councils of Australia. (2011). *Mental health and Australia's culturally and linguistically diverse communities*. Canberra: Author.
Federation of Ethnic Communities' Councils of Australia. (2015). *Review of Australian research on older people from culturally and linguistically diverse backgrounds*. Canberra: Department of Social Services.
Gubhaju, L., McNamara, B. J., Banks, E., Joshy, G., Raphael, B., Williamson, A., & Eades, S. J. (2013). The overall health and risk factor profile of Australian Aboriginal and Torres Strait Islander participants from the 45 and up study. *BMC Public Health, 13*(1), 661. doi:10.1186/1471-2458-13-661
Haralambous, B., Lin, X., Dow, B., Jones, C., Tinney, J., & Bryant, C. (2009). *Depression in older age: A scoping study*. Melbourne: National Ageing Research Institute.
Hawton, K., & Harriss, L. (2006). Deliberate self-harm in people aged 60 years and over: Characteristics and outcome of a 20-year cohort. *International Journal of Geriatric Psychiatry, 21*(6), 572-581. doi:10.1002/gps.1526
Inder, K. J., Lewin, T. J., & Kelly, B. J. (2012). Factors impacting on the well-being of older residents in rural communities. *Perspectives in Public Health, 132*(4), 182-191. doi:10.1177/1757913912447018
Leonard, W., Lyons, A., & Bariola, E. (2015). *A closer look at private lives 2: Addressing the mental health and well-being of LGBT Australians*. Monograph Series No. 103. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.
McCabe, M. P., Davison, T., Mellor, D., & George, K. (2009). Barriers to care for depressed older people: Perceptions of aged care among medical professionals. *International Journal of Aging and Human Development, 68*(1), 53-64. doi:10.2190/AG.68.1.c
McFarlane, A. (2010). The long-term costs of traumatic stress: Intertwined physical and psychological consequences. *World Psychiatry, 9*(1), 3-10. doi:10.1002/j.2051-5545.2010.tb00254.x
Minas, H., Klimidis, S., Ranieri, N., & Stuart, G. W. (2008). Relative prevalence of psychological morbidity in older immigrants. *International Journal of Culture and Mental Health, 1*(1), 58-72. doi:10.1080/17542860802149845
Mission Australia. (2017). *Ageing and homelessness: Solutions to a growing problem*. Retrieved from https://www.missionaustralia.com.au/publications/position-statements/ageing-and-homelessness-solutions-to-a-growing-problem
Mitchell, R., Draper, B., Harvey, L., Brodaty, H., & Close, J. (2017). The association of physical illness and self-harm resulting in hospitalisation among older people in a population-based study. *Aging and Mental Health, 21*(3), 279-288. doi:10.1080/13607863.2015.1099610

Morgan, C., Webb, R. T., Carr, M. J., Kontopantelis, E., Chew-Graham, C. A., Kapur, N., & Ashcroft, D. M. (2018). Self-harm in a primary care cohort of older people: Incidence, clinical management, and risk of suicide and other causes of death. *The Lancet Psychiatry, 5*(11), 905-912. doi:10.1016/S2215-0366(18)30348-1

Muir-Cochrane, E., O'Kane, D., Barkway, P., Oster, C., & Fuller, J. (2014). Service provision for older people with mental health problems in a rural area of Australia. *Aging and Mental Health, 18*(6), 759-766. doi:10.1080/13607863.2013.878307

National Ageing Research Institute. (2009). *Beyondblue depression in older age: A scoping study. Final Report*. Melbourne: National Ageing Research Institute.

National Centre for Social and Economic Modelling. (2016). *Economic cost of dementia in Australia 2016–2056*.

National Rural Health Alliance Inc. (2016). *Mental health in rural and remote Australia*. Canberra: National Rural Health Alliance Inc.

Nimri, E. (2007). *Social, care and support needs of older people from culturally and linguistically diverse backgrounds in the Gold Coast region: Needs analysis*. Ashmore, Queensland: Multicultural Seniors Program, Multicultural Communities Council.

NSW Department of Health. (2010). *Aboriginal older peoples' mental health project*. Retrieved from https://www.health.nsw.gov.au/mentalhealth/Documents/aboriginal-mh-report-2010.pdf

Orb, A. (2002). *Health care needs of elderly migrants from culturally and linguistically diverse (CALD) backgrounds: A review of the literature*. Canberra: Curtin University of Technology.

Qureshi, S. U., Kimbrell, T., Pyne, J. M., Magruder, K. M., Hudson, T. J., Petersen, N. J., . . . Kunik, M. E. (2010). Greater prevalence and incidence of dementia in older veterans with Posttraumatic Stress Disorder. *Journal of the American Geriatrics Society, 58*(9), 1627-1633. doi:10.1111/j.1532-5415.2010.02977.x

Rickwood, D. (2005). *Pathways of recovery: Preventing further episodes of mental illness*. Canberra: National Mental Health Promotion and Prevention Working Party.

Robinson, L., Smith, M., & Segal, J. (2018). *Depression in Older Adults*. Retrieved from https://www.helpguide.org/articles/depression/depression-in-older-adults.htm?pdf=13022

Sarkisian, C. A., Lee-Henderson, M. H., & Mangione, C. M. (2003). Do depressed older adults who attribute depression to "old age" believe it is important to seek care? *Journal of General Internal Medicine, 18*(12), 1001-1005.

Shen, Y.-T., Radford, K., Daylight, G., Cumming, R., Broe, T. G. A., & Draper, B. (2018). Depression, suicidal behaviour, and mental disorders in older Aboriginal Australians. *International Journal of Environmental Research and Public Health, 15*(3), 447. doi:10.3390/ijerph15030447

Slade, T., Johnston, A., Oakley Browne, M. A., Andrews, G., & Whiteford, H. (2009). 2007 National survey of mental health and wellbeing: Methods and key findings. *Australian and New Zealand Journal of Psychiatry, 43*(7), 594-605. doi:10.1080/00048670902970882

Social Policy Research Centre. (2010). *Supporting older people from culturally and linguistically diverse backgrounds*. NSW, Australia: Benevolent Society.

Stanaway, F. F., Cumming, R. G., Naganathan, V., Blyth, F. M., Creasey, H. M., Waite, L. M., . . . Seibel, M. J. (2010). Depressive symptoms in older male Italian immigrants in Australia: The concord health and ageing in men project. *Medical Journal of Australia, 192*(3), 158-162.

Stargatt, J., Bhar, S. S., Davison, T. E., Pachana, N. A., Mitchell, L., Koder, D., . . . Helmes, E. (2017). The availability of psychological services for aged care residents in Australia: A survey of facility staff. *Australian Psychologist, 52*(6), 406-413. doi:10.1111/ap.12244

Tan, Y. M., & Cheung, G. (2019). Self-harm in adults: A comparison between the middle-aged and the elderly. *New Zealand Medical Journal, 132*(1489), 15-29.

Trauer, T. (1995). Ethnic differences in the utilisation of public psychiatric services in an area of suburban Melbourne. *Australian and New Zealand Journal of Psychiatry, 29*(4), 615-623. doi:10.3109/00048679509064976

Tribe, R. (2017). Ageing, ethnicity and mental health. In P. Lane & R. Tribe (Eds.), *Anti-discriminatory practice in mental health for older people*. London, UK: Jessica Kingsley Publishers.

Trollor, J. N., Anderson, T. M., Sachdev, P. S., Brodaty, H., & Andrews, G. (2007). Age shall not weary them: Mental health in the middle-aged and the elderly. *Australian and New Zealand Journal of Psychiatry, 41*(7), 581-589. doi:10.1080/00048670701392817

Wallace, S. P., Cochran, S. D., Durazo, E. M., & Ford, C. L. (2011). The health of aging lesbian, gay and bisexual adults in California. *Policy brief UCLA Center for Health Policy Research*(PB2011-2), 1-8.
Warburton, J., Bartlett, H., & Rao, V. (2009). Ageing and cultural diversity: Policy and practice issues. *Australian Social Work, 62*(2), 168-185. doi:10.1080/03124070902748886
World Health Organization. (2013). *Mental health and older adults*. Factsheet no. 381. Geneva: WHO.
World Health Organization. (2017). *Mental health of older adults*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults
Wuthrich, V. M., & Frei, J. (2015). Barriers to treatment for older adults seeking psychological therapy. *International Psychogeriatrics, 27*(7), 1227-1236. doi:10.1017/s1041610215000241
Yaffe, K., Vittinghoff, E., Lindquist, K., Barnes, D. E., Covinsky, K. E., Neylan, T., . . . Marmar, C. (2010). Post-traumatic stress disorder and risk of dementia among US veterans. *Archives of General Psychiatry, 67*(6), 608-613. doi:10.1001/archgenpsychiatry.2010.61
Yon, Y., Mikton, C. R., Gassoumis, Z. D., & Wilber, K. H. (2017). Elder abuse prevalence in community settings: A systematic review and meta-analysis. *The Lancet: Global Health, 5*(2), e147-e156. doi:10.1016/s2214-109x(17)30006-2
Yon, Y., Ramiro-Gonzalez, M., Mikton, C. R., Huber, M., & Sethi, D. (2018). The prevalence of elder abuse in institutional settings: A systematic review and meta-analysis. *European Journal of Public Health, 29*(1), 58-67. doi:10.1093/eurpub/cky093
Zogalis, G. (2008). Mental Health and CALD Seniors. *Australian Mosaic, 20*, 36–38.