Promoting opportunities. Protecting rights. For older Victorians.

COTA Victoria & Seniors Rights Victoria

Submission to the Inquiry into the relationship between domestic, family and sexual violence, and suicide

To:

Committee Secretary
House of Representatives Standing Committee on Social Policy and Legal Affairs
Via email to: spla.reps@aph.gov.au

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1 About us

Council on the Ageing (COTA) Victoria is the leading not-for-profit organisation representing the interests and rights of people aged over 50 in Victoria. Celebrating 75 years of service in 2026, we have led government, corporate and community thinking about the positive aspects of ageing in the state.

Today, our focus is on promoting opportunities for and protecting the rights of people 50+. We value ageing and embrace its opportunities for personal growth, contribution, and self-expression. This belief brings benefits to the nation and its states alongside communities, families, and individuals.

Seniors Rights Victoria (SRV) is the key state-wide service dedicated to advancing the rights of older people and the early intervention into, or prevention of, elder abuse in our community. It is the only Community Legal Centre dedicated to preventing and responding to elder abuse within Victoria.

SRV has a team of experienced advocates, lawyers, and social workers who provide free information, advice, referral, legal advice, legal casework, and support to older people who are either at risk of or are experiencing elder abuse. SRV supports and empowers older people through the provision of legal advice directly to the older person.

2 An overview: The relationship between elder abuse and suicide

Elder abuse is a significant yet under-recognised form of family violence across Australia, and is defined by the World Health Organisation as:

> *"a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person".*[i]

Elder abuse can occur once or many times, be intentional or unintentional, and can vary in severity from subtle through to extreme. It can be financial, emotional, psychological, physical, sexual, or social, and often involves a combination of different types of abuse. Most often, elder abuse is carried out by someone known to the older person, with two thirds of those causing abuse or mistreatment being an adult child. Elder abuse affects people of all genders and all walks of life. The abuse, however, disproportionately affects women.

Under the Family Violence Protection Act 2008 (Vic), elder abuse constitutes family violence. As such, suicides linked to domestic, family and sexual violence (DFSV) include elder abuse related deaths. Despite this legislative clarity, elder abuse remains largely hidden, inconsistently identified, and unevenly captured across service, justice, and data systems. These limitations have direct implications for how suicide linked to DFSV is understood, investigated, and prevented in later life.

Available evidence suggests that elder abuse is prevalent and increasing in both scale and severity. As Victoria's population continues to age, the prevalence and pressures driving elder abuse are likely to intensify. Unlike other forms of family violence, older people experiencing abuse often seek to preserve family relationships rather than exit them, which can limit

disclosure and engagement with formal systems, including mental health support services.

Evidence also indicates a clear and concerning relationship between elder abuse and suicidality in later life. International studies suggest that older people who experience abuse are at an increased risk of suicidal ideation, attempted suicide, and death by suicide, even after accounting for other health and social factors. Suicide in later life is itself frequently under-identified. Deaths involving self-neglect, medication non-adherence, refusal of care, or ambiguous circumstances may not be classified as suicide, particularly where intent is difficult to establish. These challenges are amplified in elder abuse contexts, where harm is often subtle, relational, and poorly documented. As a result, suicide linked to elder abuse is likely to be under-counted rather than rare.

Systemic challenges further limit the identification of elder abuse related suicide. Underreporting by older people, limited recognition across mainstream family violence and aged-care services, inconsistent documentation practices, and variable frontline identification all contribute to low system visibility. While the coronial process and the Victorian Suicide Register provide important mechanisms for capturing DFSV-related deaths, their effectiveness is constrained by the quality and availability of information at early stages of reporting and investigation. Where elder abuse has not been recognised prior to death, it is less likely to be identified later through coronial processes.

Taken together, these factors mean that elder abuse related suicide is more likely to be under-identified than rare. The evidence suggests that elder abuse is a significant, growing, and distinct form of family violence that intersects with suicide risk in later life yet remains inadequately captured within current systems. Improving the visibility of elder abuse across prevention, service delivery, data collection, and coronial investigation is critical to strengthening DFSV-related suicide prevention and ensuring that older people are not overlooked in policy, practice, and reform efforts.

Specifically, we recommend that:

1. Ageism is recognised as a structural barrier to suicide prevention.
2. Nationally consistent adult safeguarding standards are established.
3. Investment is committed towards research on suicide in later life.
4. Funding is committed towards the implementation of the National Plan to End the Abuse and Mistreatment of Older People.
5. National leadership on the distinct nature of DSFV and suicide in later life is strengthened.

2.1 Evidence suggests elder abuse prevalence and severity is growing

Evidence suggests that the prevalence of elder abuse in Australia and Victoria is increasing, while limited system capacity means responses are increasingly occurring only at crisis point, leaving many cases unaddressed by services and systems.

The most detailed and rigorous study of elder abuse prevalence in Australia, published in December 2021, found that 14.8% of those 65 and over had experienced at least one recognised form of elder abuse over the previous 12 months. This translates into some 640,000 older Australians experiencing elder abuse every year, which especially concerning as it places Australia as one of the leading developed nations experiencing elder abuse, ahead of Canada (10.0%),[ii] United States (9.5%),[iii] and England and Wales (14%).[iv]

These figures suggest that 160,000 older Victorians are experiencing elder abuse each year to a level they are willing to identify to researchers, including 28,000 experiencing financial abuse. The prevalence of elder abuse is also only likely to increase as the population ages, which is a well-established structural trend, placing sustained and growing pressure on elder abuse service providers. This trend is reflected in the service demand experienced by SRV, increasing markedly over recent years, alongside a clear rise in the complexity and severity of matters presented.

In 2022/23, SRV responded to 5,085 calls to the Elder Abuse Helpline, representing a 50% increase on 2021/22, which experienced an increase of 40% from 2020/21. Demand for non-legal advice also rose substantially, with 374 advice sessions delivered, a 40% increase on the year prior. During the same period, SRV recorded a 20% increase in new cases opened. The increase in demand required SRV to deprioritise concerned third-party callers, with responses to older people experiencing abuse largely limited to more severe cases.

This trend continued into 2023/24, with 12,356 calls received to the SRV Helpline, but only 3,556 callers responded to, reflecting the growing complexity of cases reaching SRV at crisis point. In 2024/25, demand increased further, with the Helpline receiving 13,203. Despite ongoing pressures, Helpline advocates responded to 3,970 contacts. The average case duration was 646 days, with the longest case remaining open for 1,788 days, highlighting their persistent and complex nature.

2.2 Elder abuse is a distinct form of family violence

Elder abuse, while a form of family violence, is distinct in its nature, the relationships involved, its primary drivers and the dynamics that shape it. As a result, systems designed to identify, respond to, document and record family violence do not necessarily capture elder abuse unless they are explicitly designed to do so. In practice, this is often not the case, particularly when compared with the level of specificity and resourcing directed toward domestic and intimate partner violence.

The primary drivers of elder abuse include ageism operating at interpersonal, relational, societal, and systemic levels, and its intersection with other risk factors affecting both people who cause harm and victim-survivors, such as mental health concerns, complex family relationships, carer stress, financial insecurity, and social isolation. Intimate partner violence, on the other hand, is often rooted in harmful notions of masculinity characterised by “dominance, control, and aggression”.[v] This is reflected by the overwhelmingly gendered profile of perpetrators and victim survivors, which is characteristically different from elder abuse.

Unlike other forms of family violence, where victim-survivors often seek separation from

their abuser, those experiencing elder abuse tend to seek to maintain their existing family relationships. This familial dynamic complicates elder abuse cases, as the older person may rely on these individuals for essential needs like translation, care, and social interaction. Furthermore, the prospect of reporting their children or close relatives to authorities can evoke deep feelings of guilt and shame, preventing disclosure.

3 Understanding the link between elder abuse and suicide

Available research suggests that elder abuse is not only associated with suicidality in later life but may operate as a significant and independent risk factor within a broader constellation of intersecting vulnerabilities. [vi] Evidence indicates that experiences of abuse, neglect, and coercive control can contribute to suicide risk through cumulative psychological harm, particularly when combined with depression, social isolation, declining health, and functional dependence.

3.1 Suicide in later life is often distinct to suicide at other life stages

Suicide rates among older people are consistently among the highest globally compared to other age groups,[vii] including in Australia,[viii] with available evidence suggesting that suicide rates tend to increase with age[ix] However, suicide deaths in later life are also more likely to be underestimated.[x] In many cases, it can be difficult to determine intent, particularly where deaths involve circumstances such as self-neglect, refusal of care or medication non-adherence, co-existing chronic illness or disability, deaths that appear accidental or ambiguous, and limited engagement with mental health services. These factors can contribute to systemic under-identification of suicide among older adults.[xi]

Recent research highlights the potential role of ageism in shaping both suicide risk and its recognition in later life. [xii] Ageist assumptions that frame older age as synonymous with decline, dependence, or inevitability of suffering. This can influence the level of care, scrutiny and preventative response afforded to older people, as well as the extent to which their deaths attract investigative attention. As a result, suicidality in later life may be more readily overlooked, misclassified, or reframed as a natural consequence of ageing.

Some literature points to severe or persistent self-neglect as prevalent means of suicide amongst older people. In certain circumstances, behaviours such as refusal of food, medication, or medical care may sit on a continuum between neglect and passive or indirect suicidality. While intent is often difficult to establish, such patterns may signal profound loss of hope, perceived burdensomeness, or a desire to relinquish control. In these cases, deaths are by definition suicide.[xiii]

3.2 There is a clear link between elder abuse and suicide

A growing body of international literature indicates that older adults who experience mistreatment are at an increased risk of reporting or experiencing suicidal ideation. [xiv] Population-level studies suggest that this association persists even after accounting for a range of socio-demographic, health and psychosocial factors, indicating that elder abuse

may function as an independent risk factor for suicidality rather than merely co-occurring with other vulnerabilities. [xv]

Empirical studies point to a notable prevalence of suicidal ideation among older people who have experienced abuse. Analysis of the 2020 National Survey of Older Koreans (n = 9,920) found that 17.6% of older people who reported suicidal ideation had experienced elder abuse, with elder abuse emerging as the second strongest predictor of suicidal ideation after depression itself. [xvi]

More recent research from the United States similarly reported suicidal ideation in approximately 20% of a community-based sample of older adults who had experienced abuse. [xvii] Importantly, suicidal ideation was not associated with particular victim characteristics or abuse types, suggesting that suicide risk may be present across diverse experiences of elder abuse rather than confined to specific subgroups.

3.3 How does elder abuse relate to suicide?

Taken together, the literature suggests that the relationship between elder abuse and suicidality is cumulative and systemic rather than episodic or isolated. Elder abuse may contribute to suicide risk through the gradual erosion of psychological wellbeing, with experiences such as emotional abuse, coercive control, neglect, or sustained fear undermining self-worth, autonomy, and hopefulness over time. This process may be particularly pronounced where abuse co-occurs with declining health, dependency, financial stress, or social isolation, potentially lowering resistance to self-harm and reducing opportunities for disclosure or early intervention.

Elder abuse and suicidal ideation in later life also appear to share a range of overlapping risk factors, including poor social support, poor subjective health, multiple chronic illnesses, and functional or cognitive impairment. These intersecting conditions indicate that elder abuse often operates within a broader constellation of structural and psychosocial disadvantage and may both arise from and further intensify the same conditions associated with suicide risk.

4 System challenges in capturing elder abuse cases and prevalence

Underreporting by older people, limited recognition across mainstream family violence and aged-care services, inconsistent documentation practices across sectors, and variable frontline identification all contribute to low system visibility, which in turn makes it difficult to link suicides amongst older people with cases of elder abuse.

4.1 Elder abuse is often unrecognised, underreported, and undocumented

Australian research, including the National Elder Abuse Prevalence Study (NEAPS), suggests that elder abuse largely occurs outside formal system visibility with several factors preventing disclosure. Further, despite growing recognition that professionals working with older people are often best placed to identify and document signs of abuse, confidence, and capability in recognising elder abuse vary considerably, limiting opportunities for

documentation, data capture and effective early intervention. This invisibility has downstream consequences for understanding the relationship between elder abuse and suicide.

Underreporting is widely recognised as a significant barrier to identifying and responding to elder abuse. While non-disclosure is common across family violence, the drivers in later life are often distinct and compounded by age-related, relational, and structural factors. Evidence from the NEAPS indicates that although elder abuse is prevalent, an overwhelming majority of older people do not seek help, with only a small proportion engaging with formal services or justice pathways.

Older people may be less likely to identify their experiences as family violence or abuse, particularly where harm is non-physical, cumulative, or embedded within long-standing family relationships. Behaviours such as financial control, coercion or neglect may be normalised over time, reframed as part of ageing, illness, or dependency, or minimised in the context of perceived family obligations. Consistent with NEAPS findings, many victim-survivors do not self-identify as experiencing elder abuse even when they report behaviours that meet formal definitions, often recognising specific acts when described but denying abuse when asked directly.

Disclosure is further constrained by strong relational dynamics and fears about adverse consequences. Older people may be reluctant to report harm by an adult child, partner, or carer due to concerns about damaging family relationships, the impact on the person causing harm, or the loss of care, housing or autonomy. These concerns may be heightened where dependency exists, or where reporting is perceived as leading to unwanted intervention or institutionalisation. Cultural and generational norms around privacy, endurance and family may also discourage disclosure, particularly for those with trauma, migration history or mistrust of authorities.

4.2 Mainstream family violence services often do not capture elder abuse

Despite the broad legislative definition of family violence in Victoria, service systems have historically been designed around models of domestic and intimate partner violence, particularly involving younger women victim-survivors. As a result, the experiences of older people are not always well recognised or accommodated within existing service frameworks. Many family violence services are not explicitly oriented toward older victim-survivors, either in eligibility or in program design. This can limit the visibility of elder abuse within service data and reduce the likelihood that older people will be identified, referred, or supported through mainstream pathways.

Better Place Australia, Victoria's only family violence service organisation with staff dedicated to elder abuse cases, has highlighted that specialist elder abuse services cannot be replaced by generalist family violence services that are not tailored for older people.[xviii] Further research in Western Australia found that, of the older people and relevant organisations surveyed, 47.9% of respondents believed the abuse of older people is not recognised or integrated into generalist family violence responses.[xix]

Where age-specific services do exist, such as specialist elder abuse services, they often

operate separately from the family violence system. While these services play a critical role, their separation can reinforce siloed responses, limit information sharing and result in elder abuse being under-counted in broader family violence datasets. As a result, family violence services and system responses designed primarily around domestic, sexual, and intimate partner violence often fail to adequately capture elder abuse within Victoria. This includes key mechanisms such as the *Central Information Point*, *MARAM,* and *Family Violence Information Sharing Scheme*, which are intended to integrate the family violence system, and justice system, but are not attuned to elder abuse.

4.3 Gaps in system recognition and capture of elder abuse highlight the need for national leadership

The Victorian Government's response to its *Inquiry into capturing data on family violence perpetrators* represents a constructive step towards strengthening system capability. However, some gaps remain in the systems capacity to consistently recognise and capture elder abuse. While the response addresses aspects of workforce capability within The Orange Door network, broader structural factors continue to limit the visibility of elder abuse across key sectors and support systems. As a result, opportunities to identify elder abuse, document it consistently, and build a robust evidence base are not yet fully realised.

Alongside recent State investment in workforce capacity within The Orange Door network, there is an opportunity to further strengthen the identification and documentation of elder abuse within the scope of Tier 3 and Tier 4 organisations under the Family Violence Data Collection Framework. Enhancing documentation practices across these settings would support more consistent system-wide recognition of elder abuse, particularly where it occurs outside family violence–specific services.

Similar considerations arise in relation to Recommendation 42, which proposed the development of elder abuse–specific outcomes within the Family Violence Outcomes Framework. The decision not to progress this recommendation may have implications for how elder abuse is captured and understood in the evaluation of family violence reforms and service integration. At present, Domain 3 of the Framework relies heavily on the L17 form completed by police. Given the variable identification of elder abuse by police and the relatively low and uneven levels of police engagement among older victim-survivors, this measure may not fully reflect elder abuse outcomes.

Taken together, these issues highlight an opportunity for strengthened national leadership. Nationally consistent adult safeguarding standards could support improved recognition, documentation, and measurement of elder abuse across jurisdictions and service systems. Drawing on existing state-based and international approaches, a national framework could establish minimum standards, clarify roles and responsibilities, and enhance the visibility of elder abuse within family violence, health, and community service responses.

5 Detecting suicide and associated abuse amongst older people

While the coronial process and the Victorian Suicide Register provide important mechanisms for capturing DFSV related deaths, their effectiveness is constrained by the quality and availability of information at early stages of reporting and investigation. Where elder abuse has not been recognised prior to death, it is less likely to be identified later through coronial processes.

5.1 How does suicide from elder abuse get captured

Section 4 of the Coroners Act 2008 (Vic) requires that all Victorian deaths from suspected non-natural causes are reported to the Court for investigation, a process detailed in *Experience of family violence among people who suicided: Victoria, 2009–2016:* [xx]

1. The death is reported by a Victoria Police member who attends the scene, speaks with witnesses, documents the circumstances, and undertakes initial investigations. The attending officer submits a Police Report of Death for the Coroner (*Form 83*), usually on the same day the deceased is found.

   > *Form 83* captures standard identifying and contextual information, including the deceased's personal details, Aboriginal and/or Torres Strait Islander status, next of kin, treating practitioners, and when and where the deceased was last seen alive and found deceased or dying. Not all information may be available at the time the form is prepared, usually within 24 hours.
   >
   > *Form 83* also includes an unstructured free-text summary of the circumstances of death, based on information available to police at initial attendance. The level of detail and accuracy varies depending on what can be established at that time and may include accounts from family members, acquaintances, medical practitioners, or suicide notes.

2. Based on the available material, where a death is assessed as a possible or probable suicide, it is entered into the Victorian Suicide Register (VSR), with additional coding of suicide method, intent, location details, and type of incident location. Possible suicides are generally included in the VSR within 24 hours of reporting.

3. The VSR enhanced dataset incorporates more detailed information that typically becomes available only after the coronial brief of evidence has been received. Experience of family violence is captured within the VSR enhanced dataset.

> This dataset captures binary, categorical and free-text information across nine domains, including: socio-demographics, physical and mental health, intent, interpersonal and contextual stressors, service contacts, toxicology, and suicide method.
>
> Enhanced coding is resource-intensive, requiring an average of two to three hours per death. As of June 2024, enhanced coding has been completed for all Victorian suicide deaths from 2009 to 2016, with coding for 2017 underway but subject to resourcing constraints.

4. Evidence of family violence is recorded using a broad definition aligned with the Family Violence Protection Act 2008 (Vic), with no time limitation on when the violence occurred. Where identified, coders record the direction of violence (victim and/or perpetrator) and include free-text notes detailing the nature, timing, impacts and any known system contact.

> Deaths not initially classified as suicide may be reclassified as further evidence emerges. Accordingly, VSR data reflects the best available information at the time of extraction, and figures may vary between extracts as investigations progress.

5.2 Entry points and early identification

Three foundational identification challenges exist from the outset:

- identifying cause to investigate,
- identifying suicide, particularly where intent is ambiguous; and,
- identifying elder abuse as a relevant contributing context.

These challenges arise both at the time the death is first reported and during the coronial investigation. If suicide is not suspected, or if a death is attributed to age, illness, frailty, self-neglect, or accidental injury (including certain falls-related deaths where there is no immediate concern), a risk arises that the case may not proceed to a full investigation. In those circumstances, the opportunity to identify suicide, and any contributing elder abuse, is substantially reduced.

Previous research examining coronial decision-making suggests that the deaths selected for inquests may not be representative of all reportable deaths. [xxi] A study on 20,000 deaths investigated by Australian coroners across five jurisdictions found that only around 6% proceeded to inquest. Of these, just over half were discretionary rather than mandatory, meaning their selection depended on the judgement of individual coroners rather than statutory requirements.

Additionally, the likelihood that elder abuse will be identified and recorded as relevant to a suicide is closely linked to the victim-survivor having meaningful contact with relevant systems prior to death, whether those services documented observations, and whether investigators identified and examined those contact points. However, due to factors

previously mentioned, existing gaps compound invisibility and constrain what can be identified through coronial processes and the VSR.

5.3 Investigation-stage constraints and its implications

The Coroners Court of Victoria recognises that VSR coding is constrained by the nature and scope of coronial investigations, and by the material available at the time. [xxii] The quantity and depth of information can vary significantly between cases. Some investigations involve extensive documentation, multiple witness statements and, in some cases, an inquest. Others rely on limited material, such as a single police or witness report.

In practice, this variability matters because elder abuse is often hidden, cumulative and relational, and may not be readily apparent without sustained inquiry or multiple sources of information. Where documentation is limited, there may be insufficient detail to identify or code the presence, nature, or context of abuse, even where it may have shaped risk of suicide over time.

The Court also recognises that reliance on secondary sources, including police reports and witness statements, can constrain accuracy and completeness. [xxiii] In elder abuse contexts, social isolation, dependency, and family-based perpetration can reduce the availability of independent witnesses and increase the likelihood that harm is misattributed to ageing, illness or self-neglect.

As inclusion in the VSR involves detailing both a suicide method and evidence of intent, where these are ambiguous or cumulative rather than overt (for reasons mentioned earlier in this submission) the threshold for classification as suicide may not be met. Additionally, if there is no clear investigative trigger, additional information needed to establish suicide, and any contributing abuse, is unlikely to be uncovered.

While deaths may be reclassified as new information emerges, this depends on sufficient investigation and documentation occurring in the first place. Prospective and surveillance-oriented processes can also prioritise timeliness over depth, which may reduce opportunities to surface complex, cumulative harm.

5.4 Policing and frontline identification challenges

Victoria Police remain a key gateway to coronial reporting. However, evidence from SRV casework and feedback from partner service organisations suggests that elder abuse is not always consistently identified or addressed. In addition, officers may be required to document complex circumstances where coercive control, neglect or financial abuse are not immediately apparent, and where harm occurs within ongoing family or care relationships that may appear ordinary or non-criminal.

The quality and detail of information recorded in *Form 83* (Police Report of Death for the Coroner) varies and is influenced by what can be established at the time, the experience of the attending officer, and the availability and reliability of witnesses and family accounts. Where elder abuse has not previously been recognised, documented, or disclosed, it may not be identified as relevant at earliest stages of reporting.

Even where concerns exist, evidence in elder abuse contexts can be inherently difficult to obtain and interpret. This is particularly the case where the older person is socially isolated, limiting independent corroboration; witnesses are limited, absent, or themselves implicated; and abuse is cumulative, subtle or passive (including neglect, psychological abuse, and coercive control).

Financial abuse presents a specific challenge. It often requires detailed examination of banking activity, expenses, access arrangements and patterns of control over resources, activities that are not routinely undertaken in the death reporting process and may not be pursued unless financial abuse is already suspected or otherwise brought to attention.

These dynamics can constrain the capacity of investigations to establish a coherent narrative of harm, particularly where the older person's experience is not captured in contemporaneous records.

5.5 Implications for DFSV-related suicide data and prevention

Taken together, these factors mean that elder abuse related suicide is more likely to be under-identified than rare. Where system exposure and integration around elder abuse are minimal, coronial investigations may rely heavily on medical histories, autopsy findings, and incomplete documentation. In the absence of contemporaneous records noting abuse or coercive control, identifying DFSV as a contributing factor becomes substantially more difficult.

This has broader implications for data quality, trend analysis and prevention. If elder abuse-related suicides are not identified at the point of investigation, they are unlikely to be reflected accurately in suicide statistics, DFSV data sets or policy responses, limiting the capacity of prevention strategies to address risk in later life.

6 Recommendations

1. Recognise ageism as a structural barrier to suicide prevention

The inquiry should explicitly recognise ageism as a structural factor that can mask, normalise, or sustain suicide risk in later life. This includes age-based assumptions that frame depression, withdrawal, self-neglect, dependency, or declining health as inevitable consequences of ageing, rather than as potential indicators of distress, abuse or suicidality.

Recognising ageism in the final report would support more accurate identification of risk, reduce misattribution of harm to "natural ageing," and strengthen the inclusion of older people within national suicide prevention and DFSV policy frameworks.

2. Establish a nationally consistent adult safeguarding framework

The Commonwealth is well placed to demonstrate national leadership by progressing a framework that establishes minimum adult safeguarding standards across jurisdictions. This framework could set clear national expectations, including:

- a shared definition of an "adult at risk";
- core functions of adult safeguarding, such as risk assessment, investigation, coordination, and escalation; and
- minimum standards for inter-agency collaboration and information sharing.

A nationally consistent framework would support earlier identification of abuse and neglect, reduce jurisdictional variability, and strengthen the prevention of cumulative harm that may contribute to suicide in later life.

3. Invest in research on suicide in later life and its relationship to elder abuse

Funding to enable targeted research to improve understanding of the nature, prevalence and risk factors associated with suicide among older people in Australia, would support identification, prevention, and early intervention. Notably, research could:

- examines suicide in later life as potentially cumulative, passive or indirect;
- explores the relationship between elder abuse, neglect, coercive control, and suicidality; and
- addresses known limitations in existing data, including under-identification.

A contemporary, Australian evidence base is necessary to inform effective prevention strategies and ensure older people are not overlooked in national suicide research and policy.

4. Ensure sustained funding for the National Plan to End the Abuse and Mistreatment of Older People

The Commonwealth should ensure the second *National Plan to End the Abuse and Mistreatment of Older People (2024-2034)* is supported by sustained and adequate funding over its full lifespan. Funding should be sufficient to:

- meet increased demand arising from awareness-raising initiatives;
- support specialist elder abuse prevention and response services; and
- enable consistent implementation across jurisdictions.

Without secure and ongoing resourcing, the National Plan risks reinforcing crisis-driven responses rather than advancing meaningful prevention and early intervention outcomes.

5. Strengthen national leadership on the distinct nature of family violence and suicide in later life

Initiatives stemming from national strategies such as *The National Suicide Prevention Strategy* and *National Plan to End Violence against Women and Children* should explicitly recognise that family violence and suicide in later life often differ in form, drivers, and dynamics from those affecting younger cohorts. This includes differences in:

- perpetrator–victim relationships;
- patterns of dependency, caregiving, and co-residency; and
- help-seeking behaviour and engagement with formal systems.

Ensuring older people are treated as a distinct cohort within national strategies would improve the relevance, effectiveness and inclusivity of prevention and response efforts, while supporting more accurate data collection and policy design.

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