MAY 2006

NATIONAL GUIDELINES FOR SENIORS' MENTAL HEALTH

The Assessment of Suicide Risk and Prevention of Suicide

CANADIAN COALITION FOR SENIORS' MENTAL HEALTH
COALITION CANADIENNE POUR LA SANTÉ MENTALE DES PERSONNES ÂGÉES

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The CCSMH gratefully acknowledges support from:
POPULATION HEALTH FUND, PUBLIC HEALTH AGENCY OF CANADA*
*The opinions expressed in this publication are those of the authors/researchers and do not necessarily reflect the official views of the Public Health Agency of Canada

The CCSMH gratefully acknowledges support from **AIRD & BERLIS LLP** for their guidance on Copyright issues and for the review and creation of the disclaimer statement.

The CCSMH gratefully acknowledges unrestricted educational grant support for the **dissemination** of the National Guidelines for Seniors' Mental Health from:

AstraZeneca Canada Inc.

Organon Canada Ltd

Eli Lilly and Company

RBC Foundation

Janssen-Ortho Inc.

Canadian Institutes for Health Research - Institute of Aging

Foreword

About the Canadian Coalition for Seniors' Mental Health

The Canadian Coalition for Seniors' Mental Health (CCSMH) was established in 2002 following a two-day symposium on "Gaps in Mental Health Services for Seniors' in Long-Term Care Settings" hosted by the Canadian Academy of Geriatric Psychiatry (CAGP). In 2002, Dr. David Conn and Dr. Ken Le Clair (CCSMH co-chairs) took on leadership responsibilities for partnering with key national organizations, creating a mission and establishing goals for the organization. The mission of the CCSMH is to ***promote the mental health of seniors by connecting people, ideas, and resources.***

The CCSMH has a volunteer Steering Committee that provides ongoing strategic advice, leadership and direction. In addition, the CCSMH is composed of organizations and individuals representing seniors, family members and caregivers, health care professionals, frontline workers, researchers, and policy makers. There are currently over 750 individual members and 85 organizational members from across Canada. These stakeholders are representatives of local, provincial, territorial and federal organizations.

Aim of Guidelines

Clinical practice guidelines are defined as "systematically developed statements of recommendation for patient management to assist practitioner and patient decisions about appropriate health care for specific situations" (Lohr & Field, 1992).

The CCSMH is proud to have been able to facilitate the development of these clinical guidelines. These are the first interdisciplinary, national best practices guidelines to specifically address key areas in seniors' mental health. These guidelines were written by and for interdisciplinary teams of health care professionals from across Canada.

The aim of these guidelines is to improve the assessment, treatment, management and prevention of key mental health issues for seniors, through the provision of evidence-based recommendations. The recommendations given in these guidelines are based on the best available evidence at the time of publication and when necessary, supplemented by the consensus opinion of the guideline development group.

Acknowledgements

Funding for the CCSMH Guideline Initiative was provided by the Public Health Agency of Canada, Population Health Fund. The CCSMH gratefully acknowledges the Public Health Agency of Canada for its ongoing support and continued commitment to the area of seniors' mental health.

In addition, special thanks to the Co-leads and Guideline Development Group members who dedicated countless number of hours and engaged in the creation of the guidelines and recommendations. Your energy, enthusiasm, insight, knowledge, and commitment were truly remarkable and inspiring.

The CCSMH would like to thank all those who participated in the guideline workshops at the *National Best Practices Conference: Focus on Seniors' Mental Health 2005* (Ottawa, September 2005) for their feedback and advice.

We would also like to thank Mr. Howard Winkler and Aird & Berlis LLP for their in-kind support in reviewing the guideline documents and providing legal perspective and advice to the CCSMH.

Finally, the CCSMH would like to acknowledge the continued dedication of its Steering Committee members.

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Canadian Mental Health Association ..... Ms. Kathryn Youngblut
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Overview of Guideline Project

Background Context

The mission of the CCSMH is *to promote the mental health of seniors by connecting people, ideas and resources*. The primary goals of the CCSMH include:

- To ensure that Seniors' Mental Health is recognized as a key Canadian health and wellness issue
- To facilitate initiatives related to enhancing and promoting seniors' mental health resources
- To ensure growth and sustainability of the CCSMH

In order to meet the mission and goals, a number of strategic initiatives are facilitated by the CCSMH with the focus on the following areas:

- Advocacy and Public Awareness
- Research
- Education
- Human Resources
- Promoting Best Practices in Assessment and Treatment
- Family Caregivers

In January 2005, the CCSMH was awarded funding by the Public Health Agency of Canada, Population Health Fund, to lead and facilitate the development of evidence-based recommendations for best practice National Guidelines in a number of key areas for seniors' mental health. The four chosen key areas for guideline development were:

1. Assessment and Treatment of **Delirium**
2. Assessment and Treatment of **Depression**
3. Assessment and Treatment of **Mental Health Issues in Long-Term Care Homes** (focus on mood and behavioural symptoms)
4. Assessment of **Suicide Risk** and Prevention of **Suicide**

Between April 2005 and February 2006, workgroups were established for the four identified areas and they evaluated existing guidelines, reviewed primary literature and formulated documents that included recommendations and supporting text.

Necessity for the Guidelines

The proportion of Canadians who are seniors is expected to increase dramatically. By 2021, older adults (i.e., those age 65 +) will account for almost 18% of our country's population (Health Canada, 1999). Currently, 20% of those aged 65 and older are living with a mental illness (MacCourt, 2005). Although this figure is consistent with the prevalence of mental illness in other age groups, it does not capture the high prevalence rates seen within health and social institutions. For example, it has been reported that 80%-90% of nursing home residents live with some form of mental illness and/or cognitive impairment (Drance, 2005; Rovner et al., 1990).

Previously, there were no interdisciplinary national guidelines on the prevention, assessment, treatment and management of the major mental health issues facing older Canadians although there are recommendations from a Consensus Conference on the assessment and management of dementia (Patterson et al., 1999; updated version to be published shortly). With the projected growth of the seniors' population, the lack of an accepted national standard to guide their care is a serious problem.

We have to identify, collaborate and share knowledge on effective mental health assessment and treatment practices relevant to seniors. As such, the CCSMH National Guideline Project was created to support the development of evidence-based recommendations in the four key areas of seniors' mental health identified above.

Objectives

The overall project goal was to develop evidence-based recommendations for best practice guidelines in four key areas of seniors' mental health.

Project Objectives:

1. To identify existing best-practice guidelines in the area of seniors' mental health both within Canada and internationally.
2. To facilitate the collaboration of key healthcare leaders within the realm of seniors' mental health in order to review existing guidelines and the literature relevant to seniors' mental health.
3. To facilitate a process of partnership where key leaders and identified stakeholders create a set of recommendations and/or guidelines for identified areas within seniors' mental health.
4. To disseminate the draft recommendations and/or guidelines to stakeholders at the CCSMH Best Practices Conference 2005 in order to create an opportunity for review and analysis before moving forward with the final recommendations and/or guidelines.
5. To disseminate completed guidelines to health care professionals and stakeholders across the country.

Principles

Guiding **principles** included the following:

- Evidence-based
- Broad in scope
- Reflective of the continuum of settings for care
- Clear, concise, readable
- Practical

Scope

- Must be multi-disciplinary in nature
- Will focus on older adults only
- May include all health care settings across the continuum
- Should acknowlege the variation (i.e., in services, definitions, access issues, etc.) that exists between facilities, agencies, communities, regions and provinces across the country
- Must deal explicitly with areas of overlap between the four National Guidelines for seniors' mental health
- While four independent documents will be created, there will be cross-referencing between documents as need arises
- Gaps in knowledge will be identified and included in the guideline documents
- Research, education and service delivery issues should be included in the guidelines. For example, the guidelines may address "optimal services", "organizational aspects", "research", and "education."

In addition, each Guideline Development Group identified scope issues specific to their topic.

Target Audience

There are multiple target audiences for these guidelines. They include multidisciplinary care teams, health care professionals, administrators, and policy makers whose work focuses on the senior population. In addition, these guidelines may serve useful in the planning and evaluation of health care service delivery models, human resource plans, accreditation standards, training and education requirements, research needs and funding decisions.

Guideline Development Process

Creation of the Guideline Development Group

An interdisciplinary group of experts on seniors' mental health issues were brought together under the auspices of the CCSMH to become members of one of the four CCSMH Guideline Development Groups. Co-leads for the Guideline Development Groups were chosen by members of the CCSMH Steering Committee after soliciting recommendations from organizations and individuals. Once the Co-leads were selected, Guideline Development Group members and consultants were chosen using a similar process, including suggestions from the Co-leads. One of the goals in selecting group members was to attempt to create an inter- disciplinary workgroup with diverse provincial representation from across the country.

Creation of the Guidelines

In May 2005, the Guideline Development Groups convened in Toronto, Ontario for a two-day workshop. Through large and small group discussions, the workshop resulted in a consensus on the scope of each practice guideline, the guideline template, the identification of relevant resources for moving forward, and the development of timelines and accountability plans.

A number of mechanisms were established to minimize the potential for biased recommendations being made due to conflicts of interest. All Guideline Development Group members were asked to complete a conflict of interest form, which was assessed by the project team. This was completed twice throughout the process. The completed forms are available on request from the CCSMH. As well, the guidelines were comprehensively reviewed by external stakeholders from related fields on multiple occasions.

The four individual Guideline Development Groups met at monthly meetings via teleconference with frequent informal contact through email and phone calls between workgroup members. As sections of the guidelines were assigned to group members based on their area of expertise and interest, meetings among these subgroups were arranged. As well, monthly meetings were scheduled among the Co-leads. The CCSMH project director and manager were responsible for facilitating the process from beginning to end.

Phase I: Group Administration & Preparation for Draft Documents (April/June 2005)

- Identification of Co-leads and Guideline Development Group Members
- Meetings with Co-leads & individual Guideline Development Groups
- Establish terms of reference, guiding principles, scope of individual guidelines
- Development of timelines and accountability plans
- Creation of guideline framework template
- Comprehensive literature and guideline review
- Identification of guideline & literature review tools and grading of evidence tools

Phase II: Creation of Draft Guideline Documents (May/Sept. 2005)

- Meetings with co-leads & individual workgroups
- Shortlist, review & rating of literature and guidelines
- Summarized evidence, gaps & recommendations
- Creation of draft guideline documents
- Review and revisions of draft documents

Phase III: Dissemination & Consultation (May 2005/Jan. 2006)

The dissemination of the draft guidelines to external stakeholders for review and consultation occurred in the following three stages:

Stage 1: Dissemination to guideline group members (May/December 2005)

Revised versions of the guidelines were disseminated to Guideline Development Group members on an ongoing basis.

Stage 2: Dissemination to CCSMH Best Practices Conference participants (Sept. 2005)

In order to address issues around awareness, education, assessment and treatment practices, a national conference was hosted on September 26th and 27th 2005 entitled ***"National Best Practices Conference: Focus on Seniors' Mental Health."*** Those attending the conference had the opportunity to engage in the process of providing stakeholder input into the development of one of the four national guidelines. The full-day workshops focused on appraising and advising on the draft national guidelines and on dissemination strategies.

The workshop session was broken down into the following activities:

- Review of process, literature and existing guidelines
- Review of working drafts of the guidelines
- Comprehensive small and large group appraisal and analysis of draft guidelines
- Systematic creation of suggested amendments to draft guidelines by both the small and large groups
- Discussion of the next steps in revising and then disseminating the guidelines. This included discussion on opportunities for further participation

Stage 3: Dissemination to guideline consultants and additional stakeholders. (October 2005/January 2006)

External stakeholders were requested to provide overall feedback and impressions and to respond to specific questions. Feedback was reviewed and discussed by the Guideline Development Groups. This material was subsequently incorporated into further revisions of the draft guideline.

Additional stakeholders included: identified project consultants; Public Health Agency of Canada, Federal/ Provincial/Territorial government groups; CCSMH members and participating organizations; CCSMH National Best Practices Conference workshop participants; Canadian Academy of Geriatric Psychiatry; and others.

Phase IV: Revised Draft of Guideline Documents (Oct. 2005/Jan. 2006)

- Feedback from the Best Practices Conference Workshops was brought back to the Guideline Development Groups for further analysis and discussion
- Feedback from external stakeholders was reviewed and discussed
- Consensus within each guideline group regarding recommendations and text was reached
- Final revisions to draft guideline documents

Phase V: Completion of Final Guideline Document (Dec. 2005/Jan. 2006)

- Final revisions to draft guideline documents by Guideline Development Groups
- Completion of final guidelines and recommendations document
- Final guidelines and recommendations presented to the Public Health Agency of Canada

Phase VI: Dissemination of Guidelines (Jan. 2006 - onwards)

- Identification of stakeholders for dissemination
- Translation, designing and printing of documents
- Dissemination of the documents to stakeholders through electronic and paper form
- Marketing of guidelines through newsletters, conference presentations, journal papers, etc.

See *Appendix A* for the detailed Process Flow Diagram outlining the development of the guidelines.

Guideline and Literature Review

A strategic and comprehensive guideline and literature review on the assessment and treatment of suicide in older adults was completed.

Search Strategy for Existing Evidence

A computerized search for relevant evidence-based summaries, including guidelines, meta-analysis and literature reviews, and research literature not contained in these source documents, was conducted by librarian consultants to the Guidelines project and CCSMH staff. The search strategy was guided by the following inclusion criteria:

- English language references only
- References specifically addressed suicide
- Dissertations were excluded
- Guidelines, meta-analyses and reviews were dated January 1995 to May 2005
- Research articles were dated January 1999 to June 2005

Guideline, Meta-analyses and Literature Reviews Search

The initial search for existing evidence-based summaries (e.g., guidelines, protocols, etc) examined several major databases, specifically, Medline, EMBASE, PsychInfo, CINAHL, AgeLine, and the Cochrane Library. The following search terms were used: "suicide", "self-harm", "elderly", "older adult(s)", "aged", "geriatric", "suicide guideline(s)", "elderly suicide guideline(s)", "practice guideline(s) suicide", "practice guideline(s) older adults suicide", "guideline(s) self-harm", "protocol(s) suicide", "protocol(s) self-harm", "practice guideline(s)", "best practice guideline(s)", and "clinical guideline(s)".

In addition, a list of websites was compiled based on known evidence-based practice websites, known guideline developers, and recommendations from guideline development group members. The search results and dates were noted. The following websites were examined:

- American Association of Suicidology: www.suicidology.org
- American Medical Association: http://www.ama-assn.org/
- American Psychiatric Association: http://www.psych.org/
- American Psychological Association: http://www.apa.org/
- Annals of Internal Medicine: http://www.annals.org/
- Association for Gerontology in Higher Education: http://www.aghe.org/site/aghewebsite/
- Canadian Association for Suicide Prevention: www.suicideprevention.ca
- Canadian Mental Health Association: http://www.cmha.ca/bins/index.asp
- Canadian Psychological Association: http://www.cpa.ca/
- International Association for Suicide Prevention: http://www.med.uio.no/iasp/
- National Guidelines Clearinghouse: http://www.guideline.gov/
- National Institute on Aging: http://www.nia.nih.gov/
- National Institute for Health and Clinical Excellence: http://www.nice.org.uk/
- National Institute of Mental Health: http://www.nimh.nih.gov/
- Ontario Medical Association: http://www.oma.org/
- Centre for Suicide Prevention ~ Suicide Information & Education Collection (SIEC): http://www.suicideinfo.ca/
- Suicide Prevention Resource Center: http://www.sprc.org/
- Registered Nurses Association of Ontario: http://www.rnao.org/
- Royal Australian and New Zealand College of Psychiatrists: http://www.ranzcp.org/
- Royal College of General Practitioners: http://www.rcgp.org.uk/
- Royal College of Nursing: http://www.rcn.org.uk/
- Royal College of Psychiatrists: http://www.rcpsych.ac.uk/
- World Health Organization: http://www.who.int/en/

This search yielded twenty potentially relevant guidelines. These were further considered by the Guideline Development Group as to whether they addressed the guideline topic specifically and were accessible either on-line, in the literature, or through contact with the developers. Through this process and after conducting a quality appraisal of these guidelines using the Appraisal of Guidelines for Research and Evaluation Instrument (AGREE) (AGREE Collaboration, 2001), eight guidelines were selected and obtained for inclusion as the literature base for the project. These eight guidelines were:

- American Psychiatric Association (APA). Practice guideline for the assessment and treatment of patients with suicidal behaviors. American Psychiatric Association; 2004. [On-line]. Available: http://www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf

- Gaynes BN, West SL, Ford CA, Frame P, Klein J, Lohr KN. Screening for suicide risk in adults: a summary of the evidence for the U.S. Preventive Services Task Force. Annals of Internal Medicine 2004;140(10):822-37.

- Holkup PA. Evidence-based protocol – elderly suicide: secondary prevention. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2002.

- National Institute for Clinical Excellence (NICE). Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. National Institute for Clinical Excellence; 2004. [On-line]. Available: http://www.nice.org.uk/page.aspx?o=213665

- New Zealand Guidelines Group & Ministry of Health. The assessment and management of people at risk of suicide. New Zealand Guidelines Group & Ministry of Health; 2003. [On-line]. Available: http://www.nzgg.org.nz/index.cfm?fuseaction=fuseaction_10&fusesubaction=docs&documentID=22&guideline_displaymode=category

- Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-Harm. Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm. Australian and New Zealand Journal of Psychiatry 2004;38:868–84.

- Royal College of Psychiatrists. Assessment following self-harm in adults. Royal College of Psychiatrists; 2003. [On-line]. Available: http://www.rcpsych.ac.uk/publications/cr/council/cr122.pdf

- International Association for Suicide Prevention (IASP) Executive Committee. IASP guideline for suicide prevention. Crisis 1999;20(4): 155-63.

Literature Search

The librarian consultant from The Centre for Suicide Prevention (http://www.suicideinfo.ca/) conducted a literature search through their Suicide Information & Education Collection (SIEC), which is a special library and resource centre providing information on suicide and suicidal behaviour. The SIEC database contains the largest collection of resources related to suicide, housing 36,000 articles, books, and additional resources. Resources are collected from a variety of sources including the following:

- Dialog; a commercial service that searches over 1200 databases, including Medline, EMBASE, PsychoInfo, CINAHL, and AgeLine using the keywords given by SIEC. For more information regarding Dialog see: http://support.dialog.com/publications/dbcat/dbcat_2005_pp1-43.pdf
- Photocopies from local libraries and interlibrary loans
- The Internet
- Subscription to journals
- Search of bibliographies
- Articles' reference lists
- Table of contents
- Newsletters
- Notification services
- Submissions from individuals and organizations

A search of the entire SIEC database was conducted using the following key words: "elderly", "older adult(s)", "aged", "geriatric", "threatened suicide", "rates of suicide", "intent", "completed suicide", "communications", "attempted suicide", "moral aspects", and "ethics." Of the 221 citations found, 74 articles met the inclusion criteria and were identified as related to the assessment and prevention of suicide. The identified articles were disseminated to group members.

As the development of the guideline document progressed, additional literature (summaries and research articles) was identified through targeted searches and expert knowledge contributions on the part of the Guideline Development Group. The resultant reference base includes over 200 citations.

Formulation of Recommendations

The selected literature was appraised with the intent of developing evidence-based, clinically sound recommendations. Based on relevant expertise and interest, the Guideline Development Group was divided into subgroups and completed the drafting of recommendations for their particular section. The process generated several drafts that were amalgamated into a single document with a set of recommendations confirmed by consensus. Thus, the recommendations are based on research evidence, informed by expert opinion.

The strength of each recommendation was assessed using Shekelle and colleagues' (1999) *Categories of Evidence and Strength of Recommendations*. Prior to the CCSMH Best Practices Conference, the Guideline Development Group Co-leads reviewed the draft documents and approved the recommendations. After the conference, each Guideline Development Group reviewed their recommendations and discussed gaps and controversies. Areas of disagreement were discussed and recommendations were endorsed. A criterion of 80% consensus in support of a recommendation among Guideline Development Group members was required for the inclusion of a recommendation in the final document. In reality, consensus on the final set of recommendations was essentially unanimous.

The evidence and recommendations were interpreted using the two-tier system created by Shekelle and colleagues (1999). The individual studies are categorized from I to IV. The category is given alongside the references and has been formatted as (reference).[Category of Evidence]

Categories of evidence for causal relationships and treatment

Evidence from meta-analysis of randomized controlled trials	**Ia**
Evidence from at least one randomized controlled trial	**Ib**
Evidence from at least one controlled study without randomization	**IIa**
Evidence from at least one other type of quasi-experimental study	**IIb**
Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies	**III**
Evidence from expert committees reports or opinions and/or clinical experience of respected authorities	**IV**

(Shekelle et al., 1999)

The strength of the recommendations, ranging from A to D (see below), is based on the entire body of evidence (i.e., all studies relevant to the issue) ***and the expert opinion of the Guideline Development Group regarding the available evidence.*** For example, a strength level of D has been given to evidence extrapolated from literature on younger population groups or is considered a good practice point by the Guideline Development Group.

Given the difficulties (e.g., pragmatic, ethical and conceptual) in conducting randomized controlled trials with older persons at risk for suicide, it was important for the Guideline Development Group to assess and use the evidence of those trials that incorporated quasi-experimental designs (Tilly & Reed, 2004).

It is important to interpret the rating for the strength of recommendation (A to D) as a synthesis of all the underlying evidence and not as a strict indication of the relevant importance of the recommendation for clinical practice or quality of care. Some recommendations with little empirical support, resulting in a lower rating for strength on this scale, are in fact critical components of the assessment and treatment for suicidal ideation and/or behaviour.

Strength of recommendation

Directly based on category I evidence	**A**
Directly based on category II evidence or extrapolated recommendation from category I evidence	**B**
Directly based on category III evidence or extrapolated recommendation from category I or II evidence	**C**
Directly based on category IV evidence or extrapolated recommendation from category I, II, or III evidence	**D**

(Shekelle et al., 1999)

Glossary of Terms and Abbreviations

Glossary of Terms

Assisted Suicide: "In many statutes referred to as 'abetted' suicide. It is to give advice on methods of suicide or actually to assist someone subsequently to end their life" (Evans & Farberow, 1988, p. 18).

We have chosen to use the term **Death by Suicide** or **Suicide** rather than "committed suicide," "completed suicide," or "successful suicide." Sommer-Rotenberg (1998) notes that the terms "attempt" and "commit" evoke connotations of criminality, and as such are inappropriate and potentially stigmatizing to suicidal individuals and to those touched by suicide. The term "completed suicide" connotes a sense of incompleteness for those who engaged in non-fatal self-harm behaviour, and sends a potentially destructive message to those engaging in such behaviour. The term "successful suicide" is similarly problematic, as it implies that those who survive self-harm behaviour have somehow failed, a position that we neither endorse nor agree with. Additionally, the notion of success and failure ignores the ever-present ambivalence among individuals contemplating and engaging in suicidal behaviour, and suggests that a specific outcome was wholly intended.

Death Ideation: Any self-reported recurrent thoughts of dying or of wishing for one's death. It may include passive wishes for death and does not include the explicit wish to end one's own life or thinking of someone else's death.

Euthanasia: "The word 'euthanasia,' as derived from its original Greek context, means an easy or painless death. In recent years, two types of euthanasia are usually mentioned in professional discussions of termination of life. One is typed as 'active' or direct - i.e., where life is ended by 'direct' intervention, such as administering to a patient a lethal dose of a drug. The other is called 'passive' or indirect - i.e., where death results from withdrawal of life-support or life-sustaining medications" (Evans & Farberow, 1988, p. 113-114).

Postvention: "Term coined by Edwin S. Shneidman, charter director of the Center for the Study of Suicide Prevention at the National Institute of Mental Health (NIMH) in Bethesda, Maryland, to describe the help and intervention of others that is needed by *all* survivors of suicide (attempters, families of suicides, friends, associates, etc.). It means, simply, extending to suicide survivors the caring support they need immediately after a suicide and, in time, assisting them in their coming to terms with the tragedy that has struck them" (Evans & Farberow, 1988, p. 225).

Psychological Autopsy: Method to collect data on completed suicide cases. Initially conceived as a device by which to investigate equivocal cases of suicide on behalf of the Los Angeles County coroner's office. An 'autopsy' that consists of interviewing significant friends and relatives of the deceased to learn about suicidal communications, current and previous stresses, psychiatric and medical history, and general 'life style' of the victim (Evans & Farberow, 1988, p. 26).

Rational Suicide: "Term coined by Manhattan artist and former social worker Jo Roman, who advocated choosing the time of one's own death" (Evans & Farberow, 1988, p.234).

Risk Factors: "Those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment" (USA National strategy for suicide prevention: Glossary, 2001, p. 202). Equivalent term: **Vulnerability Factors**

Self-Harm: "The various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness" (USA National strategy for suicide prevention: Glossary, 2001, p. 202). Equivalent term: **Self-Harm Behaviour, Self-Injurious Behaviour, Self-Injury**

We use the term **Self-Harm** or **Self-Harm Behaviour** rather than "suicidal act," "parasuicide," "suicidal gesture," "direct or indirect self-destructive behaviour," "instrumental suicide-related behaviour," "suicide threat," and other such terms. We have chosen not to include the word "deliberate" (as in "Deliberate Self-Harm") given the debate over whether such behaviour is always deliberate, and to disentangle the term from **suicide intent**, which is separately defined.

Suicidal Behaviour: Potentially self-injurious behavior with a nonfatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some (nonzero) level to kill himself/herself. Suicidal behaviour may or may not result in injuries (O'Carroll et al., 1996's definition for "Suicide Attempt", p. 247). Equivalent terms: **Non-fatal Suicidal Behaviour, Suicidal Actions**

We have chosen to use the term **Suicidal Behaviour** rather than "attempted suicide" or "suicide attempt," in light of connotations of criminality evoked by the term "attempt" and because such language suggests that death was the only intended outcome, a problem shared by the equally problematic terms "failed suicide" or "unsuccessful suicide attempt."

Suicidality: "Risk of future suicide" (Pokorny, 1974, p. 38). "A spectrum of activities related to thoughts and behaviours that include suicidal thinking, suicide attempts, and completed suicide" (USA National strategy for suicide prevention: Glossary, 2001 under *Suicidal Behavior*, p. 203).

Suicide/Suicidal Ideation: "Any self-reported thoughts of engaging in suicide-related behaviour" (O'Carroll et al., 1996, p. 247).

Suicide/Suicidal Intent: Seriousness or degree of sincerity of the individual his *(or her)* actual or contemplated action in terms of ending his *(or her)* life. This requires inference and judgment even when the individual is available for interview (Pokorny, 1974, p. 38-39).

Suicide Survivors: "Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide" (USA National strategy for suicide prevention: Glossary, 2001, p. 203). This term has more recently been applied to individuals who have experienced the non-fatal suicidal behaviour of a family member, friend, significant other, colleague, of an acquaintance, or have themselves engaged in such behaviour. Equivalent terms: **Bereaved by Suicide, Survivor(s) of Suicide**

Abbreviations

There are a number of abbreviations utilized within this guideline. In alphabetical order, these are as follows:

ECT: Electroconvulsive Therapy

GDS: Geriatric Depression Scale

GHS: Geriatric Hopelessness Scale

GSIS: Geriatric Suicide Ideation Scale

HBS: Harmful Behaviors Scale

IPT: Interpersonal Psychotherapy

PROSPECT: Prevention of Suicide in Primary Care Elderly Collaborative Trial

RFL–OA: Reasons for Living Scale – Older Adult version

SSI: Scale for Suicide Ideation

Summary of Recommendations

All recommendations are presented together at the beginning of this document for easy reference. Subsequently, in each section we present a discussion of the literature relevant to the recommendations for that section, followed by the recommendations. We strongly encourage readers to refer to the supplemental text discussion, rather than only using the summary of recommendations. The page numbers for the corresponding text are given with the recommendations below.

Recommendations: Risk Factor: Suicidal Behaviour and Ideation (p. 15)

Health care providers should attend to the presence of suicide risk factors among older adults and should be vigilant of risk even in the absence of reported suicidality. **[D]**

In those with risk factors, assess for death ideation and suicide ideation. In those in whom these are present, assess for suicidal intent, presence of a suicide plan, and current or past suicidal behaviour, as these can increase risk for suicide. **[C]**

Repeatedly assess for suicide ideation throughout treatment for depression, as it may occur at any point, persistently or intermittently, and the person may not reveal these thoughts at the beginning of treatment to an unfamiliar individual. **[D]**

Hospitalization should be considered for older adults who express severe suicidal ideation and/or a suicide plan. **[D]**

Recommendations: Risk Factor: Mental Illness and Addictions (p. 16)

Assess for mood disorders, either alone or comorbid with other mental disorders, as these can increase risk for suicide. Recognize that depressed older adults may present for care with different sets of symptoms than younger adults. **[C]**

Attend to the possibility of mental disorders, including psychotic disorders, as it increases the risk for suicide. Be especially attentive of comorbid mental disorders. **[C]**

In every patient, assess for substance use or misuse, as substance abuse increases risk for suicide. **[C]**

Recommendation: Risk Factor: Personality Factors (p. 16)

Be aware that personality disorders, rigid personality styles, and non-adaptive coping strategies can contribute to increased risk for suicide among older adults with additional suicide risk factors. **[C]**

Recommendations: Risk Factor: Medical Illness (p. 16)

Assess for the presence of physical illness, as this can increase risk for suicide. **[C]**

Assess for the presence of perceived physical illness, as this can increase risk for suicide. **[C]**

Carefully assess for suicidal intent among those endorsing a wish to hasten death. **[D]**

Recommendation: Risk Factor: Negative Life Events, Transitions, and Social Support Variables (p. 17)

Assess for additional suicide risk factors among older adults who have experienced recent social, physical, and financial losses or negative events, and other transitional events, including housing changes. **[C]**

Recommendation: Risk Factor: Functional Impairment (p. 17)

Assess for functional decline as this may increase the risk for suicide. **[C]**

Recommendations: Resiliency or Protective Factors (p. 17)

Facilitate strategies for/with clients to develop or regain a sense of meaning and purpose in life. **[D]**

Facilitate strategies for/with clients to enhance social support and interpersonal activities. **[D]**

Facilitate strategies for/with clients to encourage better health practices. **[D]**

Recommendation: Identification of Suicidal Older Adults (p. 18)

Health care providers should remain vigilant to the presence of suicide risk factors in older patients presenting for care, especially for those who do not express mental health complaints. **[D]**

Recommendation: Assessment Tools (p. 18)

Health care providers with appropriate psychometric training may consider the use of standardized assessment instruments to assess for the presence and severity of psychological factors potentially associated with increased suicide risk. **[D]**

Recommendations: Assessment of Suicide Risk: Process (p. 19)

Healthcare providers should assess for suicide risk in a sensitive and respectful fashion, in the context of good rapport, and communicate an empathic acceptance of the patient in order to validate an older client's feelings and encourage the honest reporting of suicidal symptoms. **[D]**

Acknowledge clients' experiences in order to encourage the accurate expression of their thoughts and feelings during an assessment. **[D]**

Consult collateral sources of client information, such as other providers, family members and/or significant others, for a more complete appraisal of suicide risk. **[D]**

Seek the assistance of a supervisor and/or registered mental health professional if you encounter an older adult who might be at elevated suicide risk, especially if you do not have specialized training in mental health or in suicide prevention. **[D]**

Recommendation: Treatment and Management (p. 20)

Health care providers working with suicidal older adults should ensure that their clients are appropriately assessed and treated for depression. (Please refer to the *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression* by the CCSMH, 2006) **[B]**

Recommendations: Treatment and Management: Psychotherapy – Adaptive and Maladaptive Hope (p. 21)

Foster hope in clients who are suicidal. Health care providers may promote hope by initiating hope-focused conversations. **[D]**

Health care providers should explore strategies to assist older persons find and maintain meaning and purpose in their lives. **[C]**

Recommendation: Treatment and Risk Management - The Therapeutic Relationship (p. 21)

Develop a trusting and genuine therapeutic relationship with at-risk older adults. Actively and attentively listen to the client, and take your time. When present, these elements help contribute to a person feeling heard and respected, and can help contribute to the older client feeling connected. **[D]**

Recommendations: Risk Management Strategies: Support for Health Care Professionals (p. 21)

Don't feel you have to work alone. Suicide prevention requires a team approach. Providers are ideally encouraged to connect with a registered mental health professional. If mental healthcare professionals are unavailable, providers should connect with another member of a health care team within the community. **[D]**

Providers working with suicidal individuals require networks of support to ensure their own emotional well-being and to avoid burnout. **[D]**

When working with suicidal clients, it is essential to keep detailed notes on risk assessment, interventions, and client reactions, responses, and/or outcomes. **[D]**

When one is concerned that a suicidal client cannot or will not follow one's recommendation to seek care in a hospital emergency room, one should involve emergency services (e.g., 911). **[D]**

Where possible, restrict access to lethal means. **[D]**

Recommendation: Collaborative Care (p. 22)

For those designing and administrating systems of care, it is recommended that interdisciplinary and collaborative care models be established and supported. **[B]**

Recommendations: Mental Health Outreach (p. 23)

Community outreach and support efforts are needed to identify and treat older adults with mental illness and social problems that put them at elevated risk for suicide. **[D]**

Policy makers need to support and finance community programs, resources and models that will contribute to the well-being of older adults. These should include programs for early recognition and prevention of suicide among those at risk in the community. **[D]**

Mental health services need to be flexible enough to serve changing populations and to include services specific to ethnic groups. **[D]**

Recommendations: Education (p. 23)

Culturally sensitive education and training regarding the assessment and prevention of suicide should be provided to health care professionals in a variety of settings. **[D]**

Health care professionals should provide older adults and their families/caregivers with education regarding suicide, stigma, treatment options, and management strategies. **[D]**

Provincial and national public awareness and education efforts that focus on suicide prevention, stigma and mental health promotion in older adults are recommended. **[D]**

Part 1: Background of Issue

The purpose of this Guideline is to provide clinical practice recommendations for clinicians who encounter people 65 years of age and older who are at high risk for suicide, because they are thinking about it or planning it, or have recently tried to harm or kill themselves.

In the current guidelines, we draw largely upon the definitions of O'Carroll and colleagues (1996) for suicidal thoughts, actions, and mortality, modifying these terms to fit with language that is generally accepted by clinicians, researchers, patients and clients, and survivors of suicide (see *Glossary of Terms and Abbreviations*).

1.1 Prevalence

In 2002, 430 Canadians 65 years of age or older (361 men and 69 women) died as a result of "intentional self-harm" (Statistics Canada, 2002). Older men are at especially high risk for suicide. The 1997 suicide rate for older Canadian men (23.0/100,000) was nearly twice that of the nation as a whole (12.3/100,000) (Statistics Canada, 2005). It is widely believed that published suicide rates underestimate the total number of deaths by suicide, due, in part, to the stigma of suicide and other social pressures that may lead family members and health professionals to avoid labelling deaths as suicides. In equivocal cases, coroners might be less likely to consider the death of an older adult as suicide (Ohberg & Lonnqvist, 1998). Approximately one thousand older adults are admitted to Canadian hospitals each year as a consequence of intentional self-harm, but it is not known how often older people in Canada harm themselves without being admitted to hospital.

The lethal potential of self-harm behaviour increases with advancing age (Krug et al., 2002; United States Department of Health and Human Services, 2001). Hanging and firearm use were the most common means of suicide among older men in Canada in 2002 (see Appendix B) (Statistics Canada, 2002). In older women, self-poisoning and hanging were the two most common methods. The lethal potential of suicidal behaviour in later life is demonstrated by the ratio of suicidal behaviour to deaths by suicide. In the general population instances of non-lethal self-harm are approximately 20 times more common than suicide itself. In older adults, this ratio is less than four to one (Conwell et al., 1998; McIntosh et al., 1994). As the older population greatly increases over the coming decades in Canada (Statistics Canada, 1999), there will likely be a greater number of older lives lost to suicide.

Part 2: Suicide Risk and Resiliency Factors

2.1 Overview

The identification of risk factors requires prospective cohort studies or rigorous case-control studies. For relatively rare and often long-delayed outcomes, such as suicide, cohort studies are unduly expensive, because they involve very large samples and prolonged periods of follow-up. It may not be surprising therefore, that there have been to date only two major cohort studies investigating the link between hypothesized risk factors and suicide (Ross, 1990; Turvey, 2002).[III] They relied on the "nested" case-control method, employing a subset of the full sample. Case-control studies of suicide risk factors are of two distinct types: population-based data linkage studies; and controlled psychological autopsies. The data-linkage studies rely on the existence of large administrative datasets of information concerning aspects of health or of health service utilization of the entire population. Information regarding people who have died may have been collected during their lives, and can be retrospectively sought in these databases and correlated with the cause of their death. In order to try to understand the circumstances leading to the suicide, psychological autopsies involve interviews of those who knew the people who died by suicide, and the examination of relevant medical, psychiatric and legal records. When these studies are "controlled" (i.e., when they include a comparison with the circumstances of the people still alive, or of those who died from other causes), correlates of death by suicide can be uncovered. While extremely useful in ascertaining suicide risk and resiliency factors, both methodologies have limitations. A summary of risk factors is given in *Table 2.1*.

2.2 Risk Factors

2.2.1 Risk Factor: Suicidal Behaviour and Ideation

Prior suicidal behaviour puts one at greater risk for suicide, whether in the short or the long term (Beautrais, 2002; Chiu et al., 2004; Hawton et al., 2003; Rubenowitz et al., 2001; Waern et al., 1999).[III] Controlled psychological autopsies in Hong Kong (Chiu et al., 2004)[III] and New Zealand (Beautrais, 2002)[III] both showed that those who died by suicide were more than thirty times more likely to have had a history of self-harm behaviour than controls.

Healthcare providers need to be aware of the fact that older adults may avoid volunteering depressive and suicidal symptoms (Duberstein et al., 1999; Gallo et al., 1999; Isometsä et al., 1995; Lyness et al., 1995; Thompson et al., 1988; Waern et al., 1999).[III] Waern and colleagues (1991) reported that three quarters of older adults studied who had died by suicide had told relatives or friends of their wish to die or their thoughts regarding suicide in the year preceding their suicide. However, only 38% had discussed these thoughts with a healthcare professional.

As such, healthcare providers need to remain vigilant to suicide risk among older adults denying current suicidal symptoms despite the presence of other suicide risk factors. Vigilance is additionally needed, and hospitalization should be considered, for older adults at elevated risk for suicide by virtue of the presence of suicide risk factors, such as endorsement of a current wish to die or for suicide, suicidal intent, a suicide plan, and/or with a history of self-harm behaviour.

Recommendations: Risk Factor: Suicidal Behaviour and Ideation

Health care providers should attend to the presence of suicide risk factors among older adults and should be vigilant of risk even in the absence of reported suicidality. **[D]**

In those with risk factors, assess for death ideation and suicide ideation. In those in whom these are present, assess for suicidal intent, presence of a suicide plan, and current or past suicidal behaviour, as these can increase risk for suicide. **[C]**

Repeatedly assess for suicide ideation throughout treatment for depression, as it may occur at any point, persistently or intermittently, and the person may not reveal these thoughts at the beginning of treatment to an unfamiliar individual. **[D]**

Hospitalization should be considered for older adults who express severe suicidal ideation and/or a suicide plan. **[D]**

2.2.2 Risk Factor: Mental Illness and Addictions

In several controlled psychological autopsies of older adults who died by suicide, a history of mental illness has been found (Barnow & Linden 2000; Chiu et al., 2004; Conwell et al., 2000; Shah & Ganesvaran, 1997; Waern et al., 2003, 2002a, 2002b).[III]

Mood disorders are especially prominent among older adults who die by suicide. Elevated suicide risk is clearly associated with major depressive disorder (Conwell et al., 2000; Waern et al., 2002b), and with less severe forms of mood disorders, such as dysthymic disorder (Chiu et al., 2004; Waern et al., 2002b)[III], minor depressive disorder (Waern et al., 2002b)[III], and adjustment disorder (Chiu et al., 2004).[III] Clinicians are thus advised to assess carefully for the presence of major depressive disorder and less severe forms of mood disorders among older adults. They also need to be aware of age-specific presentations of depression, since depressed older adults may be less likely to present with dysphoria, and are more likely to present with somatic symptoms (Gallo et al., 1999; Lyness et al., 1995).[III] It is crucial to repeatedly assess for suicidal thoughts among

depressed older adults as suicidal thoughts might wax and wane over the course of a depressive episode (Szanto et al., 2001).[IIb] For further information, please refer to the *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression (CCSMH, 2006)*.

In addition to mood disorders, elevated suicide risk is associated with substance-use (Waern, 2003) and psychotic disorders (Waern et al., 2002b). Furthermore, the presence of multiple comorbid mental disorders further increases risk (Waern et al., 2002b).[III]

It is important to note that most people with mental illness do not die by suicide, and perhaps over 10% of older adults who die by suicide do not have a diagnosable mental illness (Barraclough, 1971; Conwell et al., 1991, 1990; Préville et al., 2005).[III] Therefore, when present, mental illness likely acts in concert with other risk factors for suicide.

Recommendations: Risk Factor: Mental Illness and Addictions

Assess for mood disorders, either alone or comorbid with other mental disorders, as these can increase risk for suicide. Recognize that depressed older adults may present for care with different sets of symptoms than younger adults. **[C]**

Attend to the possibility of mental disorders, including psychotic disorders, as it increases the risk for suicide. Be especially attentive of comorbid mental disorders. **[C]**

In every patient, assess for substance use or misuse, as substance abuse increases risk for suicide. **[C]**

2.2.3 Risk Factor: Personality Factors

Personality traits and disorders have been associated with elevated suicide risk among older adults. For example, one of the 10 commonalities of suicide observed by Shneidman (1991)[IV] is that "the common consistency in suicide is with life-long coping patterns" (p. 158). Although personality disorders might be less prevalent among older versus younger adults who die by suicide (Henriksson et al., 1995)[III], personality disorders or rigid personality styles might increase risk especially when combined with losses or stressors (Clark, 1993,1991; Duberstein, 1995; Duberstein et al., 2000, 1994; Filiberti et al., 2001; Harwood et al., 2001).[III]

Recommendation: Risk Factor: Personality Factors

Be aware that personality disorders, rigid personality styles, and non-adaptive coping strategies can contribute to increased risk for suicide among older adults with additional suicide risk factors. **[C]**

2.2.4 Risk Factor: Medical Illness

Various physical disorders are more common among older adults who die by suicide than among controls. These include visual impairment, seizure disorder, neurological disorders, cancer, chronic pulmonary disease, arthritis, bone fractures, and moderate or severe pain (Juurlink et al., 2004; Quan et al., 2002; Tsoh et al., 2005; Waern et al., 2002a).[III] Dementia may be a risk factor, but this has not been clearly demonstrated (Draper et al., 1998; Harwood et al., 2001; Rubio et al., 2001).[III] Although physical illnesses may increase suicide risk, perception of physical illness may also increase the risk for suicide (Duberstein et al., 2004a; Turvey et al., 2002).[III]

The majority of older adults who die by suicide do not have severe or terminal physical illness (Barraclough, 1971; Clark, 1991; Filiberti et al., 2001).[III] Furthermore, most severely physically ill older adults do not take their own lives or wish to do so. For example, in speaking with older adults who had expressed suicide ideation, Moore (1997)[III] found that these individuals did not so much desire death by suicide as the freedom from the overwhelming psychological pain ("psychache") that they were experiencing. While physician-assisted suicide and euthanasia are beyond the scope of this Guideline, the wish for death among physically ill older people may be a sign of depression or of intense despair, necessitating further assessment and possible treatment (Blank et al., 2001; King et al., 2005).

Recommendations: Risk Factor: Medical Illness

Assess for the presence of physical illness, as this can increase risk for suicide. **[C]**

Assess for the presence of perceived physical illness, as this can increase risk for suicide. **[C]**

Carefully assess for suicidal intent among those endorsing a wish to hasten death. **[D]**

2.2.5 Risk Factor: Negative Life Events, Transitions, and Social Support Variables

There is a correlation between various psychosocial factors and suicide among older adults. Risk may be higher for the following: the unmarried; those living far from friends or relatives; those who see friends or relatives infrequently; and those who are lonely or engaged in family discord (Beautrais, 2002; Duberstein et al., 2004a,b; Heisel & Duberstein, 2005; Miller, 1978; Rubenowitz et al., 2001; Turvey et al., 2002).[III] Financial or legal difficulties, employment change (Carney et al., 1994; Duberstein et al., 2004a; Heikkinen & Lönnqvist, 1995; Rubenowitz et al., 2001)[III], and housing changes may increase the risk for suicide (Tsoh et al., 2005).[III]

Recommendation: Risk Factor: Negative Life Events, Transitions, and Social Support Variables

Assess for additional suicide risk factors among older adults who have experienced recent social, physical, and financial losses or negative events, and other transitional events, including housing changes. **[C]**

2.2.6 Risk Factor: Functional Impairment

Impairment of the ability to carry out the activities of everyday life may increase the risk for suicide among older adults (Conwell et al., 2000; Filiberti et al., 2001; Préville et al., 2005; Rubenowitz et al., 2001; Tsoh et al., 2005).[III]

Recommendation: Risk Factor: Functional Impairment

Assess for functional decline as this may increase the risk for suicide. **[C]**

2.3 Resiliency or Protective Factors

Factors which may reduce the risk for suicide among older adults include the following:

- Better health care practices (Chiu et al., 2004; Juurlink et al., 2005)[III];
- Contact with family and friends (Rubenowitz et al., 2001; Tsoh et al., 2005; Turvey et al., 2002; Waern et al., 2003)[III];
- Moderate alcohol consumption (Ross et al., 1990)[III];
- Active interests (Rubenowitz et al., 2001; Waern et al., 2003)[III];
- Religious practice and recognition of meaning and purpose in life (Heisel & Flett, 2004, in press b; Moore,1997; Tsoh et al., 2005; Turvey et al., 2002)[III]; and
- Combinations of personality attributes, such as extraversion, openness to experience, and conscientiousness (Tsoh et al., 2005).[III]

Furthermore, research on suicide ideation among psychiatric patients and older adults suggests that perceived meaning in life, life satisfaction, adaptive coping, future orientation, and spirituality might increase psychological well-being and decrease suicide risk (Burbank, 1992; Heisel & Flett, 2004; Hirsch et al., in press; Moore, 1997).[III]

Recommendations: Resiliency or Protective Factors

Facilitate strategies for/with clients to develop or regain a sense of meaning and purpose in life. **[D]**

Facilitate strategies for/with clients to enhance social support and interpersonal activities. **[D]**

Facilitate strategies for/with clients to encourage better health practices. **[D]**

Table 2.1 - Risk Factors for Suicide among Older Adults (Heisel & Links, 2005)

Suicidal Factors
- Suicidal or self-harm behaviour, including equivocal behaviour such as accidental medication overdose and self-neglect
- Expression of active or passive suicidal ideation or a wish to die

Mental illness
- Any mental disorder
- Major depressive disorder
- Any mood disorder
- Psychotic disorders
- Substance misuse disorders

Medical illness
- Visual impairment, malignancy, and neurological disorder
- Chronic lung disease, seizure disorder, and moderate or severe pain
- Cancer and chronic pulmonary disease in married adults 55 and older

Negative life events and transitions
- Perceived physical illness, family discord and separation, recent financial difficulties, and change in employment
- The prospect of living with dementia

Personality factors
- Personality disorders
- High neuroticism: emotional instability or psychological difficulties
- Low extraversion: social isolation and/or loneliness
- Low openness to experience: rigidity and restriction in activities
- Narcissism: poor coping in the face of physical, emotional, and social changes

Interpersonal factors
- Lacking a confidant or being lonely
- Being unmarried, living alone, having little social interaction, and lack of religious involvement

Note: Risk factors were derived from case-controlled studies of informant interview data regarding older adults who died by suicide or controls. *This table is not intended to be used as a checklist, but rather to help guide suicide risk assessment.*

Part 3: Detection, Assessment and Diagnosis

3.1 Identification of Suicidal Older Adults

Suicide among older adults is frequently preceded by visits to a health care professional (Juurlink et al., 2004; Luoma et al., 2002; Préville et al., 2005).[III] If the risks for suicide were recognized during such encounters, it would represent an important opportunity for suicide prevention. It seems logical that assessment of risk and resiliency factors would help one to identify suicidal older people (Heisel & Duberstein, 2005)[IV], but algorithmic approaches to the assessment of suicide risk, using combinations of known risk factors, have not yet been shown to be successful (Clark et al., 1987; Hatton et al., 1977; Joiner et al., 1999; Modai et al., 2002; Pokorny, 1996).[III]

Recommendation: Identification of Suicidal Older Adults

Health care providers should remain vigilant to the presence of suicide risk factors in older patients presenting for care, especially for those who do not express mental health complaints. **[D]**

3.2 Assessment Tools

Standardized measures may help clinicians understand the psychological factors that potentially contribute to suicide risk, including depression and hopelessness, death ideation, suicide ideation, history of self-harm, presence of a suicide plan and degree of intent to die, and low levels of life satisfaction and reasons for living (Heisel & Flett, 2005; Joiner et al., 1999; Nemeroff et al., 2001; Raue et al., 2002; Shea, 1999).[IV] A paucity of clinical measures for assessment of late-life depression and suicide risk is currently available (Charney et al., 2003)[IV], and scales designed for younger groups may have limited utility. The National Institute of Mental Health published a commissioned review of suicide assessment measures for adults and older adults (Brown, 2002).[IV] However, the majority of these were neither developed nor validated with at-risk older adults. Among these tools is the ***Scale for Suicide Ideation*** (***SSI***) (Beck et al., 1979)[III], a measure that has acceptable psychometric properties with older adults (Heisel et al., 2002)[III], but was developed among younger psychiatric patients.

Measures of late-life depression (e.g., the ***Geriatric Depression Scale*** or ***GDS***) (Yesavage et al., 1983)[III] and hopelessness (e.g., the ***Geriatric Hopelessness Scale*** or ***GHS***) (Fry, 1984)[III] do not specifically assess suicide ideation. However, sets of items from these measures have been shown to differentiate older adults with high versus low suicide ideation (Heisel & Flett, 2005; Heisel et al., 2005).[III]

The three novel measures listed below have been designed to assess suicidal features among older adults (Heisel & Duberstein, 2005).[IV]

- The ***Harmful Behaviors Scale*** (***HBS***) is an internally consistent 20-item observational measure with good inter-rater reliability that assesses self-harm in nursing home residents (Draper et al., 2002).[III]
- The ***Reasons for Living Scale-Older Adult version*** (***RFL-OA***) is an unpublished 69-item self-report measure of reasons for not taking one's life despite having thoughts of suicide (Edelstein et al., 2000).[III]
- The ***Geriatric Suicide Ideation Scale*** (***GSIS***) is a 31-item self-report measure of suicide risk (Suicide Ideation, Death Ideation, and Loss of Personal and Social Worth) and resiliency (Perceived Meaning in Life) developed among Canadians 65 years of age or older (Heisel & Flett, in press a).[III]

Further research assessing the psychometric properties of these novel measures and their utility in clinical practice with older adults is required. Standardized interviews and written questionnaires should only be applied in the context of an established therapeutic rapport. The use of assessment measures in the absence of a therapeutic relationship and appropriate training in the administration and interpretation of psychological measures can be counter-productive, even appearing cold or uncaring, and can lead to underestimates of suicide risk (Heisel & Duberstein, 2005).[IV]

Recommendation: Assessment Tools

Health care providers with appropriate psychometric training may consider the use of standardized assessment instruments to assess for the presence and severity of psychological factors potentially associated with increased suicide risk. **[D]**

3.3 Assessment of Suicide Risk: Process

Assessment of suicide risk requires sensitive and careful evaluation, clinical judgment, and experience (Shea, 1999).[IV] It is often confounded by the apparent tendency of older people not to volunteer depressive and suicidal symptoms (Duberstein et al., 1999; Gallo et al., 1999; Isometsä et al., 1995; Lyness et al., 1995; Thompson et al., 1988; Waern et al., 1999).[III] One way in which health care professionals can increase their ability to identify older adults at risk for suicide is by establishing rapport and carefully,

actively, and empathically listening to their older clients, and to ensure that they are accurately hearing what is being said and validating their concerns (Bub, 2004; Shea, 1998).[IV] Although statements normalizing thoughts of suicide (e.g., "I can understand that you are thinking of suicide given what you are feeling") might be empathic and validating, *it is not advisable to normalize suicidal behaviour*. Avoid sounding superficially positive, and avoid judgmental anti-suicide preaching to a suicidal client, as these can interfere with establishing rapport and might encourage deception.

Recommendations: Assessment of Suicide Risk: Process

Healthcare providers should assess for suicide risk in a sensitive and respectful fashion, in the context of good rapport, and communicate an empathic acceptance of the patient in order to validate an older client's feelings and encourage the honest reporting of suicidal symptoms. **[D]**

Acknowledge clients' experiences in order to encourage the accurate expression of their thoughts and feelings during an assessment. **[D]**

The major risk factors for suicide among older adults (see *Part 2: Suicide Risk and Resiliency Factors*) should be detectable if looked for, and health professionals are strongly advised to look for them in their clients. Milton and colleagues (1999) found that family physicians of patients who had visited them in the weeks prior to killing themselves had often been unaware of their patients' suicidal state, not just because the patients had not volunteered it, but because the doctors had not asked, and had not made themselves aware of the patients' social circumstances. Another study by Uncapher and Areán (2000) demonstrated that family doctors are less likely to see the value of identifying or treating suicidal thinking among older patients than they are among younger patients. This belief is erroneous.

The assessment of suicide risk presents every health professional with an opportunity to discover what makes each client's life worth living and the reasons why some older adults may feel that life has lost its value. Some of these reasons may be unrealistic, such as distorted perceptions of prognosis or self worth that result from miscommunication, depression, or cognitive impairment. Some of the reasons may be realistic (e.g., pain, loss, immobility, or barriers to mobility), and susceptible to environmental modification, practical or emotional support, problem solving or other forms of psychotherapy. Recent reviews from the American Psychiatric Association and the US Preventive Services Task Force are worth consulting for detailed discussions of suicide assessment in general. However, the assessment of suicidal risk specifically in older adults requires basic attention to the circumstances, expectations, quality of life, and illness history of every older adult. *Appendix C* details the kind of questions that health professionals might consider when assessing suicide risk (Grek, submitted for publication).

Health care professionals might be reluctant to ask questions about thoughts of suicide, for fear of offending the older adult, inadvertently planting the thought of suicide in the mind of someone who had not previously considered it, and lack of knowledge regarding how to best respond. Questions regarding suicide are not always easy to ask, but they are not offensive if asked in the context of an enquiry about the person's circumstances, and his or her current experience, fears and worries. Health care professionals need not be fearful about the possibility of addressing suicide with their older clients, as decades of research and clinical practice suggest that inquiries into suicidal thoughts will not make someone consider suicide who had not already done so. Asking about suicide is essential in order to gauge the severity of the risk for suicide, and also the degree of distress and desperation. Furthermore, inquiries about suicidal thoughts could be experienced as validating by individuals contemplating suicide. Providers should consult with collateral sources of information, such as other providers and/or clients' family members and significant others, for a more complete appraisal of suicide risk (Forsell & Winblad, 1997; Heisel & Duberstein, 2005; McAvay et al., 2005).[IV]

Ongoing clinical work with suicidal older adults requires careful training and supervision. However, all providers encountering suicidal people can be respectful and helpful while assisting them in connecting with trained professionals. It is very important for those providers without specialized training in mental health or in suicide prevention who identify a client as being at potentially elevated suicide risk to consult with a supervisor and/or a registered mental health professional.

Recommendations: Assessment of Suicide Risk: Process

Consult collateral sources of client information, such as other providers, family members and/or significant others, for a more complete appraisal of suicide risk. **[D]**

Seek the assistance of a supervisor and/or registered mental health professional if you encounter an older adult who might be at elevated suicide risk, especially if you do not have specialized training in mental health or in suicide prevention. **[D]**

Part 4: Treatment and Risk Management

4.1 Treatment and Management: Overview

There are studies of the effectiveness of psychiatric treatment across the diagnostic spectrum, but reduction in the rate of suicide is difficult to study as an outcome because of its relative rarity, even in people with major mental illnesses. The same is true of self-harm. Although, suicide ideation is more common, few studies have explored whether treatment is effective in reducing or resolving suicidal thinking in older adults (Links et al., 2005).[IV]

4.1.1 Treatment and Management: Pharmacological Intervention

Several randomized controlled trials have demonstrated the effectiveness of antidepressant treatment in late-life depression (for further information see the *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression*, CCSMH, 2006). However, only one study to date, the Prevention of Suicide in Primary Care Elderly Collaborative Trial (PROSPECT), has specifically targeted suicide ideation as a primary outcome (Bruce et al., 2004b).[Ib] This study was of citalopram and/or Interpersonal Psychotherapy (IPT), in the context of collaborative care management of depression in primary care, and supports the concerted treatment of major depression in older people. In response to such active treatment, suicide ideation and other symptoms of major depression remitted more rapidly than in response to "treatment as usual." Suicide ideation and other depressive symptoms resolved more slowly and less completely among individuals with more severe suicide ideation and/or a history of self-harm behaviour. Furthermore, these individuals were more prone to relapse. Continued vigilance is thus needed throughout the period of recovery from depression. There is a need for further randomized controlled trials designed to address the effects of drug treatment on suicidal ideation and behaviour. For now, the results of the PROSPECT study support the use of a serotonin-specific reuptake inhibitor (e.g., citalopram) and psychotherapy (e.g., IPT) in the context of collaborative care for the treatment of major depressive symptoms (including, but not limited to, suicide ideation) in older people.

4.1.2 Treatment and Management: Psychotherapy

Certain forms of psychotherapy are effective in the treatment of late-life depression (see *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression*, CCSMH, 2006). However, we have been unable to find any randomized controlled trials of psychotherapy for the prevention of suicidal behaviour or death by suicide in older adults (Heisel, 2006).[IV] Cognitive Therapy (Brown et al., 2005)[Ib], Dialectical Behavior Therapy (Linehan et al., 1991; Verheul et al.,2003)[Ib], and Problem-Solving Therapy (McLeavey et al., 1994; Salkovskis et al., 1990)[Ib] appear to reduce the rate of recurrent suicidal behaviour in younger adults, but there are no trials exclusively among older populations demonstrating a significant decrease in suicidal behaviour. Additionally, not all older adults are good candidates for psychotherapy. More research exploring the process and outcomes of specific psychotherapies targeting suicidal outcomes among at-risk older adults is required.

Trials of combined antidepressants and/or IPT have shown a reduction in suicidal ideation (Bruce et al., 2004b; Szanto et al., 2003, 2001).[Ib, IIb, III] However, it is not possible, given the data presented in these papers, to discern the respective unique effects of medication and of psychotherapy.

4.1.3 Treatment and Management: Electroconvulsive Therapy

Electroconvulsive therapy (ECT) may be of value in the treatment of depression in older adults (see the *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression*, CCSMH, 2006) and some have emphasized the value of ECT in the treatment of depressed and suicidal patients (Kellner et al., 2005; Prudic & Sackheim, 1999; Sharma, 2001). There have been no studies of ECT for the amelioration of suicidal thinking or behaviour in older patients and more research is needed (Van der Wurff et al., 2003).[Ia] For more information regarding ECT and depression in older adults, refer to the *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression* (CCSMH, 2006).

Recommendation: Treatment and Management

Health care providers working with suicidal older adults should ensure that their clients are appropriately assessed and treated for depression. (Please refer to the *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression*, CCSMH, 2006) **[B]**

4.1.4 Treatment and Management: Psychotherapy – Adaptive and Maladaptive Hope

Bergin and Walsh (2005)[IV] critically reviewed the literature on adaptive and maladaptive hope, and persuasively argued for enhancing and maintaining hope in psychotherapy with older adults. Research has linked hopelessness with suicidal ideation and behaviour among older adults (Conaghan & Davidson, 2002; Heisel & Flett, 2005; Heisel et al., 2002; Szanto et al., 2001, 1998; Uncapher, 2000-2001).[III] As such, psychotherapeutic interventions targeting hopelessness

among older adults could reduce psychological distress and suicide risk. Clients frequently report feeling more hopeful when they are invited to speak about hope and the kinds of things/people that make them hopeful. This may serve to alleviate some despair (Edey & Jevne, 2003). Lack of perception of meaning and purpose in life are associated with more severe suicide ideation (Heisel & Flett, in press b; Moore, 1997; Moore et al., 2000; Nekolaichuk et al., 1999; Rudolph & Burt, 2003).[III, IV] Therefore, interventions aimed at increasing recognition of meaning and purpose may help reduce suicide risk.

Recommendations: Treatment and Management: Psychotherapy – Adaptive and Maladaptive Hope

Foster hope in clients who are suicidal. Health care providers may promote hope by initiating hope-focused conversations. **[D]**

Health care providers should explore strategies to assist older persons find and maintain meaning and purpose in their lives. **[C]**

4.2 Treatment and Risk Management: The Therapeutic Relationship

The client/therapist relationship can be enhanced by actively attending to client expressions of thoughts and feelings, by being genuine, and by taking one's time and not rushing the therapeutic process. Establishing and maintaining a treatment alliance might be more difficult with suicidal older adults who have difficulty relating to others, establishing trusting relationships, and are ambivalent or lacking in motivation towards treatment (Szanto et al., 2003). More research exploring the process and outcomes of specific psychotherapies targeting suicidal outcomes among at-risk older adults is required.

Recommendation: Treatment and Risk Management - The Therapeutic Relationship

Develop a trusting and genuine therapeutic relationship with at-risk older adults. Actively and attentively listen to the client, and take your time. When present, these elements help contribute to a person feeling heard and respected, and can help contribute to the older client feeling connected. **[D]**

4.3 Risk Management Strategies: Support for Health Care Professionals

Working with suicidal individuals can be anxiety provoking. Thoughtful risk management strategies, attending to patient safety and to the well being of both clients and providers, may help reduce clients' suicide risk and provider burnout. Providers working with suicidal clients should never work in isolation. Suicide prevention always requires a team approach, and providers can greatly benefit from the social support of colleagues and co-workers. Suicide prevention teams should ideally be interdisciplinary and involve one or more registered mental health professionals. Whenever possible, those working in clinic settings should ideally book potentially at-risk individuals for appointments during office hours when other providers and/or supervisors are available, and/or when crisis or emergency services are available. When individual providers do see potentially at-risk clients independently (e.g., outreach visits), they should have a way of immediately contacting supportive back-ups (e.g., by cellular telephone, pagers/wireless devices, or alternative means).

Timely note keeping is essential for monitoring risk, especially in team or clinic settings. Good notes include detailed information on risk assessment, interventions, consultations, and client reactions, responses, and/or outcomes. Safety strategies should include specific instructions for accessing assistance when needed, including from co-workers, supervisors, registered mental healthcare practitioners, crisis and emergency workers, and the police. There is currently no solid data to confirm the efficacy of "no suicide contracts" in preventing suicide (Szanto et al., 2002).[IV]

Clinicians should try to find out whether clients at risk of suicide have access to means of killing themselves. If so, it will obviously be necessary to try to limit such access. Physicians can limit the risk of lethal overdoses by prescribing only small quantities of medications at a time, and monitoring their use.

Recommendations: Risk Management Strategies: Support for Health Care Professionals

Do not feel you have to work alone. Suicide prevention requires a team approach. Providers are ideally encouraged to connect with a registered mental health professional. If mental healthcare professionals are unavailable, providers should connect with another member of a health care team within the community. **[D]**

Providers working with suicidal individuals require networks of support to ensure their own emotional well-being and to avoid burnout. **[D]**

When working with suicidal clients, it is essential to keep detailed notes on risk assessment, interventions, and client reactions, responses, and/or outcomes. **[D]**

When one is concerned that a suicidal client cannot or will not follow one's recommendation to seek care in a hospital emergency room, one should involve emergency services (e.g., 911). **[D]**

Where possible, restrict access to lethal means. **[D]**

Part 5: Systems of Care

5.1 Collaborative Care

Older adults who die by suicide often visit a primary health care provider in the days and weeks prior to taking their lives (Juurlink et al., 2004),[III] but their suicidal thinking often goes undiscussed or undetected (Luoma et al., 2002).[IV] These older adults rarely seek help directly from mental health care providers during the period before their suicide.

Primary care providers face competing demands in the limited time available during patient visits and often only the most salient patient concerns receive their attention (Oxman et al., 2003).[IV] Older adults might minimize or under-report depressive and suicidal symptoms, impeding risk detection (Duberstein et al., 1999; Gallo et al., 1999; Lyness et al., 1995).[III] Physicians may believe that suicidal older adults are non-compliant with treatment (Kaplan et al., 1999)[III] and tend to be reluctant to refer depressed older patients for mental healthcare (Alvidrez & Areán, 2002).[III]

Systems of care regarding the mental health of older adults have been changing and research into the development of shared care approaches has been increasing. The PROSPECT (Prevention of Suicide in Primary Care Elderly Collaborative Trial) initiative investigated the use of collaborative care models in the early detection of suicide risk and the treatment of depression and suicide ideation in older people. A guided management intervention within a collaborative care model was utilized and demonstrated a decrease in suicide ideation (Bruce et al., 2004b).[Ib]

In addition, collaborative models of medical and mental health care in primary care settings have been developed in the United States to help overcome systemic barriers to care (Oxman et al., 2003).[IV] These studies have indicated that collaborative care can help enhance mental health treatment utilization (Bartels et al., 2004)[Ib], improve resolution of depression and functional impairment, improve quality of life (Unützer et al., 2002)[Ib], and reduce depression and suicidal ideation among older adults (Bruce et al., 2004b).[Ib] This research was conducted in an American managed health care context and its lessons may be transferable to the Canadian primary care context (see Kates & Craven, 2002), although the real-life feasibility has yet to be demonstrated (Bruce et al., 2004a; Colenda, 2004; Lebowitz, 2004).[Ib, IV]

Caution is specifically warranted, as treatments shown efficacious in the controlled environments of clinical trials have not proven to be effective in so-called "real world" conditions. Research establishing best practices for translation of knowledge and skills from clinical research contexts into community contexts is required. However, there is support for interdisciplinary and shared care models in the detection and prevention of suicide.

Recommendation: Collaborative Care

For those designing and administrating systems of care, it is recommended that interdisciplinary and collaborative care models be established and supported. **[B]**

5.2 Mental Health Outreach

Outreach efforts for older adults reluctant to seek mental health services might reduce suicide risk. A quasi-experimental study in Japan, involving public mental health presentations, depression screenings, and outreach counseling, appeared to demonstrate a decreased risk of suicide among those exposed to the intervention (Oyama et al., 2004).[IIb] A study in Italy demonstrated a lower than anticipated incidence of suicide among users of a telephone-based social-support service (DeLeo et al., 2002).[IIb] Duberstein and colleagues (2004b)[III] note that family members and clergy are in key positions to act as gatekeepers in the prevention of suicide. Clergy can support suicide prevention efforts by speaking openly and freely about the importance of mental health treatment and encouraging mental health workshops by professionals within their places of worship. In addition, collaboration among frontline and primary care providers, other community workers, and mental health care providers might help reduce suicide risk among at-risk older adults (Conwell & Heisel, 2006; Duberstein et al., 2004b; Raue et al., 2002).[III, IV]

As the Canadian population ages, it is also becoming more culturally diverse. Tam and colleagues (2004) note that "the increasing heterogeneity of Canada's population is largely a result of changing immigration patterns, which have been changing over the past century" (paragraph 2). They note that, prior to the 1960's, immigrants to Canada were primarily European. However, since the late 1980's, increasing numbers of immigrants have come from Asia, Central and South America and Africa. In addition, a recent Toronto study found that ethnic minorities experienced difficulties in accessing appropriate mental health services (Sadavoy et al., 2004). This example raises the issue that mainstream services need to provide acceptable and appropriate entry points for individuals from other cultures. Furthermore, mental health services need to be flexible enough to serve changing populations and to include services specific to ethnic groups.

Recommendations: Mental Health Outreach

Community outreach and support efforts are needed to identify and treat older adults with mental illness and social problems that put them at elevated risk for suicide. **[D]**

Policy makers need to support and finance community programs, resources and models that will contribute to the well-being of older adults. These should include programs for early recognition and prevention of suicide among those at risk in the community. **[D]**

Mental health services need to be flexible enough to serve changing populations and to include services specific to ethnic groups. **[D]**

5.3 Education

The role of education in the prevention of suicide among older adults is important and there is an increased need for health care professionals who are trained in such matters. Identification of risk and protective factors, strategies and tools for assessment, intervention skills, management of risks, and ongoing monitoring should be considered in education and training programs. Education should be directed at current and future health care professionals, older adults, caregivers and the public through a variety of ways, including the media, to increase awareness and reduce stigma. The American Foundation for Suicide Prevention has published guidelines for the reporting of suicide by the media. Readers are encouraged to consult these guidelines and direct media representatives to them to ensure responsible reporting (http://www.afsp.org/education/recommendations/5/1.htm).

Recommendations: Education

Culturally sensitive education and training regarding the assessment and prevention of suicide should be provided to health care professionals in a variety of settings. **[D]**

Health care professionals should provide older adults and their families/caregivers with education regarding suicide, stigma, treatment options, and management strategies. **[D]**

Provincial and national public awareness and education efforts that focus on suicide prevention, stigma and mental health promotion in older adults are recommended. **[D]**

Part 6: Additional Issues

6.1 The Ethics of Assisted Suicide

Assisted suicide, much in the news recently, raises significant ethical and legal questions, as do "rational" suicide and euthanasia. Individuals who advocate euthanasia, assisted suicide and rational suicide argue that older, terminally ill patients have the right to decide when and how they want to die, and that they have the right to request assistance from others to do so. These arguments are frequently linked to personal and subjective experiences of pain and terminal illness (Trotter, 2000). Opponents argue that the legalization of assisted suicide will be the beginning of a "slippery slope" toward a view that some older persons have a duty to die and "get out of the way." Leenaars (2001) wisely suggests that "the right-to-die issue must continue to be discussed among suicidologists and all people, with caution about quick answers and quick acquiescence" (p. 472).

6.2 Privacy and Confidentiality

Morally and legally, health practitioners must respect the privacy of their clients, and protect the confidentiality of the information they collect or receive. But it is also the responsibility of health practitioners to reduce or eliminate significant risk of serious bodily harm to their clients. Clearly, suicide and self-harm fall into this category. Health care practitioners should be aware of their professional association's regulations or policy standards regarding limits of confidentiality. If there are reasonable grounds for a practitioner to be concerned regarding the risk for suicide or self harm in a particular client, then it is both necessary and proper to acquire the information needed to decide if the person is actually at risk, and to disclose the information to those people or institutions who are in a position to protect the patient from such risk – *even if the patient has not consented or objects to the acquisition or disclosure of such information.*

Sometimes, clients ask for an assurance that everything they say will be kept confidential, but it is not honest to make such a promise. The reason for undertaking the assessment is to determine the safety of the person, and it may be necessary to inform family members, a psychiatrist, another doctor, or members of emergency services regarding the risk this older adult is facing. One could assure the person that information will not be misused, or treated lightly, while making it clear that information might need to be divulged for their safety.

Ordinarily, the consent of a patient is necessary before a practitioner collects information about the person, or performs an assessment. Implied consent can be assumed, unless the person refuses to participate. In such cases, it is necessary to find out whether the patient is competent to give or refuse consent to the collection of health information, directly or indirectly. If the person will not or cannot cooperate, and one is reasonably concerned about the risk of self-harm, one should get information from other sources.

6.3 Research Needs

In February of 2003, Health Canada together with the Canadian Institutes of Health Research (CIHR) assembled leading Canadian suicide researchers and policy experts to establish a national collaborative agenda for suicide research over the coming decade (Strachan-Tomlinson, 2003). Priority areas identified by this working group are highly relevant to suicide among older adults and include:

- ***Improvement and expansion of data systems:*** Data systems monitoring prevalence and correlates of suicidal thoughts, behaviour, and death by suicide are needed.

- ***Evidence based practices:*** Very few intervention trials exist related to suicide risk. This is an area that is in desperate need of research. As noted by Heisel and Duberstein (2005), "research is needed to test the clinical efficacy of standard, adapted, and innovative psychotherapies that specifically target the problem of suicide in older adults" (p. 251).

- ***Mental health promotion:*** Research is needed on resiliency and promotion of psychological well being for older adults.

- ***Multidimensional models for understanding suicide-related behaviours:*** Multidimensional theoretical models of suicide among older adults are needed.

- ***Spectrum of suicide behaviours:*** Little research exists investigating risk factors for lethal versus non-lethal suicidal behaviour among older adults. Research is needed to examine similarities and differences in these two groups, as well as for those engaging in self-harm for the first time and recurrently suicidal individuals (Heisel, 2006; Heisel & Duberstein, 2005).

- ***Suicide in social and cultural contexts:*** Relatively little has been written regarding sex-specific aspects of suicidal behavior, and is another area for research (Rudolph & Burt, 2003). Research is additionally needed on differential risk factors in different cultures, and exploring cultural scripts for suicide (e.g., Canetto & Lester, 1998).

Part 7: Conclusion

Suicide among the elderly is a tragedy that should be prevented. Shifting population demographics, coincident with the aging of the large baby-boom cohort, highlight the increasing need for knowledge, education, and training in the detection and assessment of risk, specific interventions and best practices, and public health level prevention strategies for older adults at elevated risk for suicide.

These guidelines for the assessment of suicide risk and prevention of suicide among seniors provides an overview of the epidemiology of late-life suicide, highlights associated risk and protective/resiliency factors, assessment, treatment, and risk management practices. In addition, it provides an overview of systems of care, mental health outreach, education, and medico-legal issues related to ethics, privacy, and confidentiality.

These guidelines represent the work of an interdisciplinary team dedicated to improving systems of risk detection and prevention of suicide among older adults, drawing upon the best available evidence at the time of writing. That many of our recommendations have relatively low levels of evidentiary strength (i.e., primarily C and D-level recommendations) represents the paucity of controlled intervention trials with at-risk older adults currently available in the literature. Similar gaps exist in the literature regarding the following: protective and resiliency factors; mental health promotion for older adults; detection of suicide risk; assessment instruments and techniques; and the effectiveness of programs of public health education and prevention efforts. As such, these guidelines are best viewed as a work in progress, reflecting aspirational recommendations for best practices according to the current available evidence, to be modified and updated as needed research adds to what is known regarding this critical tragic public health problem.

It is the sincere hope of those involved in developing these guidelines that they contribute to the excellent work being done by mental health professionals and frontline workers who provide care and support to Canada's seniors, and ultimately help to preserve, extend, and enrich lives. This goal can only be reached by including these guidelines within broader mental health efforts, research and education initiatives, and suicide prevention programs currently under way and under development throughout Canada. We all have a role to play in the prevention of suicide among older adults as suicide affects all Canadians, and suicide prevention is everybody's business.

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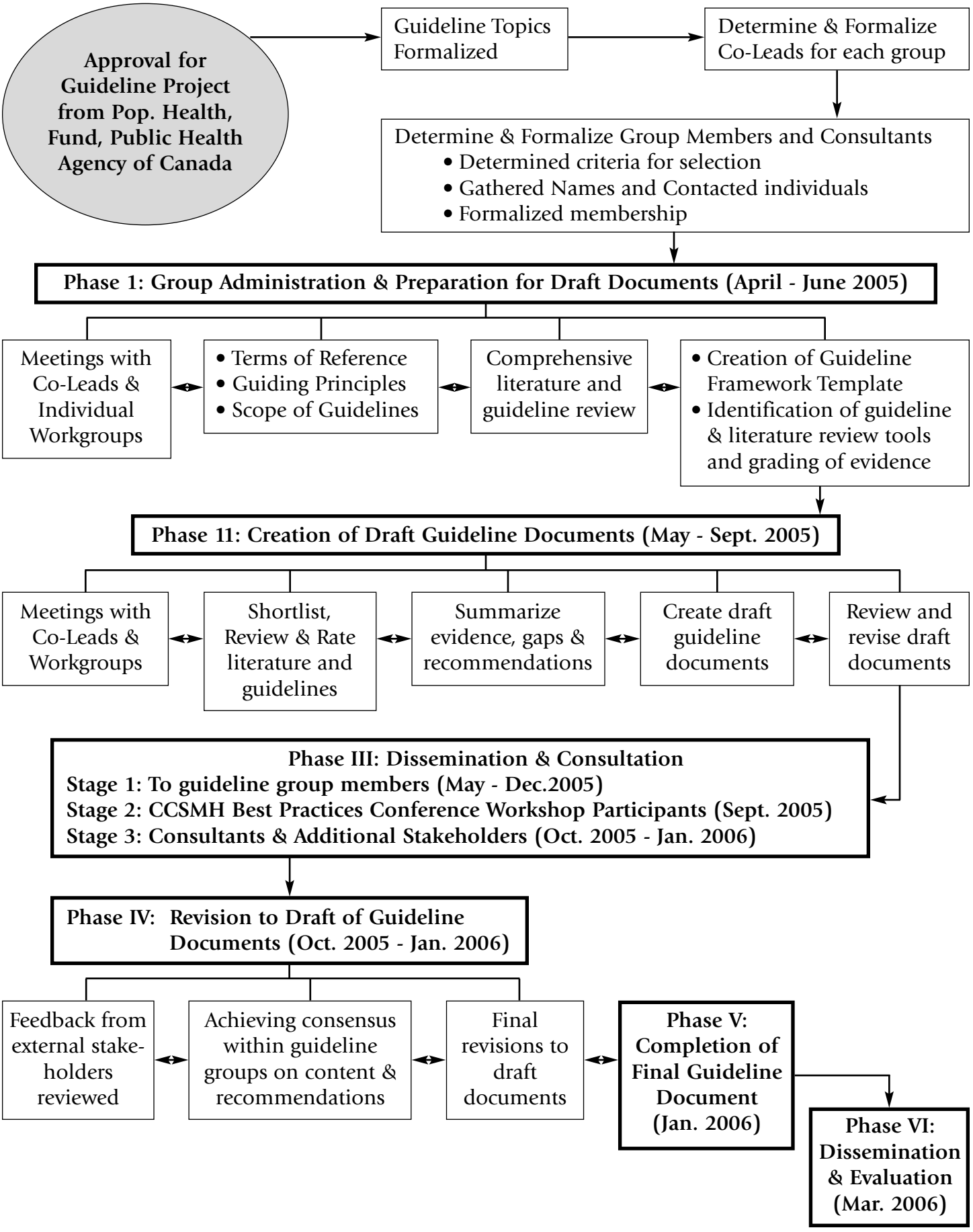
Appendix A: Guideline Development Process



Appendix B: Means of Suicide Among Adults 65 Years or Older in Canada in 2002

Cause of Death	N (Males≥65)	N (Females≥65)	N (Total≥65)
X60-69 Poisoning/exposure to substances	56	28	84
X70 Hanging/strangulation/suffocation	123	15	138
X71 Drowning/submersion	20	8	28
X72-74 Firearm	122	0	122
X75 Explosive material	0	0	0
X76-77 Smoke/fire/steam/hot objects, etc.	3	1	4
X78 Sharp object	6	5	11
X80 Jumping from a height	16	7	23
X81 Jumping/lying before a moving object	9	0	9
X82 Crashing a motor vehicle	0	1	1
X83 Other specified means	3	3	6
X84 Unspecified means	3	1	4
Total	361	69	430

Note: This table was generated based on official mortality data reported by Statistics Canada (2005).

Appendix C: Questions to Consider Asking

The spectre of suicide presents to every clinician an opportunity to find out what makes each patient's life worth living, and the reasons why some patients may feel that life has lost its value. Suicidal thinking is the tip of an iceberg of despair, and an empathic approach to despairing patients will include not just the assessment of suicidal risk, but also basic attention to the circumstances, expectations, quality of life and illness history of every patient. This approach will not only reveal those in need of specific risk assessment and precautions, but will also provide a context for difficult questions about suicide; yield valuable information about the help a person may need; and demonstrate the clinician's interest in the person as an individual. The following questions may be helpful. (Grek, in press)

- With whom does a patient live? What is his or her social network like? How well does he or she get on with his family? Do practical barriers prevent socialization?

- Can the patient manage the activities of everyday life? Basic self-care? Housework, shopping, banking, getting out and about? Does he or she have enough help? If not, why not?

- What is the state of the patient's physical health? Does he or she have a serious physical disease – in particular, one serious enough to have required hospitalization recently? Is the patient's perception of the physical illness and the prognosis accurate, has the nature of the illness and the prognosis, and the possibility of management and treatment been clearly explained, in order to dispel the patient's doubts and fears, common in sick people.

- What is the state of the patient's mental health? Have there been previous psychiatric hospitalizations, or self-harm behaviour?

- How much does the patient drink?

- Is the misuse of prescribed medication a problem? In particular, how well is the person sleeping, and is he or she misusing hypnotic medicines?

- Related to all the considerations above, and important also in its own right, is the question of whether or not the patient has symptoms of depression? Sadness, pessimism, guilt, loss of pleasure, social withdrawal may not be volunteered, and must be specifically sought.

- If any of the above risk factors are present, it is necessary to enquire about the worth to the patient of his or her life. Is life worth living? What is there to live for? Is the patient orientated towards, or anticipating, or planning for events or occasions in the future? What is the patient's attitude towards death? This is not an unnatural question to ask of an older patient, especially if one has discovered that he is worried about his health, or is lonely, or is not taking pleasure from life. Does the patient wish for death, or even pray for it? Does he or she have thoughts about ending it all. Does he or she have specific plans, and, if so, the means to carry out such plans?