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Brenda Robinson brobinson@andrewjohnpublishing.com

Accounting Susan McClung Group Publisher John D. Birkby

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## National Guidelines for Seniors' Mental Health: Introduction and Project Background

David K. Conn MB, BCh, BAO, FRCPC; Faith M. Malach, MHSc, MSW, RSW; Kimberley J. Wilson, MSW; Diane Buchanan, RN, DNSc, GNC(C); Maggie C. Gibson, PhD, C.Psych; Adrian Grek, MB, BCh, FRCPC; Marnin J. Heisel, PhD, C.Psych; David B. Hogan, MD, FACP, FRCPC; Laura Gage, MD, FRCPC; Jennifer Mokry, MSW, RSW; Sharon L. Moore, RN, MEd, PhD, C.Psych; Marie-France Tourigny-Rivard, MD, FRCPC

#### ABSTRACT

In January 2005, the Canadian Coalition for Seniors' Mental Health (CCSMH) embarked on the facilitation and development of the first-ever national, multidisciplinary guidelines. The four guideline documents were completed in the spring of 2006. To date over 7,500 hard copies have been distributed and 7,200 downloads of the document have occurred. Summaries of the four documents can be found in this supplement and can be downloaded in their entirety from www.ccsmh.ca.

Key words: mental health, guidelines, geriatrics, delirium, depression, suicide, long-term care

#### Background: Canadian Coalition for Seniors' Mental Health National Guideline Project

The Canadian Coalition for Seniors' Mental Health (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 identified areas for guideline development were

- 1. The assessment and treatment of delirium
- 2. The assessment and treatment of depression
- 3. The assessment and treatment of mental health issues in long-term care homes (focus on mood and behavioural symptoms)
- 4. The Assessment of Suicide Risk and Prevention of Suicide

In April 2005, workgroups were established for the four identified areas. The workgroups evaluated existing guidelines, reviewed the primary literature, and formulated documents that included recommendations with supporting text. Dissemination of the guidelines began in June 2006.

*David K. Conn MB, BCh, BAO, FRCPC*: Psychiatrist-in-Chief, Baycrest Geriatric Health Care System; Associate Professor, Department of Psychiatry, University of Toronto; Co-Chair, Canadian Coalition for Seniors' Mental Health; Past President, Canadian Academy of Geriatric Psychiatry, Toronto, ON; *Faith M. Malach, MHSc, MSW, RSW*: Executive Director, Canadian Coalition for Seniors' Mental Health; Adjunct Practice Professor, Faculty of Social Work, University of Toronto, Toronto, ON; *Adjunct Professor, Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto. Toronto, ON; <i>Kimberley J. Wilson, MSW*: Project Manager, Canadian Coalition for Seniors' Mental Health; *Diane Buchanan, RN, DNSc, GNC(C)*: Assistant Professor, School of Nursing, Queen's University, Kingston, ON; *Maggie C. Gibson, PhD, C.Psych:* Psychologist, Veterans Care Program, St. Joseph's Health Care London, ON; Associate Scientist, Lawson Health Research Institute; Adjunct Clinical Professor, Department of Psychology, University of Western Ontario, London, ON; *Adrian Grek, MB, BCh, FRCPC*: Geriatric Psychiatry, Mount Sinai Hospital, University of Toronto; Associate Clinical Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, ON; *Marmin J. Heisel, PhD, C.Psych*: Assistant Professor, Department of Fsychiatry, and Prevention of Suicide, Department of Psychiatry, University of Rochester Medical Center, Rochester, NY, *David B. Hogan, MD, FACP, FRCPC*: Professor and the Brenda Stafford Foundation Chair in Geriatric Medicine, University of Coronto; *Nasdie*, *Care Network*, *Coronto, ON; <i>Jennifer Mokry, MSW*, *RSW*: Project Manager, Canadian Coalition for Seniors' Mental Health, Care System? Naster Professor, Chair, Sasociate Clinical Professor, Department of Psychiatry, University of Toronto, Toronto, ON; *Margin J. Heisel, PhD, C.Psych*. Sasistant Professor, Department of Psychiatry and Pervention of Suicide, Department of Psychiatry, University of Rochester Med

#### Introduction

This introductory article provides the background for the CCSMH National Guidelines Project, in addition to the process used during the creation of the four guideline documents. The following four articles are summaries of the evidence-based recommendations from the CCSMH National Guidelines Project. Readers are encouraged to consult the full-text documents available for free through the CCSMH Web site (www.ccsmh.ca) after reading the summary articles presented in this supplement. The CCSMH has created key messages for the National Guideline Project to accompany the dissemination of the Guidelines, which may be found in Table 1.

#### **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+ years) will account for almost 18% of our country's population.<sup>1</sup> Currently, 20% of those aged 65 years and older are living with a mental illness.<sup>2</sup> Although this figure is consistent with the prevalence of mental illness in other age groups, it does not capture the high rates seen within health and social institutions. For example, it has been reported that 80 to 90% of nursing home residents live with some form of mental illness and/or cognitive impairment.3 Previously, there were no interdisciplinary national guidelines on the prevention, assessment, treatment, and management of the major mental health issues facing older Canadians other than the recommendations of two Canadian consensus conferences on dementia.45 A new version of the latter recommendations will be released in the near future. Given the projected growth of the seniors' population, the lack of an accepted national standard to guide their care was a serious problem. There was an urgent need to identify, collaborate, and share knowledge on effective mental health assessment and treatment practices relevant to seniors. In response to this need, 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.

#### Table 1. CCSMH National Guideline Project Key Messages

- Mental illness is not a normal consequence of aging and can be prevented, treated, and managed.
- The guidelines for seniors' mental health have been developed to address knowledge gaps and to provide an evidence-based approach to the prevention, assessment, treatment, and management of mental health problems in seniors.
- A comprehensive consultative process resulted in identification of four areas in seniors' mental health—depression, delirium, suicide, and mental health issues in long-term care homes—as priority areas for guideline development.
- The CCSMH led the creation of Canada's first evidence-based guidelines for seniors' mental health, in collaboration with four multidisciplinary teams of recognized experts from across the country.
- Dissemination, knowledge transfer, and application of the guidelines in practice and policy are imperative to ensure improved mental health outcomes for seniors.
- The CCSMH is committed to the dissemination and use of the guidelines for the care of seniors' mental health in Canada.

#### 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."<sup>6</sup> These are the first interdisciplinary, national best-practice clinical guidelines that specifically address four key areas for the mental health of seniors. 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 prevention, assessment, treatment, and management of four mental health issues for seniors through the provision of evidence-based recommendations. The recommendations in these guidelines are based on the best available evidence at the time of publication, supplemented by the consensus opinion of the Guideline Development Group. Funding for the creation of the guidelines was provided by the Public Health Agency of Canada, Population Health Fund.

#### **Goals and 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 included the following:

- To identify existing best-practice guidelines in the selected areas both within Canada and internationally
- To facilitate the collaboration of key health care leaders within the realm of seniors' mental health to review existing guidelines and the relevant literature
- To facilitate a process of partnership whereby key leaders and identified stakeholders create a set of recommendations and/or guidelines for identified areas within seniors' mental health
- To disseminate the draft recommendations and/or guidelines to stakeholders at a national conference (CCSMH Best Practices Conference, September 2005) to create an opportunity for review and analysis before moving forward with the final recommendations and/or guidelines
- To disseminate completed guidelines to health care professionals and stakeholders across the country

#### Scope of the National Guideline Project

Guideline Development Group members determined that the guidelines would

- · Be multidisciplinary in nature
- · Focus only on older adults
- Have relevance to all health care settings across the continuum (or, in the case of the long-term care guideline, have relevance to all service settings that provide long-term care)
- Acknowledge the variation (i.e., in services, definitions, access issues) that exists between facilities, agencies, communities, regions, and provinces across the country
- Deal explicitly with areas of overlap between the four national guidelines for seniors' mental health, including cross-referencing as appropriate
- · Identify gaps in knowledge
- Address research, education, and service delivery issues. For example, the guidelines may address "optimal services,"

"organizational aspects," "research," and "education."

• Identify 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, caregivers, and policy makers whose work focuses on the senior population. In addition, these guidelines may prove useful in the development and/or evaluation of health care service delivery models, human resource plans, accreditation standards, training and education requirements, research needs, and funding decisions.

#### Creation of the Guideline Development Group

An interdisciplinary group of experts on seniors' mental health issues was 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 coleads were selected, Guideline Development Group members and consultants were chosen using a similar process that included requesting suggestions from the co-leads. One of the goals in selecting group members was to attempt to create an interdisciplinary workgroup with provincial representation from across the country.

#### **Creation of the Guidelines**

In May 2005, the Guideline Development Groups convened in Toronto, Ontario, for a 2-day workshop. Through large and smallgroup 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 time lines and accountability plans. The four individual Guideline Development Groups met at monthly meetings via teleconference with frequent informal contact through electronic mail and telephone 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 held among the co-leads. The CCSMH project director and manager were responsible for facilitating the process from beginning to end.

#### **Guideline Development Process**

The guideline development process is summarized in Figure 1. A comprehensive review of the process is provided in each of the guideline documents. For more details on the process used by the CCSMH, consult the full-text documents (www.ccsmh.ca).

#### Search Strategy for Existing Evidence

A computerized search for relevant evidence-based summaries (including guidelines, meta-analyses, and literature reviews), as well as primary research literature not contained in these source documents, was conducted by librarian consultants and the CCSMH workgroups. The search strategy was guided by the following inclusion criteria:

English-language references only

- References specific to the guideline topics
- Guidelines, meta-analyses, and reviews from January 1995 to May 2005
- Primary research literature from January 1999 to June 2005

## Guideline, Meta-analyses, and Literature Review Search

The initial search for existing evidence-based summaries examined the following major databases: Medline, EMBASE, PsycINFO, CINAHL, AgeLine, and the Cochrane Library. In addition, a list of Web sites was compiled based on known evidence-based practice Web sites, known guideline developers, and recommendations from Guideline Development Group members. The search results and dates were noted. Refer to individual guidelines for more specific information on which Web sites were consulted and resources used as the literature base for each Guideline Development Group.

The Guideline Development Groups used the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument<sup>7</sup> to appraise which of the identified guidelines were of sufficient quality that they could be used in the development of the guidelines. This process served both to select quality guidelines and to enhance awareness of the factors that must be taken into consideration during the development of our contribution to this literature.

#### Supplemental Research Literature Search

The time frame (1999–2005) for the supplemental research literature search was selected in consideration of the publication dates of identified guidelines (1995–2005). It was assumed that the pre-existing guidelines and review articles collectively could be relied on as acceptable sources of the literature. Searches were conducted separately for each database (Medline, EMBASE, PsycINFO, CINAHL, AgeLine, the Cochrane Library), with necessary variance in controlled vocabulary (i.e., minor differences in search terms as proscribed by each database). The core search strategy for all databases was to limit it to articles dealing with humans, written in English, and published between 1999 and 2005. Each search also included terms to encompass location (e.g., exploded terms: *long-term care, nursing home, residential care institutions*), age (*aged*), and symptoms/disorders.

## Development of Recommendations for the National Guideline Project

The selected literature was appraised with the intent of developing evidence-based, clinically sound recommendations. Based on relevant expertise and interest, each Guideline Development Group was divided into subgroups and completed the drafting of recommendations for its 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' categories of evidence and strength of recommendations.<sup>8</sup> The individual studies are categorized from I to IV (Table 2). In the text of the guideline documents the category is given alongside the references and has been formatted as (reference). <sup>Category of Evidence</sup>



#### Figure 1. Guideline process flow chart.

## Table 2. Categories of Evidence for CausalRelationships 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: Ila
- 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

#### Adapted from Shekelle et al.8

The strength of the recommendations, ranging from A to D (Table 3), 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. It is important to interpret ratings for the strength of recommendation (A to D) as a synthesis of all of 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 service delivery. Level of risk has also been considered when assigning strength of recommendation.

The Guideline Development Group co-leads reviewed the draft documents and approved recommendations in draft form in anticipation of stakeholder review under the auspices of the CCSMH National Best Practices Conference in September 2005. After the conference, each Guideline Development Group again reviewed the recommendations and discussed gaps and controversies. Areas of disagreement were discussed and recommendations were revised as necessary prior to the second round of endorsement. A minimum of 80% support (defined as consensus) for 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 unanimous.

#### Disclosures

A number of mechanisms were established to minimize the potential for biased recommendations being made owing to conflicts of interest. All Guideline Development Group members were asked to complete a

#### Table 3. 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

Adapted from Shekelle et al.8

conflict of interest form. This was completed twice during the process (at its commencement and on completion). 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.

#### **Dissemination Activities to Date and Next Steps**

Since the completion of the CCSMH National Guidelines for Seniors' Mental Health over 7,500 copies of the Guidelines have been mailed to Canadian hospitals, long-term care facilities, government officials, members of the Canadian Academy of Geriatric Psychiatry, and identified key leaders in the field of seniors' mental health. As of mid-August 2006, over 7,200 copies of the Guidelines have been downloaded from the CCSMH Web site. The CCSMH and Guideline Development Group members have presented to several audiences on the guideline recommendations and are looking to create partnerships and opportunities to collaborate on the review, implementation, and evaluation of the guidelines and recommendations. The CCSMH is eager and open to receiving feedback on the guideline documents and recommendations. In addition, we encourage your comments and experiences as you review, implement, and evaluate the guidelines. Comments should be e-mailed to Faith Malach at fmalach@baycrest.org.

#### Acknowledgements

For a complete list of acknowledgements, including financial supporters for the dissemination of the guidelines, refer to the full guideline document. Over 50 individuals were formally involved in the development of the four national guideline documents. The CCSMH is grateful to these individuals, who dedicated countless hours of work and energy to the National Guidelines Project. For complete lists of Development Group Members, refer to the full-text guidelines. Special thanks to the CCSMH National Guidelines Project Steering Committee Members: Dr. David Conn (chair), Dr. Maggie Gibson, Dr. David Hogan, Dr. Laura McCabe, Dr. Diane Buchanan, Dr. Marie-France Tourigny-Rivard, Dr. Adrian Grek, Dr. Marnin Heisel, Dr. Sharon Moore, Ms. Faith Malach, Ms. Jennifer Mokry, and Ms. Kimberley Wilson.

#### About the CCSMH

The CCSMH was established in April of 2002 in response to concerns raised by health care professionals and government representatives over inadequate awareness of seniors' mental health and the quality of care provided to people over age 65 years. The mission of the CCSMH is to promote the mental health of seniors by connecting people, ideas, and resources. The primary goals include the following:

- To ensure that seniors' mental health is recognized as a key Canadian health and wellness issue
- To facilitate the development, dissemination, and promotion of initiatives and resources related to seniors' mental health
- · To ensure growth and sustainability of the CCSMH

A truly national organization, CCSMH has over 850 individual members and 85 institutional representatives from health and seniors' organizations coast to coast. The CCSMH is governed by the following national organizations:

Canadian Academy of Geriatric Psychiatry

- Alzheimer Society of Canada
- CARP Canada's Association for the Fifty Plus
- Canadian Association of Social Workers
- Canadian Caregiver Coalition
- Canadian Geriatrics Society
- Canadian Healthcare Association
- Canadian Mental Health Association
- Canadian Nurses Association.
- Canadian Psychological Association
- Canadian Society of Consulting Pharmacists
- College of Family Physicians of Canada
- Public Health Agency of Canada (advisory)

For further information on the CCSMH contact Faith Malach, executive director, at fmalach@baycrest.org or 416-785-2500 ext. 6331.

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A full list of references used in the guidelines may be found in the fulltext documents. Available: http://www.ccsmh.ca.

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## National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Delirium

David B. Hogan, MD, FACP, FRCPC; Laura Gage, MD, FRCPC; Venera Bruto, PhD, C.Psych; Deborah Burne, RN, BA(Psych); CPMHN (C), Peter Chan, MD, FRCP; Cheryl Wiens, BSc (Pharm), PharmD; Faith M. Malach, MHSc, MSW, RSW; Jennifer Mokry, MSW, RSW

#### **ABSTRACT:**

Delirium is a common, serious condition encountered in older persons that can have important long-term consequences. The prevention, identification, assessment and management of delirium present significant challenges to clinicians. For these guidelines a comprehensive literature review on the assessment and management of delirium in older persons was conducted. This literature was used to develop a series of evidence-based recommendations that the Delirium Guideline Development Group ratified using a consensus process. In this paper, a summary of the recommendations directed at practitioners and interdisciplinary care teams is provided. The Delirium Development Group believes that the occurrence of delirium is not the inevitable complication of an acute illness in an older person. We can modify its incidence and when it occurs we must provide competent, humane care.

Key words: acute confusion, aged, delirium, geriatric psychiatry, geriatrics, guidelines

Delirium is a common and serious condition encountered in older persons that has important long-term consequences. Compared with similarly aged individuals, older hospitalized persons who develop a delirium have prolonged hospital stays, worse functional outcomes, higher institutionalization rates, an increased risk of cognitive decline, and higher mortality rates.<sup>1-3</sup> Delirium is a marker of an increased risk of the development of a dementia, even in older people without previous cognitive or functional impairment.<sup>4</sup> Its presence is associated with worse rehabilitation outcomes.<sup>5-7</sup> Among hospitalized older persons who survive a delirious episode, most recall it as a highly distressing event.<sup>8</sup>

Often delirium is not recognized or is misdiagnosed as either dementia or depression.<sup>9</sup> Under-recognition is particularly common for hypoactive-hypoalert cases occurring in very old (80+) individuals with impaired vision and/or pre-existing dementia.<sup>10</sup> When all four of these features are present, the risk of under-recognition is increased more than 20-fold. Non-recognition of delirium was associated with a higher mortality rate among older (mean age 80.1 years) delirious persons seen in emergency departments who were discharged home.<sup>11</sup> Delayed recognition of delirium was found to be associated with worse

outcomes in a group of older (mean age 78.5 years) hospitalized persons.  $^{\scriptscriptstyle 12}$ 

The occurrence of delirium is not inevitable. Frequently it is precipitated by potentially modifiable factors, such as medications, dehydration, malnutrition, immobilization, use of physical restraints, sleep deprivation, and iatrogenesis. Delirium is a window that allows us to examine the quality of care being provided to older persons.<sup>13</sup>

#### **Definition of Delirium**

The criteria of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* were designed to be simple to use and sensitive for the presence of delirium in different settings.<sup>14</sup> Laurila and colleagues found that the *DSM-IV* criteria identified a greater number of older persons as delirious and the group identified had a similar prognosis to those fulfilling more restrictive criteria.<sup>15</sup> Cole and colleagues reported that the *DSM-IV* criteria were more sensitive than the *DSM-III, DSM-IIIR*, or the tenth revision of the *International Classification of Diseases (ICD-10)* criteria in diagnosing delirium in older persons hospitalized on medical units with or without a dementia.<sup>16</sup>

David B. Hogan, MD, FACP, FRCPC: Professor and the Brenda Stafford Foundation Chair in Geriatric Medicine, University of Calgary, Calgary, AB; Laura Gage, MD, FRCPC: Staff Psychiatrist, Whitby Mental Health Centre, Whitby, ON; Assistant Professor, Department of Psychiatry, University of Toronto, ON: Venera Bruto, PhD, C.Psych: Neuropsychologist, Neurology Service, Toronto Rehabilitation Institute; Assistant Professor, Department of Human Development and Applied Psychology, University of Toronto, ON; Deborah Burne, RN, BA (Psych), CPMHN (C): Educator and Consult-Liaison Psychiatry, University of Ontario, Toronto, ON, Peter Chan, MD, FRCP, Geriatric and Consult-Liaison Psychiatry, University of Ontario, Toronto, ON; MD, FRCP, Geriatric and Consult-Liaison Psychiatry, University of Soft Ontario, Toronto, ON, Peter Chan, MD, FRCP, Geriatric and Consult-Liaison Psychiatry, University of British Columbia, Vancouver, BC; Cheryl Wiens, BSc (Pharm), PharmD: Associate Professor, Faculty of Pharmacy and Pharmaceutical Sciences, University of Alberta; Clinical Pharmacist (Geriatrica), Capital Health, Edmonton, AB; Faith M. Malach, MHSc, MSW, RSW: Executive Director, Canadian Coalition for Seniors' Mental Health; Adjunct Practice Professor, Faculty of Sociation for Seniors' Mental Health; Adjunct Practice Professor, Faculty of Sociation for Seniors' Mental Health; Adjunct Practice Professor, Faculty of Sociation for Seniors' Mental Health, Toronto, ON) (Since the publication of the Guidelines has relocated to the Cardiac Care Network of Ontario, Toronto, ON)

Address for correspondence: David B. Hogan, HSC-3330 Hospital Dr. NW, Calgary, AB T2N 4N1; FAX 403-283-6151; e-mail dhogan@ucalgary.ca. Conflict of interest: Details are available from the CCSMH. Please contact the CCSMH at 416-785-2500 ext. 6331 for this information *Can J Geriatr* 2006;9(Suppl 2):S42–51.

The *DSM-IV* core features of delirium are as follows:

- A. A disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention;
- B. A change in cognition (i.e., memory deficit, disorientation, language disturbance) or a perceptual disturbance that is not better accounted for by a pre-existing, established, or evolving dementia; and
- C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.<sup>14</sup>

Delirium can occur as a consequence of a medical illness, substance intoxication or withdrawal, or other conditions (e.g., sensory deprivation). Not infrequently delirium in a given older person is due to multiple factors. It arises from an interplay of predisposing and precipitating factors. The greater the vulnerability of the individual and/or severity of the insult, the higher the likelihood of delirium occurring. It is not always possible to firmly establish the specific etiology of delirium in an older person. It is important not to ignore patients who do not achieve the full syndrome of delirium. Subsyndromal delirium (SSD) is a condition in which a person has one or more of the symptoms of a delirium but does not progress to a *DSM*-defined delirium. The risk factors for SSD are similar to those of delirium, whereas the outcomes of those with SSD are intermediate between those with delirium and those without.<sup>17</sup>

Delirium can present in a hyperactive-hyperalert, hypoactive-hypoalert, or a mixed manner. Those with the hyperactive-hyperalert subtype are restless, agitated, aggressive, psychotic (delusions, hallucinations), and/or hyperreactive.<sup>18</sup> The patient with the hypoactive-hypoalert variety appears lethargic, drowsy, sluggish, inactive, apathetic, quiet, and confused. She or he has a loss of facial expression and responds slowly to questions.<sup>18</sup> The hyperactive-hyperalert subtype accounts for 15 to 47% of cases, whereas 19 to 71% of cases are categorized as hypoactive-hypoalert.<sup>19-25</sup> The literature is inconsistent as to which variety has a worse prognosis. The hypoactive-hypoalert type is more often unrecognized and can be misdiagnosed as a depression.<sup>10,26</sup>

#### **Target Population and Audiences**

These guidelines focus on delirium and the care of older persons (i.e., those 65+ years). The assessment, prevention, and management of delirium for this age group were examined in a variety of settings, such as the community, acute care hospitals (including intensive care units), and long-term care facilities. Delirium from alcohol withdrawal was covered, but we did not deal in detail with other types of substance withdrawal delirium. Our target audiences are nurses, physicians, and other health care professionals who provide care to older persons and the interdisciplinary teams in which they work. We feel that care of older delirious persons should be provided by interdisciplinary teams, including older individuals and their families, working in an integrated, coordinated manner. Team leadership and roles should depend on the needs of the older patient.

#### Epidemiology

In a community study of non-demented individuals aged 85+ years, Rahkonen and colleagues found that 10% had an episode of delirium over a 3-year period.<sup>27</sup> Among individuals aged 65+ years with a dementia followed for 3 years, 13% developed a delirium.<sup>28</sup> Most of the published studies on the epidemiology of delirium deal with inpatient populations. Delirium occurs in up to 50% of older persons admitted to acute care settings.<sup>29,30</sup> Among older persons admitted to medical or geriatric hospital units, most studies report prevalence rates of  $\cong$  10 to 20% and incidence rates of  $\cong$  5 to 10%.<sup>31</sup> Among older persons undergoing general surgery the reported frequency of postoperative delirium is  $\cong$  10 to 15%. Cardiothoracic surgery ( $\cong$  25–35%) and repair of a hip fracture ( $\cong$  40–50%) have been consistently associated with higher rates of post-operative delirium.<sup>31</sup> A study of persons 65+ years seen in an emergency department found the prevalence of delirium to be  $\cong 10\%$ .<sup>32</sup> Long-term care home residents represent a vulnerable group predisposed to the development of delirium, but relatively few studies have been done in this setting. Most reports of the prevalence among residents of long-term care facilities show rates that range from 6 to 14%.33 One small study found an incidence of 40%.34 Reported rates among selected populations are as follows: 70% incidence during the index hospitalization for persons aged 65+ years admitted to an intensive care unit,35 22 to 89% prevalence of delirium in hospitalized and community populations aged 65+ years with a pre-existing dementia,36 and 88% incidence of a terminal delirium among persons receiving palliative care (mean age 62 years) with advanced cancer.37

#### **Risk Factors**

Risk factors for delirium among older hospitalized persons include pre-existing dementia (this is the factor most strongly associated with the development of delirium), the presence of a severe medical illness (second most strongly associated risk factor), increasing age, male sex, depression, alcohol abuse, abnormal serum sodium, hearing impairment, visual impairment, pre-existing challenges with activities of daily living, and disability.38 Risk factors for alcohol withdrawal delirium in hospitalized persons include concurrent infections, tachycardia (i.e., heart rate above 120 beats per minute) on admission, signs of alcohol withdrawal accompanied by an alcohol concentration of more than 1 g/L, a history of seizures, and a history of delirious episodes.39 If none of these factors are present, alcohol withdrawal delirium is unlikely. A report of adults admitted to hospital for alcohol withdrawal found that although alcohol withdrawal severity scores and benzodiazepine requirements were similar across age groups, persons aged 60+ years were at increased risk of cognitive and functional impairment during withdrawal.<sup>40</sup> The adjusted odds ratio for delirium was 4.7 for those aged 60+ years compared with younger individuals. These findings support the recommendation that older persons with alcohol withdrawal are best treated in closely supervised settings.

#### **Delirium Guideline Development: Methods**

A comprehensive literature review on the assessment and treatment of delirium in older adults was completed. A computerized search for relevant evidence-based manuscripts, including guidelines, metaanalysis, and literature reviews, and original literature not contained in these source documents, was conducted by librarian consultants to the Guidelines Project. The search strategy was guided by pre-specified inclusion criteria (i.e., English-language references only, references that specifically addressed delirium, no dissertations, guidelines or meta-analyses or reviews dated January 1995 to May 2005 and research articles dated January 1999 to June 2005) and examined several major

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databases (Medline, EMBASE, PsycINFO, CINAHL, AgeLine, Cochrane Library). The following search terms were used: *delirium*, *acute confusion*, *organic brain syndrome*, *alcohol withdrawal*, *encephalopathy*, *sedative withdrawal*, *narcotic withdrawal*, *opiates*, *benzodiazepine withdrawal*, *elderly*, *older adult*, *aged*, *geriatric*, *delirium guideline(s)*, *elderly delirium guideline(s)*, *practice guideline(s) delirium*, *practice guideline(s) older adults delirium*, *protocol(s) delirium*, *clinical pathways*, *clinical practice guideline(s)*, *and clinical guideline(s)*. In addition, a number of Web sites were examined (addresses available through the Canadian Coalition for Seniors' Mental Health [CCSMH]).

This search yielded 11 potentially relevant guidelines. The Guideline Development Group determined whether the identified guidelines addressed our guideline topic specifically and were accessible either on-line, in the literature, or through contact with the developers. The selected guidelines were then assessed using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument.<sup>41</sup> Seven guidelines (published between 1998 and 2001) were selected to form the base of the project.<sup>42-48</sup>

The time frame 1999 to 2005 was used for a supplemental literature search. It was assumed that the seven selected guidelines could be relied on as an acceptable summary of the prior literature. We felt that we should focus on updating this review. Searches were conducted separately for each database (Medline, EMBASE, PsycINFO, CINAHL, AgeLine, Cochrane Library), with necessary variance in controlled vocabulary (i.e., minor differences in search terms as proscribed by each database). The search strategy for all databases was limited to research dealing with humans and written in English. The key words used in all of the literature searches were delirium, delirious, confused, acute confusion, organic brain syndrome, sedative withdrawal, narcotic withdrawal, benzodiazepine withdrawal, qualitative studies, clinical trial(s), controlled clinical trial(s), evaluation studies, meta-analysis, and randomized controlled trial(s). Additional searches were conducted using the following terms: physical restraint(s), restraint(s) physical, and restraint(s); monitoring and outcome tools; assessment, diagnosis, geriatric assessment, screening; education, education of staff, education of patients, and education of families; and system(s) of care, policy, policies, and protocol(s). This process yielded 3,708 citations. The abstracts were circulated to the Guideline Development Group co-leads and the CCSMH project director, and 149 articles were selected for distribution to the Guideline Development Group members. Additional literature (e.g., review articles or summaries, research reports) was identified through targeted searches and from members of the Group.

The selected literature was used to develop evidence-based, clinically sound recommendations. The members of the Guideline Development Group were divided into subgroups that were charged with the responsibility of drafting recommendations for their particular section. These were reviewed by stakeholders, our consultants, and the entire Group (who had to ratify them using a consensus process). The final consolidated list of recommendations was based on the literature review, informed by expert opinion.

#### Results

A full text of the guidelines may be downloaded for free from the CCSMH Web site (www.ccsmh.ca). A summary of the

recommendations directed at practitioners and interdisciplinary care teams is provided in Table 1. Because of space limitations, important clarifying information is not provided and our recommendations dealing with education and the organization of care are not presented. We encourage the reader to refer to the full text of the guidelines for this important information.

#### **Table 1. Summary of Recommendations**

#### Prevention

- Prevention efforts should be targeted to the older person's individual risk factors for delirium. [D]
- Interventions to prevent delirium should be interdisciplinary. [A]
- Multicomponent interventions targeting multiple risk factors should be implemented in older persons who are at intermediate to high risk of developing delirium. [A]
- Older hospitalized persons with pre-existing cognitive impairment should be offered an orientation protocol and cognitively stimulating activities. [B]
- Older hospitalized persons who are having problems sleeping should be offered non-pharmacologic sleep-enhancing approaches. Use of sedative-hypnotics should be minimized. [B]
- Older hospitalized persons should be mobilized as quickly as possible. The use of immobilizing devices/equipment should be minimized. [B]
- Older persons with impairments of vision should be provided with their visual aids and/or other adaptive equipment. [B]
- Older persons with impairments of hearing should be evaluated for reversible causes and provided with hearing aid(s) and/or other amplifying devices. [B]
- Older persons with evidence of dehydration should be encouraged to increase their oral fluid intake. Other measures may be required depending on the severity of the dehydration and patients' response to efforts to increase their oral intake. [B]
- Environmental risk factors should be modified, if possible. [D]
- Where available, proactive consultations to a geriatrician, geriatric or general psychiatrist, or a general internist should be considered for older persons undergoing emergency surgery to minimize the risk of postoperative delirium. [B]
- Prevention, early detection, and treatment of postoperative complications in older persons are important in preventing delirium. These would include (but are not limited to) the following: myocardial ischemia, arrhythmias, pneumonia, exacerbations of chronic obstructive pulmonary disease, pulmonary emboli, and urinary tract infections. [B]
- Based on current evidence, psychopharmacologic interventions for unselected older persons to prevent the development of delirium are not recommended. [D]

#### Detection

- All clinicians working with older persons should be alert to the possibility of delirium developing after surgical procedures (especially cardiopulmonary bypass and surgical repair of a hip fracture), with acute medical conditions (e.g., infections), and/or during exacerbations of chronic medical conditions (e.g., congestive heart failure). [C]
- All clinicians working with older persons should be aware that the symptoms of delirium may be superficially similar to those of a dementia and that the two conditions frequently coexist. Clinicians should be aware of the features that can help differentiate delirium from dementia. [C]
- All clinicians working with older persons should be aware that delirium can show a fluctuating course with periods of lucidity during which the person's mental/cognitive status can appear unremarkable. Therefore, repeated screening and looking for diurnal variation are recommended. [C]

- Owing to the fluctuating course of delirium and because many older persons will not be able to provide an accurate history, collateral information should be sought. [C]
- All clinicians working with older persons should be aware that intact functional status does not rule out delirium. [C]
- All clinicians working with older persons should be vigilant of recentonset lethargy and unexplained somnolence, which might indicate the development of the hypoactive-hypoalert subtype of delirium. [C]
- All clinicians working with older persons should recognize that although symptoms of delirium typically develop abruptly, an insidious onset can occur. [C]
- Older persons should be routinely screened for delirium during their stay in hospital. [C]
- Delirium should be considered a potential cause of any abrupt change in the cognition, functional abilities, and/or behaviour of an older person seen in an ambulatory clinic, primary care, or long-term care setting. [C]
- The evaluation of older persons for the possibility of delirium should include a review of their previous cognitive functioning (e.g., over the previous 6 months). [C]
- Any clinician noticing changes in the mental status or alertness of an older hospitalized person should bring this to the attention of the nurse caring for the individual and/or the person's attending physician. [C]
- In response to either observations or reports of changes in mental status/alertness from members of the clinical team, the older person, or members of their family, nurses caring for the older person should initiate an assessment searching for evidence of delirium. [C]
- The physician responsible for the older person should promptly review the delirium screening results and determine the need for further evaluation. [C]
- Older persons with complex presentations such as those with preexisting neurocognitive decline, cerebrovascular disease, and/or aphasia may require referral for assistance in the diagnostic workup. The referral may be directed to a geriatrician, geriatric or general psychiatrist, neurologist, and/or neuropsychologist. [C]

#### Screening Instruments

- Any clinician using a screening measure for delirium should be competent in its administration and interpretation. [D]
- Screening for symptoms of delirium should be done using standardized methods with demonstrated reliability and validity. [C]
- In choosing an instrument for screening or case finding, it is important to ensure that the symptoms surveyed are consistent with the symptoms of delirium as specified in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), that the tool has met acceptable standards of reliability/validity, and that it is appropriate for the proposed purpose and setting. [C]
- Although brief neurocognitive measures are often used in the assessment of delirious individuals, clinicians should be aware of their limitations. More broadly based neurocognitive measures may be required in uncertain cases. [C]
- Referral to neuropsychology should be considered in complex presentations requiring sophisticated examination of mental status to assist with differential diagnosis, such as ruling out a dementia. [C]
- Sensory impairments and physical disability should be considered in the administration of mental status tests and in the interpretation of the findings obtained. [D]
- While clinicians use screening tools to identify persons with probable delirium in need of further evaluation and follow-up, the results from these tools must be interpreted within a clinical context and do not in themselves result in a diagnosis of delirium. [D]
- It is recommended that clinicians use the Confusion Assessment Method (CAM) for screening and as an aid in the assessment/diagnosis of delirium occurring in older persons on acute medical/surgical units and in emergency departments. [C]

- Ratings on the CAM should be informed by an objective mental status examination. [C]
- In complex cases, clinicians should use the Delirium Symptom Interview to elicit additional information from the point of view of the patient to inform CAM ratings. [C]
- The CAM-ICU is recommended for use with persons in intensive care units who are not able to communicate verbally. [C]
- The revised Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) is recommended for monitoring the symptoms of alcohol withdrawal. [C]
- The Delirium Rating Scale-R-98 or the Delirium Index is recommended to measure the severity of delirium states. [C]

#### **Diagnosis of Delirium**

• The DSM-IV criteria for delirium should be used for establishing a diagnosis of a delirium. [C]

## Assessment and Investigations to Determine the Cause of Delirium

History/Physical Examination

- The initial history obtained on a delirious older person should include an evaluation of their current and past medical conditions and treatments (including medications), with special attention paid to those conditions or treatments that might be contributing to the delirium. [D]
- Many older persons with a delirium will be unable to provide an accurate history. Wherever possible, corroboration should be sought from health records, medical/nursing staff, family, friends, and other sources.
   [D]
- The initial assessment should include an evaluation of the patient's potential for harm to self or others, the availability of means for harm to self or others, and the lethality of those means. [D]
- Environmental factors that might be contributing to the delirium should be identified, reduced, and preferably eliminated. [C]
- A comprehensive physical examination should be carried out, with emphasis on selected areas. [D]

#### Laboratory Investigations

- Routine investigations should be conducted on all older persons with a delirium unless there are specific reasons not to perform them. Other investigations would be determined by the findings on history, physical examination, and initial laboratory investigations. [D]
- Neuroimaging studies have not been shown to be helpful when done on a routine basis in cases of delirium and should be reserved for those persons in whom an intracranial lesion is suspected. This would include those with the following features: focal neurologic signs, confusion developing after head injury/trauma (e.g., fall), and evidence of raised intracranial pressure on examination (e.g., papilledema). [D]
- An electroencephalogram should not be done routinely. It can be useful where there is difficulty in differentiating delirium from dementia or a seizure disorder (e.g., non-convulsive status epilepticus, partial-complex seizures) and in differentiating hypoactive delirium from depression. [D]
- A lumbar puncture should not be done routinely. It should be reserved for those in whom there is some reason to suspect a cause such as meningitis. This would include persons with meningismus/stiff neck, new-onset headache, and/or evidence of an infection (e.g., fever, high white count) of an uncertain source. [D]

#### Infections

- Infections are one of the most frequent precipitants of delirium and should always be considered a contributing factor. Please note that older persons may not develop typical manifestations of an infection and can present in a muted or non-specific manner. [D]
- If there is a high likelihood of infection (e.g., fever, chills, high white count, localizing symptoms or signs of an infection, abnormal urinalysis, abnormal chest examination), appropriate cultures should be taken and antibiotics commenced promptly. Select an antibiotic (or antibiotics) that is (are) likely to be effective against the established or presumed infective organism. [D]

#### Delirium in Terminally III Persons

- The decision to search aggressively for causes of delirium in terminally ill
  persons should be based on the older person's goals for care (or the
  goals of their proxy decision maker if the patient is incapable of
  consenting to treatment), the burdens of an evaluation, and the
  likelihood that a remediable cause will be found. [D]
- When death is imminent, it is appropriate to forgo an extensive evaluation and to provide interventions to ameliorate distressing symptoms. [D]

#### Monitoring

- To provide protection for the patient and to ensure the collection of accurate information to guide care, close observation of the delirious older person should be provided. This would include monitoring vital signs (including temperature), oxygenation, fluid intake/hydration, electrolytes, glucose level, nutrition, elimination (including output), fatigue, activity, mobility, discomfort, behavioural symptoms, sleep-wake pattern, and the patient's potential to harm himself/herself or others. [D]
- The environment of the delirious older person should be monitored for safety risks. [D]
- Older persons with a delirium should have a pressure sore risk assessment and receive regular pressure area care. Older persons should be mobilized as soon as their illness allows. [D]
- Serial cognitive and functional measurements should be done. They will help in monitoring the older person's progress and their need for care.
   [D]
- When the care of an older person with delirium is transferred to another practitioner or service, the receiving practitioner or service must be informed of the presence of the delirium, its current status, and how it is being treated. [D]
- Because of the long-term consequences of the condition, older persons with a delirium require careful, long-term follow-up. [C]
- The revised CIWA-Ar should be used to quantify the severity of alcohol withdrawal syndrome, to monitor the patient over time, and to determine the need for medication. [C]

#### Non-Pharmacologic Management

(Includes recommendations about the general use of medications and the role of pharmacotherapy for specific issues like pain management)

#### General Measures

- Treatment of all potentially correctable contributing causes of the delirium should be done in a timely, effective manner. [D]
- Strive to establish and maintain cardiovascular stability, a normal temperature, adequate oxygenation, normal fluid and electrolyte balance, normal glucose levels, and an adequate intake of nutrients. Biochemical abnormalities should be promptly corrected. [D]
- Older persons with delirium are at risk of micronutrient deficiencies (e.g., thiamine), especially if they are alcoholic and/or have evidence of malnutrition. A daily multivitamin should be considered. [D]
- Strive to maintain a normal elimination pattern. Aim for regular voiding during the day and a bowel movement at least every 2 days. [D]
- Urinary retention and fecal impaction should be actively looked for and dealt with if discovered. [D]
- Continuous catheterization should be avoided whenever possible. Intermittent catheterization is preferable for the management of urinary retention. [D]

#### Mobility and Function

- Strive to maintain and improve (where appropriate) the older person's self-care abilities, mobility, and activity pattern. Allow free movement (provided that the older person is safe) and encourage self-care and other personal activities to reinforce competence and to enhance self-esteem. [D]
- The implementation of intensive rehabilitation that requires sustained

attention or learning from the delirious older person is not likely to be beneficial and may increase agitation. It should be delayed until the older person is able to benefit from the intervention. [D]

#### Safety (see Physical Restraints)

- Take appropriate measures to prevent older persons from harming themselves or others. The least restrictive measures that are effective should be employed. [D]
- Attempt to create an environment that is as hazard free as possible. Remove potentially harmful objects and unfamiliar equipment/devices as soon as possible. [D]
- Although it is often necessary to increase supervision during delirium, it
  would be preferable if security personnel did not provide this unless it is
  absolutely necessary for safety reasons. Given older delirious persons'
  difficulties in reasoning and their tendency to see even innocuous
  behaviours as aggressive, the presence of security personnel may
  entrench delusional thinking and agitation. If the family cannot stay
  with the older person and staff cannot provide the required degree of
  surveillance, consider the use of a private-duty nurse (also known as a
  nurse sitter, personal care attendant, or patient companion). [D]

#### Communication

- Given difficulties in sustaining attention, when communicating with a delirious older person ensure that instructions and explanations are clear, slow-paced, short, simple, and repeated. The older person should be addressed face to face. [C]
- Avoid abstract language/ideas and do not insist that the older person appreciate the information that is being given. Do not engage in discussions that the older person cannot appreciate. [C]
- Discuss topics that are familiar and/or of interest, such as hobbies and occupation, with the older person. [D]
- Routinely provide orienting information in the context of care. For example, frequently use the older person's name and convey identifying information (e.g., "I'm your nurse."). [D]
- When providing care, routinely explain what you are about to do. This is to reduce the likelihood of misinterpretation. [D]
- Keep your hands in sight whenever possible and avoid gestures or rapid movements that might be misinterpreted as aggressive. Try to avoid touching the older person in an attempt to redirect him/her. [D]
- Evaluate the need for language interpreters and ensure their availability if required. [D]
- Reminding older persons of their behaviour during episodes of delirium is not generally recommended. Many older persons with delirium retain memories of the fear they experienced during a time of delirium. Others become embarrassed by their behaviour during delirium. [D]

#### Behavioural Management

- Those caring for a delirious older person should convey an attitude of warmth, calmness, and kind firmness. They should acknowledge the older person's emotions and encourage verbal expression. [D]
- Strategies for managing the behaviour of a delirious patient should be derived from an understanding of the neurocognitive/neurobehavioural features of delirium and behavioural management principles. [D]
- Given difficulties in sustaining attention with delirium, present one stimulus or task at a time to the older person. [D]
- If agitation occurs, use behavioural management strategies to identify triggers for agitation. This information should be used to modify the older person's environment and/or delivery of care to reduce the incidence of agitation. Any interventions implemented will require evaluation to confirm their effectiveness. [B]
- Do not directly contradict delusional beliefs as this will only increase agitation and not likely orient the person. If there is a question of safety, attempt to use distraction as a way of altering behaviour. [D]
- Avoid confrontations with older persons even when they say inaccurate/inappropriate things. Disagreements with the older person can lead to increased agitation and are not likely to be effective in altering perceptions or behaviour. If the older person is becoming

agitated, try distracting him/her. If it is important to correct the older person, wait and try offering the required information at another time in a calm, matter-of-fact tone of voice. Ignore the content of their statements when it is not necessary to correct them. [D]

 In complex cases, referral to geriatric psychiatry, neuropsychology, psychology, and/or psychiatry for behavioural management strategies is recommended. [D]

Care Providers/Caregivers

- Effective care of the delirious older person requires interdisciplinary collaboration. [D]
- Request family members, if available, to stay with the older person. They
  can help reorientate, calm, assist, protect, and support the older person.
  As well, they can help facilitate effective communication and advocate
  for the older person. To fulfill their role in an effective manner, family
  members do require introductory education about delirium and its
  management. [D]
- If family cannot stay with the older person and staff cannot provide the required degree of surveillance, consider the use of a private-duty nurse (also known as a nurse sitter, personal care attendant, or patient companion). Please note that their use does not obviate the need to ensure adequate staffing in health care facilities. Any person engaged in this activity requires appropriate training in the assessment and management of delirium. [D]
- As much as possible, the same staff members should provide care to the delirious older person. [D]

#### Environment

- Avoid both sensory deprivation (e.g., windowless room) and sensory overload (e.g., too much noise and activity). The older person's room should be quiet, with adequate lighting. Overstimulation is a common antecedent of agitation. [C]
- Implement unit-wide noise reduction strategies at night (e.g., silent pill crushers, vibrating beepers, quiet hallways) in an effort to enhance sleep. [C]
- Check if the older person wants a radio or television for familiar background stimulation and arrange for it if requested and possible. Allow delirious older persons to listen to music of their choice. If it is felt that these devices are distracting, disorientating, and/or disturbing to the older person when used, they should be removed from the room. [C]
- Ensure that the older person's room has a clock, calendar, and/or chart of the day's schedule. Give the older person frequent verbal reminders of the time, day, and place. [C]
- Attempt to keep the older person in the same surroundings. Avoid unnecessary room changes. [C]
- Obtain familiar possessions from home, particularly family pictures, sleepwear, and objects from the bedside, to help orient and calm the older person. [D]
- It is generally not recommended to put older persons with delirium (especially if hyperactive-hyperalert) in the same room. Agitation tends to be reinforced by the presence of agitation in other individuals. The exception to this would be if delirious persons are being congregated to provide enhanced care. [D]

#### Infections

- If there is a high likelihood of an infection, antibiotics should be started promptly after appropriate cultures have been taken. [D]
- The antibiotic or antibiotics initially selected should be ones that are likely to be effective against the established or presumed infective organism. [D]

#### Pain Management

- Strive to adequately manage the older person's pain. This can be complicated by the observation that some of the medications used to treat pain can also cause delirium. The treatment goal is to control the older person's pain with the safest available intervention(s). [D]
- Non-pharmacologic approaches for pain management should be implemented where appropriate. [D]

- Local or regional drug therapies (e.g., local blocks, epidural catheters) for pain that have minimal systemic effects should be considered. [D]
- For persistent severe pain, analgesics should be given on a scheduled basis rather than administered as needed [D]
- Non-narcotic analgesics should be used first for pain of mild severity and should usually be given as adjunctive therapy to those receiving opioids in an effort to minimize the total dose of opioid analgesia required. [D]
- If opioids are used, the minimum effective dose should be used, for the shortest appropriate time. Opioid rotation (or switch) and/or a change in the opioid administration route may also be helpful. [D]
- The opioid meperidine (pethidine) should be avoided as it is associated with an increased risk of delirium. [C]
- The practitioner should always be alert to the possibility of narcoticinduced confusion. [D]

#### Sensory Deficits

- Sensory deprivation is a frequent contributor to a delirium, especially in an acute care setting. If present, take steps to eliminate it; if this is not possible, minimize its impact. [D]
- Glasses and hearing aids used by the older person should be available and worn. For deaf patients consider the use of a pocket amplifier to facilitate communication. [D]

#### Medications: Precipitating or Aggravating a Delirium

- Withdraw all drugs being consumed that might be contributing to the older person's delirium whenever possible. Psychoactive medications, those with anticholinergic effects, and/or drugs recently initiated or with a dosage change are particularly suspect as inciting causes. [D]
- If suspect drugs cannot be withdrawn, the lowest possible dose of the suspected medication(s) should be used or substitution with a similar but lower-risk medication should be considered. [D]
- Monitor for potential adverse drug-disease interactions and drug-drug interactions. [D]
- Regularly review the older person's medication regimen in an attempt to simplify it by eliminating medications not needed. Avoid adding unnecessary medications. [D]
- Avoid the routine use of sedatives for sleep problems. Try to manage insomnia by taking a non-pharmacologic approach with the patient and modifying the environment so as to promote sleep. [C]
- Ensure that medication schedules do not interrupt sleep. [D]
- Diphenhydramine should be used with caution in older hospitalized persons and its routine use as a sleep aid should be avoided. [C]
- Use of anticholinergic medications should be kept to a minimum. [C]
- Restarting a formerly consumed sedative, hypnotic, or anxiolytic should be considered for a delirium that developed during or shortly after a withdrawal syndrome. [D]

#### Pharmacologic Management

#### General Principles

- Psychotropic medications should be reserved for older persons with delirium who are in distress owing to agitation or psychotic symptoms to carry out essential investigations or treatment, and/or to prevent older delirious persons from endangering themselves or others. [D]
- In the absence of psychotic symptoms causing distress to the patient, treatment of hypoactive delirium with psychotropic medications is not recommended at this time. Further study is needed. [D]
- The use of psychotropic medications for the specific purpose of controlling wandering in delirium is not recommended. [D]
- When using psychotropic medications, aim for monotherapy, the lowest effective dose, and tapering as soon as possible. [D]
- The titration, dosage, and tapering of the medication should be guided by close monitoring of the older person for evidence of efficacy of treatment and the development of adverse effects. [D]

#### Antipsychotics

- Antipsychotics are the treatment of choice to manage the symptoms of delirium (with the exception of alcohol or benzodiazepine withdrawal delirium. [B]
- High-potency antipsychotic medications are preferred over low-potency antipsychotics. [B]
- Haloperidol is suggested as the antipsychotic of choice based on the best available evidence to date. [B]
- Baseline electrocardiography is recommended prior to initiation of haloperidol. For prolongation of Q–Tc intervals to greater than 450 msec or greater than 25% over baseline electrocardiogram, consider cardiology consultation and antipsychotic medication discontinuation. [D]
- Initial dosages of haloperidol are in the range of 0.25 to 0.5 mg daily to twice daily. The dose can be titrated as needed, and severely agitated persons may require a higher dosage. [D]
- Benztropine should not be used prophylactically with haloperidol in the treatment of delirium. [D]
- Atypical antipsychotics may be considered as alternative agents as they have lower rates of extrapyramidal signs. [B]
- In older people with delirium who also have Parkinson's disease or Lewy body dementia, atypical antipsychotics are preferred over typical antipsychotics. [D]
- Droperidol is not recommended in the elderly. [D]
- Benzodiazepines
- Benzodiazepines as monotherapy are reserved for older persons with delirium caused by withdrawal from alcohol/sedative-hypnotics. [B]
- As benzodiazepines can exacerbate delirium, their use in other forms of delirium should be avoided. [D]

#### Management of Alcohol Withdrawal Delirium

- Sedative-hypnotic agents are recommended as the primary agents for managing alcohol withdrawal delirium (AWD). [B]
- Shorter-acting benzodiazepines such as lorazepam are the agents of choice in the elderly. [B]
- Antipsychotics may be added to benzodiazepines if agitation, perceptual disturbances, or disturbed thinking cannot be adequately controlled with benzodiazepines alone. [D]
- Antipsychotics may be considered when other medical causes of delirium complicate AWD. [D]
- The dosage of medication should be individualized with light somnolence as the usual therapeutic end point. [D]
- Older persons should be frequently reevaluated for the control of symptoms and the development of excessive sedation. [D]
- Benzodiazepines should be tapered following AWD rather than abruptly discontinued. [D]
- Parenteral administration of thiamine is recommended to prevent or treat Wernicke encephalopathy or Wernicke-Korsakoff syndrome. [D]
- Older persons with alcohol withdrawal are best treated in closely supervised settings. [D]

#### Ethical Issues

Capacity

As delirium can impair capacity, older persons with delirium who are

being asked to provide consent for treatment require a review to ensure that they have the capacity to provide informed consent. [C]

- Clinicians should be familiar with relevant provincial legislation regarding capacity (including capacity to consent to treatment) and the identification of a substitute decision maker if the older person is deemed to lack capacity. Capacity assessments must elicit sufficient information to allow for the determination of the older person's capacity as defined by the appropriate provincial legislation. [D]
- Measures of neurocognitive functions known to underlie capacity (i.e., attention, language, verbal learning/memory, and higher-order cognitive functions) should be included as part of an in-depth assessment. [C]
- It is recommended that brief measures of neurocognitive functions (e.g., Mini-Mental Status Examination) be supplemented by other cognitive measures that also assess judgment and reasoning. [C]
- The clinician should strive to make the assessment as brief as possible while still obtaining the required information. [C]
- In view of the fluctuating nature of delirium, serial evaluations may be necessary as treatment decisions arise. [C]
- Screening for psychotic features relevant to decision-making capacity is recommended. [D]
- The use of a structured interview with known reliability and validity is recommended for the assessment of capacity when there is uncertainty. [D]
- The use of The MacArthur Competency Assessment Tool Treatment is recommended for the assessment of capacity to consent to treatment in cases where there is uncertainty. [D]
- The use of The MacArthur Competency Assessment Tool Clinical Research is recommended for the assessment of capacity to participate in research in cases in which there is uncertainty. [D]
- If uncertainty regarding capacity persists after the clinician in charge has assessed the older person, neuropsychological consultation is recommended. [C]

#### Physical Restraints

- Avoidance of physical restraints is an important component of interdisciplinary interventions to prevent the development of delirium in an older person. [A]
- Physical restraints for older persons suffering from delirium should be applied only in exceptional circumstances. Specifically this is when (a) there is serious risk of bodily harm to self or others; or (b) other means for controlling behaviours leading to harm have been explored first, including pharmacologic treatments, but were ineffective; and (c) the potential benefits outweigh the potential risks of restraints. [D]
- The use of physical restraints to control wandering behaviour or to prevent falls is not justified. [D]
- The least restrictive physical restraint that is appropriate for the situation should be attempted first. [D]
- Frequent monitoring, reevaluation, and documentation are necessary to justify the continued use of physical restraints. Restraints should be applied for the least amount of time possible. Restraints should be discontinued when the harmful behaviour(s) is controlled, when there is a less restrictive alternative that becomes viable (e.g., a sitter for constant supervision), or when there are physical complications arising from the continued use of restraints. [D]

#### **Risk Assessment/Prevention**

- determine older person's premorbid status, determine presence of precipitating and predisposing factors for delirium, assess for prodromal symptoms
- mental status assessment: behaviour, affect, and cognition; assess for presence of delirium, depression, and/or dementia
- if delirious, determine subtype (i.e., hyperactive, hypoactive, mixed); consider specialist referral
- · assess capacity
- assess safety; if restraints required, use the least restrictive one consistent with ensuring safety

#### Establish Physiological Stability and Address Modifiable Risk Factors

- ensure cardiovascular stability, adequate oxygenation, and electrolyte balance
- maintain/restore hydration; monitor fluid intake and urinary output, elimination pattern, nutrition, and skin integrity; intervene as required
- identify/correct sensory deficits; provide hearing aids, pocket amplifier, and/or glasses
- assess and manage pain; support normal sleep pattern

#### Establish and Maintain Communication and Therapeutic Alliances

Provide Multicomponent Intervention

- 24-hour monitoring of mental status: behaviour, affect, and cognition; document and inform team members using care plan
- provide for safety: frequent observation; use least restrictive restraint possible and monitor if used
- use a calm, supportive approach to allay fear and foster trust
- use therapeutic communication with agitated /frightened older person with delirium; relate primarily to feeling expressed, not content
- avoid confrontation: use distraction/change subject; sustain the therapeutic relationship
- strive to have supportive interactions with older person
- use reorientation strategies/supports (e.g., clocks, calendars)
- · mobilize older person; promote meaningful activities to maintain functional abilities and self-esteem
- have consistency in staff providing patient care; avoid room transfers
- determine and support the older person's routines and encourage self-care
- involve family/friends to support the older person
- provide the older person and family with ongoing education about delirium
- · treat underlying predisposing/precipitating causes for the delirium
- · decide on need for pharmacotherapy of the symptoms of delirium and select agent/dosage if required

#### Environmental Considerations

- control/minimize noise to promote rest/normal sleep pattern; use calming music as appropriate
- provide appropriate lighting to reduce misinterpretations (e.g. reduce shadows) and promote sleep at night
- · family/friends to provide objects familiar to the older person to reduce disorientation

#### Evaluate Response to Management and Modify as Required

based on the monitoring of the older person's physiological condition/mental status, evaluate response to care provided and modify as indicated.

#### Figure 1. Delirium management flow chart.

#### Discussion

A few points require emphasis. The views or interests of the funding sources for the development and dissemination of these guidelines had no influence on the final recommendations. Many of the recommendations received C or D grades for their strength. These grades do not indicate the importance of the recommendations for clinical practice or quality of care. We view some of our recommendations with little empirical support as critical components to appropriate care. Certain aspects of care will never be subjected to placebo-controlled trials as it would be unethical to withhold from this vulnerable patient population what is now acknowledged as standard, effective care. An important limitation of these guidelines is that we did not assess the workflow and cost implications of our recommendations. Refer to Figure 1 for a summary of how we feel that these recommendations can be operationalized. Readers are encouraged to refer to the full text of the guidelines available at the CCSMH Web site (www.ccsmh.ca).

All health care providers require education on the assessment and management of delirium. Ongoing education on this topic must be provided in a format that will be sustainable in the work setting of practitioners. Families of older persons admitted to hospital should be educated about delirium. Attention must be paid to policy and organizational factors if the care of older persons is to improve. Critical organizational factors underpinning improvements include the Assessment and Treatment of Delirium

presence of clinical leadership, a willingness to adapt recommendations to local circumstances, and long-term organizational support.<sup>49</sup> Although strides have been made in our understanding of delirium, much remains to be done. Research is desperately needed on nearly all aspects of this condition.

#### Conclusion

Delirium is a medical emergency. Its occurrence is not an inevitable complication of illness in older persons. We can modify its incidence, and when it occurs we can provide competent, humane care.

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A full list of references used in the guideline may be found in the full text document: Canadian Coalition for Seniors' Mental Health (CCSMH). National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Delirium. Toronto: CCSMH; 2006. Available: http://www.ccsmh.ca.

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## National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression

Diane Buchanan, RN, DNSc, GNC(C); Marie-France Tourigny-Rivard, MD, FRCPC; Philippe Cappeliez, PhD; Chris Frank, MD, FCFP; Pronica Janikowski, R.Ph, BSc.Phm; CGP, Lily Spanjevic, RN, BScN, MN, CPMHN(C); GNC(C), Faith M. Malach, MHSc, MSW, RSW; Jennifer Mokry, MSW, RSW; Alastair Flint, MB, FRCPC, FRANZCP; Nathan Herrmann, MD, FRCPC

#### ABSTRACT

The aim of this guideline is to improve the assessment, treatment, and management of depression in older adults and to promote mental health through the provision of evidence-based recommendations. The initial sections address issues related to screening and assessing for depression and outline the various treatment approaches (i.e., psychotherapy and pharmacologic interventions) recommended, depending on the type of depression and degree of severity. The treatment modalities for depression are then presented in more detail, followed by recommendations for monitoring treatment. The final sections address issues related to education, special populations, and systems of care for depression in older adults.

Key words: depression, guidelines, elderly assessment, treatment

#### **Depression in Older Adults**

Late-life depression is a serious and growing mental health problem.<sup>1</sup> Prevalence studies based on structured or semi-structured interviews by British and American clinicians indicate the presence of substantial depressive symptomatology in 14.7 to 20% of elderly living in the community. In their respective studies, Copeland and colleagues reported an 11.5% presence of "diagnostic syndrome cases of depressive disorder" in Liverpool,<sup>2</sup> whereas Gurland and colleagues found 13% and 12.4% of "clinical (pervasive) depression" in London and New York community samples.3 Furthermore, Blazer and Williams reported a 14.7% presence of substantial depressive symptomatology (3.7% with major depression) in Durham County, U.S.<sup>4</sup> Studies based on diagnostic criteria, such as the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM),5 and interviews by trained interviewers identified a much lower percentage of cases (1% major depression and 2% dysthymia),<sup>67</sup> partly because depressions associated with physical disorders and those complicating bereavement were excluded. Even when lower estimates from these studies are used, a very significant number of elderly Canadians living in the community (over 100,000) have a depressive illness and an additional 400,000 live with substantial depressive symptoms that may benefit from treatment. Research has shown the rate of depression to be even higher in older adults within hospitals (21%8; range 12-45%9) and long-term care settings, where rates can be as high as 40%.<sup>10,11</sup> Depression is the most common mental

health problem for older adults and has profound negative impacts on all aspects of their life, not to mention the impact on family and the community. Despite its prevalence, depression should not be considered a normal part of aging. Common depressive symptoms, such as decreased energy and interest, poor sleep, and increasing preoccupations with health problems, should be viewed as possible symptoms of a treatable illness rather than inevitable changes of aging. However, conditions that are common with aging can be associated with or complicated by depression. These include dementia, stroke, and Parkinson's disease.

The identification and diagnosis of depression can be a challenge in all age groups but particularly in the elderly, leading to underdiagnosis or misdiagnosis. Common barriers to identification and assessment include communication limitations, such as hearing impairment, and the presence of dementia or cognitive impairment, which interferes with accurate reporting of depressive symptoms and their duration. Dementia, a common illness in this age group, may contribute to symptoms of depression but may also be mistaken for depression, particularly early in its course, when withdrawal from usual interests and apathy may be prominent. With the present cohort of elderly, other factors affecting presentation and diagnosis include greater social stigma of depression and poor understanding of normal aging changes versus illness. As such, older adults may be less likely to report depression or visit a physician for mood concerns. Given that depression affects bodily functions (e.g., sleep, digestion) it is often

Diane Buchanan, RN, DNSc, GNC(C): Assistant Professor, School of Nursing, Queen's University, Kingston, ON; Marie-France Tourigny-Rivard, MD, FRCPC: Professor and Chief of the Geriatric Psychiatry Division, Department of Psychiatry, University of Ottawa; Clinical Director, Geriatric Psychiatry Program, Royal Ottawa Hospital, Ottawa, ON; Philippe Cappeliez, PhD: Professor, School of Psychology, University of Ottawa, ON; Chris Frank, MD, FCP: Care of the Elderly, Assistant Professor, Department of Medicine, Queen's University, Kingston, ON; Pronica Janikowski, R.A.P. BSC.Phm; CGP. Certified Geriatric Pharmacist, Long Term Care Facility Consultant, Picton Clinic Pharmacy, Picton, ON; Lify Spanjevic, RN, BSCN, MN, CPMHNIC): Advanced Practice Leader–Geriatric Rehabilitation Program, Toronto Rehabilitation Institute, Toronto, ON; Adjunct Professor, Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, ON; Adjunct Professor, Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, ON; Adjunct Professor, Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, ON; Adjunct Professor, Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, ON; Adjunct Professor of Psychiatry, University of Toronto, Toronto, ON; Adjunct Professor of Psychiatry, University of Toronto, Ontario); Alastair Flint, MB, FRCPC, FRANZCP. Professor of Psychiatry, University of Toronto, Toronto, ON; and Nathan Herrmann, MD, FRCPC: Head, Division of Geriatric Psychiatry, Sunnybrook Health Sciences Centre; Professor of Psychiatry, University of Toronto, Toronto, ON Address for correspondence: Diane Buchanan: Assistant Professor, School of Nursing, Queens University, 92 Barrie Street, Kingston ON, K7L 3N6 Conflict of Interest: Details available from the CCSMH. Please contact 416-785-2500, ext. 6331 Can J Geriatr 2006;9(Suppl 2):552–58.

difficult to sort out whether these physical changes are due to depression or concurrent medical illnesses that are prevalent in the elderly.

There are huge personal, social, and economic costs associated with depression in the elderly. Depression late in life is associated with significant functional decline, family stress, greater risk of medical illness, reduced recovery from illness, and premature death from suicide or other causes.<sup>12-14</sup> Older patients with depression may become functionally impaired and require placement when the level of assistance they require exceeds the capacity of their formal and informal caregivers in the community. Depression often interferes with recovery from common medical problems of old age (e.g., stroke), and efforts to physically rehabilitate depressed people are often thwarted by low motivation and participation, leading to poor outcomes.

It is important that clinicians be aware of the prevalence of depression, the challenges of diagnosis, and the complexity of caring for older adults, who are often also medically ill. However, it is also vital that clinicians realize that depression in the elderly is treatable and that treatment can result in major functional, social, and health gains.

#### **Depression Guideline Development: Method**

A strategic and comprehensive guideline and literature review on the assessment and treatment of depression in older adults was completed. 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 Canadian Coalition for Seniors' Mental Health (CCSMH) staff. The search strategy was guided by inclusion criteria that specified English-language references only, references that specifically addressed depression, no dissertations, inclusion of guidelines, meta-analyses and reviews dated January 1995 to May 2005, and research articles dated January 1999 to June 2005.

The initial search for existing evidence-based summaries (e.g., guidelines, protocols) examined several major databases, specifically, Medline, EMBASE, PsycINFO, CINAHL, AgeLine, and the Cochrane Library. The following search terms were used: *depression, major depression, depressive disorder, bipolar disorder, elderly, older adult, aged, geriatric, depression guideline(s), elderly depression guideline(s), practice guideline(s) depression, practice guideline(s) older adults depression, protocol(s) depression, clinical pathways, clinical practice guideline(s), and clinical guideline(s)*. In addition, a list of Web sites was compiled based on known evidence-based practice Web sites, known guideline developers, and recommendations from Guideline Development Group members. The search results and dates were noted.

This search yielded 24 potentially relevant guidelines. These were further considered by the Guideline Development Group as to whether they addressed the guideline topic specifically and were accessible online, 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 (AGREE) instrument,<sup>15</sup> seven guidelines<sup>16-22</sup> were selected and obtained for inclusion as the literature base for the project.

The time frame (1999–2005) for the supplemental research literature search was selected in consideration of the publication dates of the relevant guidelines as it was assumed that these guidelines, collectively, could be relied on as acceptable sources of the literature.

Searches were conducted separately for each database (Medline, PsycINFO, HealthStar, Embase, CINAHL, Cochrane Library), with necessary variance in controlled vocabulary (i.e., minor differences in search terms as proscribed by each database). The core search strategy for all databases was to limit it to articles dealing with humans and written in English. The key words used in all of the literature searches were endogenous depression, reactive depression, spreading depression, recurrent depression, involutional depression, anaclitic depression, treatment-resistant depression, depression, major depression, depressive disorder, bipolar disorder, affective disorder, evidence-based practice, best practice, meta-analysis, systematic review, empirical studies, clinical trial(s), interdisciplinary treatment approach, care plan, medical diagnosis, diagnosis, therapy, treatment, prevention, rehabilitation, drug therapy, professional practice, research based, geriatric, aged, and elderly.

This process yielded over 200 citations. The abstracts were circulated to the Guideline Development Group co-leads, and 149 recent research articles were selected. Full-text articles were obtained and disseminated to guideline 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.

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, which 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.

#### Results

A full text of the guidelines may be downloaded for free from the CCSMH Web site (www.ccsmh.ca). Readers are encouraged to treat the present summary as a companion document to the full guideline. Readers are strongly discouraged from solely reading this document to the exclusion of the complete guideline. The summary of recommendations for each major section of the guideline is provided in Tables 1 to 8.

#### Screening and Assessment

Although access to specialized geriatric mental health services remains limited in many parts of the country and in long-term care settings, family physicians and primary care practitioners are able to provide appropriate follow-up and effective treatment for a large proportion of depressed older patients, either on their own or with the assistance of various mental health professionals in their communities (e.g., psychologists, general psychiatrists). Clinicians often screen for the presence of a mood or adjustment disorder when they are aware of a precipitating event or recent loss. However, a complex array of physical, psychological, and social factors increase the risk of depression in old age.

When patients have a positive screen or when clinicians suspect depression based on presentation, patient self-report, or family concerns, a more comprehensive assessment is in order. A sound understanding of the criteria for depression and knowledge of presentation in older patients are keys for the assessment.

## Table 1. Recommendations: Screening andAssessments

#### **Risk Factors**

- Health care providers should be familiar with the physical, psychological, and social risk factors for depressive disorders in older adults and include a screening for depression for their clients/patients who present with some of these risk factors. [D]
- We recommend targeted screening of those elderly at higher risk of depression owing to the following situations:
  - Recently bereaved with unusual symptoms (e.g., active suicidal ideation, guilt not related to the deceased, psychomotor retardation, mood congruent delusions, marked functional impairment after 2 months of the loss, reaction that seems out of proportion to the loss)
  - Bereaved individuals 3 to 6 months after the loss
  - Socially isolated
  - Persistent complaints of memory difficulties
  - Chronic disabling illness
  - Recent major physical illness (e.g., within 3 months)
  - Persistent sleep difficulties
  - Significant somatic concerns or recent-onset anxiety
  - Refusal to eat or neglect of personal care
  - Recurrent or prolonged hospitalization
  - Diagnosis of dementia, Parkinson's disease, or stroke
  - Recent placement in a nursing/LTC home [B]

#### Screening and Screening Tools

- Health care providers should have knowledge and skills in the application of age-appropriate screening and assessment tools for depression in older adults. [D]
- In hospital settings, we recommend screening high-risk elderly on intake or as soon as the acute condition has stabilized. [D]

- Appropriate depression screening tools for elderly persons without significant cognitive impairment in general medical or geriatric settings include the self-rating Geriatric Depression Scale (GDS), the SELFCARE self-rating scale, and the Brief Assessment Schedule Depression Cards (BASDEC) for hospitalized patients. [B]
- For patients with moderate to severe cognitive impairment, an observerrated instrument, such as the Cornell Scale for Depression in Dementia, is recommended instead of the GDS. [B]

#### Further Assessment

- Following a positive screen for depression, a complete biopsychosocial assessment should be conducted, including
  - A review of diagnostic criteria outlined in DSM-IV-TR or ICD-10 diagnostic manuals
  - An estimate of severity, including the presence of psychotic or catatonic symptoms
  - Risk assessment for suicide
  - · Personal and family history of mood disorder
  - Review of medication and substance use
  - Review of current stresses and life situation
  - Level of functioning and/or disability
  - · Family situation, social integration/support, and personal strengths
  - Mental status examination, including assessment of cognitive functions
  - Physical examination and laboratory investigations looking for evidence of medical problems that could contribute to or mimic depressive symptoms [D]
- LTC homes' assessment protocols should specify that screening for depressive and behavioural symptoms will occur in the early postadmission phase and subsequently, at regular intervals, as well as in response to significant change. [D]

#### Suicide

Clinicians should always assess the risk of suicide in patients with suspected depression by directly asking patients about suicidal ideation, intent, and plan. Those at high risk of suicide should be referred to a specialized mental health professional and/or service as a priority for further assessment, treatment, and suicide prevention strategies. [D]

DSM-IV-TR = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision; ICD-10 = International Classification of Diseases, 10th Revision; LTC = long-term care.

#### **Treatment of Depression**

The recommendations and discussion of treatment options are divided into the following sections:

- *Treatment Options for Type and Severity of Depression* (see Table 2). This section focuses on how diagnosis influences the choice of treatment.
- *Psychotherapies and Psychosocial Interventions* (see Table 3). This section reviews the non-pharmacologic interventions.
- *Pharmacologic Treatment* (see Table 4). This section reviews the pharmacologic treatment while considering that for the majority of persons who have depression, a combination of biological, psychological, and social interventions should be considered
- Monitoring and Long Term Treatment (see Table 5)

#### Treatment Options for Type and Severity of Depression

Given that several treatment modalities have proven efficacy for depression, it may be difficult to decide which treatment(s) will best meet the needs of a specific individual with depression. Individual preferences, previous response to treatment, and accessibility of services need to be considered in the elaboration of the treatment plan.

#### Psychotherapies and Psychosocial Interventions

To date, Cognitive Behavioural Therapy (CBT) has been the most studied form of psychotherapy in terms of efficacy in the treatment of depression in older adults.<sup>23</sup> Trials have focused mainly on major depression, with research on dysthymia and minor depression lagging behind. Samples in existing studies are predominantly composed of white, relatively young (60–75 years), mostly middle– and higher–socioeconomic status participants. Studies on the use of psychotherapy for depressed older adults who have medical or other psychiatric conditions, cognitive impairments, or disabilities are either too small in scale or have not been conducted. This also applies to older adults from low-income minorities and in rural areas.

#### Pharmacological Treatment

The pharmacologic treatment of depressed elderly is part of an overall treatment approach involving social/environmental and psychological

## Table 2. Recommendations: Treatment Options forType and Severity of Depression

#### Adjustment Disorder with Depressed Mood

 We recommend initial treatment with supportive psychosocial interventions or psychotherapy. If symptoms become severe enough to meet DSM-IV diagnostic criteria for a depressive disorder or persist after resolution of the stressor, more specific therapies in keeping with the revised diagnosis should be considered (e.g., medication, more intensive/specific psychotherapy). [D]

#### Minor Depressive Disorder

- Patients with minor depression of less than 4 weeks' duration should be treated with supportive psychotherapy or psychosocial interventions. [D]
- Pharmacologic treatment or evidence-based psychotherapy should be considered if symptoms persist for more than 4 weeks after psychosocial interventions have been initiated. [D]

#### Dysthymic Disorder

- Patients with dysthymic disorder should be treated with pharmacologic therapy, with or without psychotherapy, with periodic reassessment to measure response. [B]
- In specific clinical situations, for example, when patients do not wish to take antidepressants, psychotherapy may be used alone with periodic reassessment to measure response. [D]

#### Major Depressive Disorder, Single or Recurrent Episode— Mild to Moderate Severity

 Mild or moderate unipolar major depression should be treated pharmacologically using antidepressants or with psychotherapy or a combination of both. [A]

#### Major Depressive Disorder, Single or Recurrent Episode— Severe but Without Psychosis

- Patients with severe unipolar depression should be offered a combination of antidepressants and concurrent psychotherapy when appropriate services are available and there is no contraindication to either treatment. [D]
- ECT should be considered if adequate trials of antidepressants combined with psychotherapy have been ineffective or if the health of the patient is deteriorating rapidly owing to depression. [D]

#### Major Depressive Disorder, Single or Recurrent Episode— Severe with Psychotic Features

If there is no specific contraindication to its use, patients with psychotic depression should be offered treatment with ECT when available. Alternatively, a combination of antidepressant plus antipsychotic medication should be used. If this combination is not effective (e.g., poorly tolerated, no improvement in at least some of the symptoms within 4–8 weeks of treatment, or lack of remission despite optimization of dose and duration of treatment over more than 8–12 weeks), ECT needs to be offered. ECT should also be considered if severe health consequences (e.g., suicide, metabolic derangement) are imminent because pharmacologic treatment has been poorly tolerated or would be too slow to provide needed improvements. [D]

#### Referrals for Psychiatric Care at Time of Diagnosis

Clinicians should refer patients with the following to available psychiatry services:

- Psychotic depression
- Bipolar disorder
- Depression with suicidal ideation or intent

Additionally, patients with the following conditions may benefit from such referral:

- Depression with co-morbid substance abuse
- Major depressive episode, severe
- Depression with co-morbid dementia [D]

 $\mathsf{DSM}\text{-}\mathsf{IV}=\mathsf{Diagnostic}$  and Statistical Manual of Mental Disorders, Fourth Edition;  $\mathsf{ECT}=\mathsf{electroconvulsive}$  therapy.

#### Table 3. Recommendations: Psychotherapies and Psychosocial Interventions

- Supportive care should be offered to all patients with depression. [B]
- Evidence-based psychotherapies recommended for geriatric depression include behaviour therapy; cognitive-behaviour therapy; problem-solving therapy; brief dynamic therapy; interpersonal therapy; and reminiscence therapy. [A]
- Psychotherapy and/or psychosocial interventions should be available to patients with dysthymic disorder, minor depression, or depressive symptoms of normal grief reactions during bereavement. [B]
- Psychotherapy should be available to patients suffering from major depression, either alone as first-line treatment or in combination with antidepressant medication, for individuals who prefer this treatment modality and are able to safely participate in treatment (e.g., no severe cognitive impairment, no psychotic symptoms). [A]
- Psychotherapy in combination with antidepressant medication should be available to patients with severe major depression or chronic or recurrent depression. [A]
- At least one form of psychosocial intervention should be offered to the patient depending on the patient's needs and preferences and available resources. These interventions should be delivered by professionals who have had some training in the provision of geriatric care. [C]
- Psychotherapies should be delivered by trained mental health professionals. It is recommended that health care teams and professionals treating elderly depressed patients have access to personnel with training and competence in delivering psychotherapies that have demonstrated efficacy. When psychotherapy is not available, supportive care should be offered and other psychosocial interventions should be considered. [D]

modalities to address all of the modifiable contributing factors of an individual's depression as identified through a thorough initial assessment. Therefore, health professionals must be aware of and be prepared to offer or access different pharmacologic and nonpharmacologic care strategies for depressed individuals. The majority of studies on antidepressant medications have been conducted with younger populations, but there is a growing body of research specifically about older patients. It should be noted that subjects who participate in studies of antidepressant efficacy may not be representative of patients seen in clinical practice.24 The generalizability of results from clinical trials to the older adult population at large is further impaired by the under-representation of older participants in research with mixed-age adult samples. The pharmacologic treatment entails not only selection of the appropriate pharmacologic treatment but also the monitoring for side effects and drug interactions, which may be more challenging with the older population. Other key aspects of this treatment are the initial dose titration and the frequency of monitoring (see Table 5).

#### Monitoring and Long Term Treatment

Although depression studies have traditionally focused on measuring improvement in symptoms (e.g., 50% reduction on the Hamilton Depression Rating Scale scores), there is now an increasing emphasis on targeting remission of depressive symptoms as the most appropriate goal of therapy. Remission is an important target for both the acute and maintenance phases of treatment as residual symptoms increase the rate of relapse, recurrence, suicide, and the degree of chronicity and is associated with poor quality of life and greater health services use. Thus, monitoring has come to include not only

#### Table 4. Recommendations: Pharmacologic Treatment

#### Selecting an Appropriate Antidepressant

- Older patients have a response rate with antidepressant therapy similar to that of younger adults. Clinicians should approach elderly depressed individuals with therapeutic optimism. [A]
- Antidepressants should be used when indicated, even in patients with multiple co-morbidities and serious illnesses, as they have similar efficacy rates compared with use in well elderly. Adverse events in patients with multiple co-morbidities can be minimized by careful selection of drugs that are not likely to worsen or complicate patient-specific medical problems. [B]
- Co-morbid psychiatric disorders, particularly generalized anxiety disorders and substance abuse, should be identified and appropriately treated as they will adversely influence the outcome of depression. In cases in which benzodiazepines must be used to prevent acute withdrawal or as a temporary measure until antidepressants or psychotherapeutic interventions take effect, there should be a review and gradual discontinuation when feasible. Clinicians should avoid the use of benzodiazepines for treatment of depressive symptoms with elderly patients. [B]

#### Monitoring for Side Effects and Drug Interactions

- Clinicians should choose an antidepressant with the lowest risk of drugdrug interactions when patients are taking multiple medications. Good choices include citalopram, sertraline, venlafaxine, bupropion, and mirtazapine. [C]
- We recommend that physicians and pharmacists consult up-to-date drug interaction databases when a new antidepressant is prescribed to patients taking multiple medications. [C]
- When choosing agents from a specific class, clinicians should select those found to be safer with the elderly (e.g., selecting drugs with the lowest anticholinergic properties among available antidepressants). [D]
- When starting antidepressant therapy (e.g., SSRI or venlafaxine), clinicians should monitor for serotonin-related side effects (such as agitation) and for short-term worsening of symptoms. [B]
- When initiating any antidepressant, we recommend monitoring for suicidal ideation and risk. [C]
- TCAs should not be used in patients with conduction abnormalities on electrocardiogram or postural hypotension. [B]
- If TCAs are used, clinicians should monitor for postural hypotension, cardiac symptoms, and anticholinergic side effects and blood levels. [D]
- We recommend checking sodium blood levels after 1 month of treatment with SSRIs, especially with patients taking other medications that can

cause hyponatremia (e.g., diuretics). [C]

 We recommend checking sodium levels before switching to another agent owing to poor response or tolerance or when patients display symptoms of hyponatremia (e.g., fatigue, malaise, delirium). [C]

#### Titration and Duration of Therapy

- When starting antidepressants, patients should be seen at weekly intervals for several weeks to assess response and side effects and to titrate the dose. Visits should include, at a minimum, supportive psychosocial interventions and monitoring for worsening of depression, agitation, and suicide risk. [D]
- Clinicians should start at half of the recommended dose for younger adults but aim at reaching an average dose within 1 month if the medication is well tolerated at weekly reassessments. If there is no sign of improvement after at least 2 weeks on an average dose, further gradual increases are recommended until there is some clinical improvement, limiting side effects, or one has reached the maximum recommended dose. [D]
- Before considering a change in medication, it is important to ensure an adequate trial. Change should be made if there is no improvement in symptoms after at least 4 weeks at the maximum tolerated or recommended dose or there is insufficient improvement after 8 weeks at the maximum tolerated or recommended dose. [C]
- When significant improvement has occurred but recovery is not complete after an adequate trial, the clinician should consider the following:
  - A further 4 weeks of treatment with or without augmentation with another antidepressant or lithium or specific psychotherapy (e.g., IPT, CBT, problem solving)
  - A switch to another antidepressant (same or another class) after discussing with the patient the potential risk of losing any significant improvements made with the first treatment. [C]
- Augmentation strategies require supervision by experienced physicians.
   [D]
- When switching agents, it is generally safe to reduce the current medication while starting low doses of the alternate agent. Specific drug interaction profiles need to be checked for both drugs involved during this overlap since antidepressants commonly interact with each other. [C]
- Given its long half-life and risk of interaction with many of the drugs prescribed for the elderly, we do not recommend the use of fluoxetine as first-line treatment despite its documented efficacy. [C]
- Antidepressants, especially SSRIs, should not be abruptly discontinued but should be tapered off over a 7- to 10-day period when possible. [C]

CBT = Cognitive Behavioral Therapy; IPT = Inter Personal Therapy; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant.

monitoring after the initial response to therapy but also considering the factors that might influence remission and relapse and the duration of needed treatment.

#### **Education and Prevention**

As the number of people in Canada over the age of 65 years continues to climb, there is an increased need for health care professionals who have specialized gerontological/geriatric preparation. Education needs to be available in a variety of forms to increase not only the health care professional's knowledge of depression and available treatment options but also their ability to seek and find the necessary assistance and advocate for patients' needs (Table 6). The patient-professional relationship is an important factor in achieving better patient participation in care. Recent research demonstrates that improving systems of care for longitudinal management can result in important improvements in patient outcomes. This would entail the education of health care professionals, as well as older adults, their caregivers, and the public.

#### **Special Populations**

The section referred to in Table 7 acknowledges that there are some older adult populations for whom we need to have special considerations when treating for depression. These groups also tend to be the ones for whom there is less research guiding best practice.

#### Systems of Care

Systems of care are defined as an organized grouping of health care networks working in collaboration to provide treatment for older adults with depression. Systems of care for the mental health of older adults have been changing, and there is increased research in this area

## Table 5. Recommendations: Monitoring and Long-TermTreatment

- Health care providers should monitor the older adult for recurrence of depression for the first 2 years after treatment. Ongoing monitoring should focus on depressive symptoms that were present during the initial (index) episode. [B]
- Assistance from specialists may be required for the long-term treatment
  of patients with severe symptoms affecting function and overall health,
  psychotic depression, depression with active suicidal ideation, depression
  with bipolar disorder, and depression that has not responded to
  treatment trials. [D]
- Older patients who achieve remission of symptoms following treatment of their first episode of depression should be treated for a minimum of 1 year (and up to 2 years) with their full therapeutic dose. [B]
- When discontinuing antidepressant treatment after remission of symptoms, we recommend a slow taper over months, monitoring closely for recurrence of symptoms and resuming the full therapeutic dose if there is any sign of relapse or recurrence. [D]
- An evidence-based psychotherapy represents a treatment option for patients who present with relapse and incomplete remission. [B]
- Older patients with partial resolution of symptoms should receive indefinite maintenance therapy and ongoing efforts at a complete resolution of symptoms through the use of augmentation or combination strategies, as well as consideration for ECT. [B]
- Older patients who have had more than two depressive episodes, had particularly severe or difficult-to-treat depressions, or required ECT should continue to take antidepressant maintenance treatment indefinitely unless there is a specific contraindication to its use. [D]
- For those patients who fail to remain well with traditional maintenance therapy but have responded well to ECT, maintenance ECT may be a useful option. [D]
- In long-term care homes, the response to antidepressant therapy should be evaluated monthly after initial improvement and at quarterly care conferences, as well as at the annual assessment after remission of symptoms. A decision to continue or discontinue the antidepressant therapy should be based on whether the depression has been treated long enough to allow sustained remission of symptoms (e.g., now 1 year of full remission) or whether the treatment is still tolerated well in the context of their health problems and the risks of discontinuation (i.e., return of original depressive symptoms) are less than those associated with continuation of medication. [D]

ECT = electroconvulsive therapy.

#### Table 6. Recommendations: Education and Prevention

- Specialized content in regard to assessment and treatment of depression in older adults should be included as part of the basic education and continuing education programs of all health care professionals. [D]
- Specific training on geriatric mental health issues should be provided for personnel caring for depressed older adults. [D]
- Health care professionals should provide older depressed adults with education regarding the nature of depression; its biological, psychological, and social aspects; effective coping strategies; and lifestyle changes that will assist their recovery while being mindful of the individual's stresses and strengths. [B]
- Families of depressed older adults should be provided with information regarding the signs and symptoms of depression, attitudes and behaviours of the depressed person and their own reaction to them, and depression coping strategies, as well as available treatment options and the benefits of treatment. [D]
- Public education efforts should focus on the prevention of depression and suicide in older adults. [D]

#### **Table 7. Recommendation: Special Populations**

#### Bipolar Disorder

- Elderly individuals who present with manic or hypomanic symptoms for the first time after age 65 years need a thorough assessment for possible underlying medical causes. [C]
- A mood stabilizer (e.g., lithium) should be the first-line treatment of bipolar disorder. When depressive episodes occur despite previous stabilization with a mood stabilizer, an antidepressant medication needs to be added. [B]
- The choice of mood stabilizer should be based on the previous response to treatment, type of illness (e.g., rapid cycling or not), medical contraindications to the use of specific mood stabilizers (i.e., side effects that could worsen pre-existing medical problems), and potential interactions with other drugs required by the patient. [C]
- All mood stabilizers require monitoring over time for possible short-term and longer-term adverse events. [B]

#### Dementia

- Patients who have mild depressive symptoms or symptoms of short duration should be treated with psychosocial supportive interventions first. [D]
- Pharmacologic treatment is recommended for patients who have major depression coexisting with dementia. [B]
- In selecting pharmacologic treatment for depression with dementia, clinicians should select drugs that have low anticholinergic properties, such as citalopram and escitalopram, sertraline, moclobemide, venlafaxine, or bupropion. [C]
- Psychosocial treatment should be part of the treatment of depression coexisting with dementia. This treatment should be flexible to account for the decline in functioning as well as multifaceted to provide help with the diversity of problems facing the patient and caregiver. It should be delivered by clinicians sensitized to the vulnerabilities and frailties of older adults with dementia. This treatment should include helping caregivers deal with the disease in a skill-oriented manner. [A]
- For patients who have psychotic depression and dementia, a combination
  of antidepressant and antipsychotic medication is usually the first choice,
  although electroconvulsive therapy may be used if medications are
  ineffective or a rapid response is required to maintain safety. [D]

#### Vascular Depression

- Patients who have had strokes should be monitored closely for the possible development of depression as a common complication of stroke, even in those who do not report depressed mood. [B]
- Patients who have depression following single or multiple cerebral vascular injuries should be treated following the guidelines outlined in Section 8.3, Vascular Depression, of the guideline, taking care not to worsen their ongoing vascular risk factors. [D]

#### Table 8. Recommendation: Systems of Care

- Health care professionals and organizations should implement a system
  of care that addresses the physical/functional and the psychosocial needs
  of older depressed adults. Given the complex care needs of older adults,
  these are most likely to require interdisciplinary involvement in care,
  whether in primary care or specialized mental health settings. [B]
- Health care professionals and organizations should implement a model of care that promotes continuity of care as older adults appear to respond better to consistent primary care providers. [B]

that supports providing coordinated care for those with depression in the various community and in-patient settings. However, the literature is minimal in regard to demonstrating the care of the depressed older adult across the continuum in an integrated health care system. This section of the guidelines addresses some of the recent attempts made to address the best possible systems of care (see Table 8). It is recognized that not all treatment options are consistently available across the country.

#### Conclusion

The guidelines on depression in older adults were written from an interdisciplinary perspective for health care professionals working with depressed older adults in any setting (e.g., rural or urban, home, or institution) across Canada. Specifically, these guidelines aim to offer guidance to primary care providers and health care teams working with older adults. The guidelines begin with a focus on screening and assessment and the types of depression diagnoses seen in older adults. Based on available research evidence of efficacy, assistance is then provided on the selection of intervention strategies with respect to psychotherapies and other psychosocial interventions and pharmacologic treatments. The guidelines include several sections that need to be addressed to successfully help those with depression, namely, the importance of ongoing monitoring and treatment for depression, issues of concern regarding special populations, education, and systems of care.

These guidelines bring together the evidence available to date. However, it is recognized that although the body of research on depression in older adults is steadily increasing, there are still many areas in which the more controlled levels of research (i.e., categories of evidence Ia-II) are lacking. In those instances, we had to rely on more descriptive, case study and qualitative research (category of evidence III) and on expert opinions (category of evidence IV) from the developers of these guidelines themselves, from colleagues and stakeholders, and from other published guidelines.

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A full list of the references used in the guideline may be found with the full-text document: Canadian Coalition for Seniors' Mental Health (CCSMH). National Guidelines for Seniors' Mental Health: The Assessment of Depression. Toronto: CCSMH; 2006. Available: www.ccsmh.ca.

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### National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Mental Health Issues in Long-Term Care Homes (Focus on Mood and Behaviour Symptoms)

David K. Conn, MB, BCh, BAO, FRCPC; Maggie Gibson, PhD, C.Psych; Sid Feldman, MD CCFP, FCFP; Sandi Hirst, RN, BScN, MSc(Ned), PhD, GNC(C); Sandra Leung, BSCPharm, FASCP; Penny MacCourt, MSW, PhD; Kathy McGilton, BScN, MSc, PhD; Ljiljana Mihic, MA, PhD Candidate; Faith M. Malach, MHSc, MSW, RSW; Jennifer Mokry, MSW, RSW

#### ABSTRACT

Canadian Guidelines focusing on the Assessment and Treatment of Mental Health Issues in Long-Term Care Homes were released in May 2006. This article provides a summary of the recommendations. The prevalence of mental disorders in Long-Term Care Homes is high and there is limited availability of psychiatric and other mental health services in most facilities. Much of the care is provided by primary care physicians, personal support workers and a small number of registered nurses. The goal of these Guidelines is to provide attending staff and consultants with a comprehensive approach to the care of residents with mental illness. General care issues are highlighted, as optimal care can reduce the incidence of behavioral symptoms. Organizational issues such as the development of the environment as a therapeutic milieu and the need for staff training are also emphasized. Recommendations for the screening and assessment of residents with behavioural or depressive symptoms are provided. Management recommendations focus on appropriate investigations, a full array of non-pharmacological interventions and the benefits versus risks of specific groups of psychotropic medications. The Guidelines emphasize the need for ongoing monitoring and evaluation of therapeutic interventions, with periodic tapering or discontinuation when the resident is stable.

Key words: long-term care, nursing home, mental health, depression, behaviour

#### Scope of the Long-Term Care Guidelines

The Assessment and Treatment of Mental Health Issues in Long-Term Care Homes (Focus on Mood and Behaviour Symptoms) guideline is intended to promote mental health and address mental health problems (including mental disorders) in older residents of long-term care (LTC) homes. The specific focus is on depressive and behavioural symptoms.

Facilities that provide LTC for seniors across Canada vary widely in size, appearance, resources, and service models. It is beyond the scope of this project to examine this variability. What LTC homes have in common, however, is that they house combined accommodation and health services for individuals who are unable to manage in a less supportive physical and social environment. Reflecting this common purpose, there are several core assumptions that underpin these recommendations, including the following:

- 1. There is a need to focus on both mental health and mental illness in LTC homes.
- 2. There is significant diversity in the LTC population. Each resident deserves an individualized approach to care delivery.
- 3. Effective mental health management requires an interdisciplinary approach.
- 4. Relationships among residents, family members, and staff are central in meeting mental health needs.
- 5. The milieu (social and physical environment) can promote or undermine mental health.

Overarching principles that promote and support the mental health of all LTC residents, whether or not they have mental health problems or mental disorders, include facility-wide commitment to: individualized, person-centred care; respect for family ties; a biopsychosocial care planning framework; a culture of caring that prioritizes quality of life; a social and physical environment that is

David K. Conn, MB, BCh, BAO, FRCPC: Psychiatrist-in-Chief, Baycrest Geriatric Health Care System; Associate Professor, Department of Psychioly, University of Toronto; Co-Chair, Canadian Academy of Geriatric Psychiatry, Toronto, ON; *Maggie Gibson, PhD, C.Psych*: Psychologist, Veterans Care Program, St. Joseph's Health Care London; Associate Scientist, Lawson Health Research Institute; Adjunct Clinical Professor, Department of Psychology, University of Western Ontario, London, ON; *Sid Feldman, MD CCPF, FCFP*. Chief, Department of Family and Community Medicine, Baycrest Geriatric Health Care System; Associate Professor, and Director, Care of the Elderly Program, Department of Family and Community Medicine, Baycrest Geriatric Health Care System; Associate Professor, Faculty of Nursing, University of Calgary, Calgary, AB; Sandra Leung, BSCPharm, FASCP. Clinical Pharmacist, Behavioral Stabilization Unit and Mental Health, Capital Care Lynnwood, Edmonton, AB; Consultant Pharmacist, Community Care Services- Continuing Care Services, Capital Health, Edmonton, AB; Penny MacCourt, MSW, PhD: Post Doctoral Fellow, Centre on Aging, University of Victoria, Victoria, BC; Kathy McGilton, BScN, MSc. Scientist, Toronto Rehabilitation Institute; Affiliate Scientist, Kunin-Lunenfeld Applied Research Unit, Baycrest; Assistant Professor and co-investigator Nursing Effectiveness, Utilization, and Outcomes Research Unit, Faculty of Nursing, University of Toronto, ON; *Jiljana Mihic, MA, PhD Candidate*: Department of Psychology, University of Toronto, ON; *Health Policy, Maagement* and Evaluation, Faculty of Nursing, University of Social Work, University of Toronto, ON; *Health Policy, Maagement* and Evaluation, Faculty of Medicine, University of Toronto, ON; *Jaid Engine* Mokey, MSW. RSW: Project Manager, Canadian Coalition for Seniors' Mental Health, Toronto, ON; and Jennifer Mokry, MSW, RSW: Project Manager, Canadian Coalition for Seniors' Mental Health, Toronto, ON; and Jennifer Mokry, MSW. Roject Manager, Canadian Coalition for S

Address for correspondence: David Conn, MB, BCh, BAO, FRCPC, Baycrest, 3560 Bathurst St. Toronto ON M6A 2E1 Conflict of interest: Details available from the CCSMH. Please contact 416-785-2500, ext. 6331 *Can J Geriatr* 2006;9(Suppl 2):S59-64.

responsive to changing needs; a focus on early intervention and prevention as well as treatment; and staff training and development as necessary to enable the provision of informed and competent care.<sup>1-3</sup>

The LTC guideline provides recommendations to guide care for older adults living in LTC homes within two broad categories: (1) general care and (2) symptom and disorder management. The first category, general care, includes recommendations for delivering care to all LTC residents in a manner that will promote mental health. Under the second category, we provide recommendations for the assessment and treatment of depressive and behavioural symptoms and disorders. We also provide recommendations that apply to the broader context of care delivery, at the facility and system level. This supplement should be read in conjunction with the full-text document available at www.ccsmh.ca.

## Depressive and Behavioural Symptoms in LTC Residents

In recent decades as the elderly population in modern industrial countries has rapidly increased, the number of seniors receiving care in LTC homes has also increased dramatically. In Canada the actual number has risen from 203,000 in 1986 to 240,000 in 1996,<sup>4</sup> and this number is continuing to increase. By 2021, seniors will account for 18% of the population, for a total of 6.7 million people.<sup>5</sup> Projections for 2031 suggest that the number of LTC beds will triple or even quadruple. The population aged 85 years and over is growing at the fastest rate, and this is the group that is most likely to require LTC. According to Statistics Canada, in 1996 38% of all women aged 85 years and over lived in an institution compared with 24% of similarly aged men.<sup>6</sup> The literature suggests that there is an extremely high prevalence of mental disorders among nursing home residents. Recent studies using sophisticated methods report prevalence rates of between 80 and 90% (all disorders).<sup>7</sup>

Studies suggest that between 15 and 25% of nursing home residents have symptoms of major depression and another 25% have depressive symptoms of lesser severity.<sup>89</sup> The incidence of newly diagnosed depression has been estimated to be 12 to 14% per year, with about half of all new cases meeting the criteria for major depression. In addition, follow-up studies of residents with mild depression have shown that many are likely to become more significantly depressed over time. Studies also suggest that depression is associated with increased mortality rates in LTC, with a relative risk of between 1.5 and 3, compared with non-depressed patients.<sup>10</sup>

Individuals with dementia suffer from cognitive impairment, usually consisting of memory impairment and difficulty in at least one other cognitive area. In addition to memory disturbance, many residents with dementia also have behavioural symptoms, which include agitation, aggression, wandering, repetitive or bizarre behaviours, shouting, disinhibited behaviours, and sexually inappropriate behaviour. A review of the literature regarding the prevalence of the behavioural and psychological symptoms of dementia reported median figures of 44% for global agitation, 24% for verbal aggression, and 14% for physical aggression.<sup>11</sup> Note that delirium, a reversible condition that may present with behaviour symptoms such as acute confusion, agitation and/or withdrawal, and drowsiness, is also common in LTC residents. See the companion document, *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Delirium.*<sup>12</sup>

Despite the high prevalence of mental disorders, studies have demonstrated limited availability of psychiatric and mental health services for residents living in Canadian LTC homes.<sup>13,14</sup>

#### LTC Guideline Development: Method

A strategic and comprehensive review of the existing research literature on the assessment and management of mood and behaviour symptoms in LTC homes was completed. A computerized search for relevant evidence-based summaries, including guidelines, metaanalyses, and literature reviews, and research literature not contained in these source documents, was conducted by librarian consultants to the Guidelines Project and by the Canadian Coalition for Seniors' Mental Health (CCSMH). The inclusion criteria for the search strategy specified English-language references only and references that specifically addressed depressive and/or behaviour symptoms in LTC homes. Guidelines, meta-analyses, and reviews dated January 1995 to May 2005, and research articles dated January 2000 to June 2005 were included.

The initial search for existing evidence-based summaries examined several major databases, specifically, Medline, EMBASE, PsycINFO, CINAHL, AgeLine, and the Cochrane Library. The following search terms were used: long-term care, residential care institutions, nursing homes, homes for the aged, agitation, wandering, agitated behavior, bipolar disorder, depression, mood disorders, affective disorders, social behavior disorders, behavioral symptoms, dementia, delirium, disruptive behavior, elderly, older adult(s), aged, geriatric, guideline(s), practice guideline(s), practice guideline(s). In addition, a list of Web sites was compiled based on known evidence-based practice Web sites, known guideline developers, and recommendations from Guideline Development Group members.

This search yielded 26 potentially relevant guidelines. These were further considered by the Guideline Development Group co-leads as to whether they specifically addressed the guideline topic and were accessible either on-line, in the literature, or through contact with the developers. Through this process 10 guidelines were selected and obtained for inclusion in the literature base for the project.<sup>1,3,15-22</sup> In addition, the search yielded several key review articles.<sup>23-26</sup> The reference lists for these articles were hand-searched by members of the Guideline Development Group for relevant research articles. A supplemental literature search was also conducted. As the development of the guideline document progressed, additional literature (i.e., 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.

#### Recommendations

Often behaviours such as agitation, restlessness, aggression, and combativeness are an expression of unmet needs (e.g., hunger, thirst, pain, or toileting need). Care providers should try to identify when this is the case and intervene to prevent and minimize behavioural symptoms that are a reflection of unmet needs. At the same time, careful attention to assessing and understanding other factors that may be contributing to behavioural presentations (e.g., potential mental health problems and disorders, as well as other physical disorders and illnesses) is essential.

#### Table 1. Recommendations: General Care

#### Family Involvement

 Encourage and support the involvement and education of the family in the institutional life of the older resident, including decision-making processes, as appropriate. [C]

#### Care Plan

 Individualize care plans, with due consideration to best-practice guidelines and recommendations. [D]

#### Communication

 Implement strategies to promote communication between care providers and residents. [B]

#### Dressing

• Develop an individualized approach when assisting the resident with dressing. [B]

#### Bathing

 Develop an individualized protocol for each resident that minimizes negative affect and promotes a sense of well-being during bathing. [A]

#### Activities

• Consider the need to pace activities that residents are involved in throughout the day. [B]

#### Mealtime

 Consider the need to develop mealtime care-giving activities to enhance nutrition and prevent behaviours that interfere with nutritional and social needs.[D]

In the section on assessment, it is assumed that a facility adheres to an overarching assessment protocol that ensures compliance with both site-specific policies and statutory requirements. The recommendations outline the suggested components of the assessment protocol.

There are numerous tools available in the literature to assist the screening process, as detailed in the full guideline. Clinical situations may require, in addition to or in place of standardized scales, the use of customized behavioural observation techniques to adequately screen for atypical or complex behaviours.<sup>27,28</sup> The assessment protocol should include a triggering/decision-making algorithm to guide clinicians in determining when further detailed investigation is required.<sup>16,29</sup> Although behavioural observations, self-report data, concerns expressed by others, and psychometric data should direct the assessment focus, a high index of suspicion should be maintained to ensure that less obvious factors or diagnoses that are contributing to the precipitation, maintenance, and exacerbation of depressive and behavioural symptoms are not missed. Among the medical and psychological conditions and disorders that may need to be included in the detailed investigation are, for example, pain, delirium, sleep disorders, and suicide risk (refer to the National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide).30 The social factors and features of the physical environment that may need to be assessed include, for example, a change in the resident's social or family situation and factors in the physical environment, such as a change in room.1,16

Depressive and behavioural symptoms may reflect psychiatric diagnoses commonly seen in residents of LTC homes and/or medical diagnoses that are also common in this population. Assessment should be guided by awareness and understanding of relevant diagnostic

## Table 2. Recommendations: Assessment of Mental Health Problems and Mental Disorders

#### Screening

- The facility's assessment protocol should specify that screening for depressive and behavioural symptoms will occur in the early postadmission phase and subsequently, at regular intervals, as well as in response to significant change. [C]
- A variety of screening tools that are appropriate to the setting and resident population should be available to facilitate the screening process. [D]
- Tool selection should be determined by the characteristics of the situation (e.g., resident capacity for self-report, nature of the presenting problem). [D]
- Screening should trigger detailed investigation of depressive and behavioural symptoms under defined circumstances. [D]

#### Detailed Investigation

- Core elements of a detailed investigation should include a history and physical examination, with follow-up laboratory and psychological investigations, investigations of the social and physical environment, and diagnostic tests as indicated by the results of the history and physical examination, and treatment history and response. [C]
- It is important to consider all contributing factors. Investigation of potentially contributing factors (e.g., delirium, chronic pain) should refer to clinical practice guidelines for these conditions where available. [D]
- Diagnosis and differential diagnosis should be an assessment objective where appropriate. [D]
- The end point of a detailed investigation should be the determination of the need for, type, and intensity of treatment. [D]

#### **Ongoing Evaluation**

- The treatment plan should specify the timeline and procedure for ongoing evaluation of clinical outcomes and treatment effectiveness. [D]
- Ongoing evaluation should include a history and assessment of change in the target symptoms. [D]
- Assessment of change should include quantification, preferably with the same tool that was used pre-intervention. [D]
- Unexpected clinical outcomes and treatment effects should trigger reassessment and potentially reconceptualization of the factors precipitating, maintaining, and exacerbating depressive and behavioural symptoms. Potential adverse reactions to treatment should be evaluated. [D]

criteria.<sup>31</sup> The need for, type, and intensity of treatment are determined on the basis of consideration of all relevant assessment information, including medical and physical findings, psychosocial findings, ratings on validated scales, behavioural analysis, risk assessment, formal diagnosis where applicable, and the perspectives and wishes of individual residents and their families. Ongoing evaluation is essential in the LTC setting, given the frailty of the population, high prevalence of co-morbid conditions, and potential for rapid decline when symptoms escalate. As well, ongoing evaluation is essential to ensure that intervention objectives stay current with client-centred goals.

#### **Treatment of Depression**

It is always important to consider the potential benefit of both nonpharmacologic and pharmacologic interventions in the treatment of depressive symptoms and disorders. The psychological and social intervention recommendations provided in these guidelines are grouped based on the effects or goals they hope to achieve. This

## Table 3. Recommendations: Treatment of DepressiveSymptoms and Disorders

#### General Treatment Planning

• Consider the type and severity of depression in developing a treatment plan. [B]

#### Psychological and Social Interventions

- Social contact interventions, including interventions that promote one's sense of meaning, should be considered where the goal is to reduce depressive symptoms. [C]
- Structured recreational activities should be considered where the goal is to engage the resident. [C]
- Psychotherapies should be considered where the goal is to reduce depressive symptoms. [B]
- Self-affirming interventions (e.g., validation and reminiscence therapies) should be considered where the goal is to increase a sense of self-worth and overall well-being. [C]
- Consider the impact of co-morbid dementia in developing a treatment plan. [C]

#### Pharmacologic Interventions

- First-line treatment for residents who meet criteria for major depression should include an antidepressant. [A]
- Appropriate first-line antidepressants for long-term care home residents include selective serotonin reuptake inhibitors (e.g., citalopram and sertraline), venlafaxine, mirtazapine, and bupropion. [B]
- For residents with major depression with psychotic features, a combination of antidepressant and antipsychotic medications is appropriate. [B]
- Residents with a first episode of major depression responding well to antidepressant treatment should continue on full-dose treatment for at least 12 months. Residents who have had at least one previous episode of depression should continue with treatment for at least 2 years. [A]
- The treatment of depressed residents with a history of bipolar mood disorder should include a mood stabilizer such as lithium carbonate, divalproex sodium, or carbamazepine. [B]
- Residents with severe depression not responding to medications should be considered for a trial of electroconvulsive therapy. (These residents will likely require transfer to a psychiatric facility.) [B]
- Psychostimulants (e.g., methylphenidate) may have a role in treating certain symptoms that are commonly associated with depression (e.g., apathy, decreased energy). [C]

approach reflects recent understanding that "common factors" underlie various interventions, and a focus on these might be the best strategy for further development in this field.<sup>32</sup> Given the complexity and uniqueness of LTC settings, we have included interventions that would be delivered by mental health clinicians, as well as other care providers, family, and volunteers. LTC homes differ in their resources, and residents differ in the extent to which family and friends are available and willing to be involved in care. This section takes an aspirational approach to the task of identifying psychological and social interventions that can contribute to the treatment of depressive symptoms of residents in LTC homes, recognizing that the reality of what is available may differ.

The appropriateness and effectiveness of different interventions will vary for different stages in the progression of dementia, and individualized assessment and care planning informed by the

#### Table 4. Recommendations: Treatment of Behavioural Symptoms

#### **Psychological and Social Interventions**

- Social contact interventions should always be considered, especially where the goal is to minimize sensory deprivation and social isolation, provide distraction and physical contact, and induce relaxation. [C]
- Sensory/relaxation interventions (e.g., music, snoezelen, aromatherapy, bright light) should be considered where the goal is to reduce behavioural symptoms, stimulate the senses, and enhance relaxation.
   [B/D]
- Structured recreational activities should be considered where the goal is to engage the resident. [C]
- Individualized behaviour therapy should be considered where the goal is to manage behaviour symptoms (e.g., contextually inappropriate, disturbing, disruptive, or potentially harmful behaviours). [C]

#### Pharmacologic Interventions

- Carefully weigh the potential benefits of pharmacologic intervention versus the potential for harm. [A]
- Appropriate first-line pharmacologic treatment of residents with severe behavioural symptoms with psychotic features includes atypical antipsychotics. [B] Atypical antipsychotics should be used only if there is marked risk, disability, or suffering associated with the symptoms. [C]
- Appropriate first-line pharmacologic treatment of residents with severe behavioural symptoms without psychotic features can include (a) atypical antipsychotics [B] and (b) antidepressants such as trazodone or selective serotonin reuptake inhibitors (e.g., citalopram or sertraline) [C].
- Pharmacologic treatment of residents with severe behavioural symptoms can also include (a) anticonvulsants such as carbamazepine [B] and (b) short- or intermediate-acting benzodiazepines [C].
- Appropriate pharmacologic treatment of residents with severe sexual disinhibition can include (a) hormone therapy (e.g., medroxyprogesterone, cyproterone, leuprolide), (b) selective serotonin reuptake inhibitors, or (c) atypical antipsychotics. [D]
- Appropriate pharmacologic treatment of behavioural symptoms associated with frontotemporal dementia can include trazodone or selective serotonin reuptake inhibitors. [B]
- Appropriate pharmacologic treatment of residents with behavioural symptoms or psychosis associated with Parkinson's disease or dementia with Lewy bodies includes (a) cholinesterase inhibitors [B] or, as a last resort, (b) an atypical antipsychotic with less risk of exacerbating extrapyramidal symptoms (e.g., quetiapine) [C].
- Pharmacologic treatments for behavioural symptoms or psychosis associated with dementia should be evaluated for tapering or discontinuation on a regular basis (e.g., every 3–6 months). Ongoing monitoring for adverse effects should be undertaken. [A]

dementia care literature are essential.<sup>33</sup> The resident's capacity to understand and willingly engage in the intervention should be carefully considered to avoid unintended outcomes, such as increased agitation or distress.

Selection of an appropriate antidepressant medication for nursing home residents should be based on (a) the history and experience of the resident; (b) other medical co-morbidities; (c) side-effect profiles of the antidepressants; and (d) potential drug-drug interactions. It is important to obtain a history of bipolar illness as the treatment of bipolar depression will likely require the use of a mood stabilizer. Psychotic symptoms associated with depression rarely respond to antidepressant medication alone and usually require the addition of an antipsychotic medication. A full discussion of the pharmacologic management of depression can be found in the companion document, National Guidelines for Seniors' Mental Health: Assessment and Treatment of Depression.<sup>34</sup>

#### **Treatment of Behavioural Symptoms**

Psychological and social interventions should generally be used before initiating pharmacologic treatment; however, in urgent situations, or when symptoms are severe, it is appropriate to initiate pharmacologic and non-pharmacologic interventions together. Residents with moderately severe symptoms may also benefit from medication. The selection of specific behavioural interventions should be based on a solid behaviour analysis (e.g the ABC approach which tracks Antecedants, Behaviours and Consequences). Moreover, it is important to note that the process of behaviour analysis can in itself have beneficial effects, often through the changes in staff behaviour that follow from increased understanding.<sup>28</sup>

Regarding medications, the best evidence from placebo-controlled trials in LTC homes would support the use of atypical antipsychotics for severe behavioural symptoms, with or without psychosis.<sup>1,35</sup> Clinicians should carefully evaluate the risks versus the benefits of psychotropic medication in each resident and obtain informed consent. In consideration of the potential risks, many experts in the field believe that the use of antipsychotics in individuals with dementia should be reserved for residents with severe agitation or psychosis, where severity is evaluated on the basis of the degree of danger, suffering, or excess disability.<sup>36</sup> Clinicians should aim for the lowest possible effective dosage.

Despite the limited evidence for the effectiveness of antidepressants in the treatment of behavioural symptoms they are widely used and some patients seem to respond to them. Combination pharmacologic therapy for residents with severe behavioural symptoms may be necessary if monotherapy of a sufficient dose and duration is unsuccessful. It is important to be aware that certain behaviours are unlikely to respond to medications (e.g., wandering, exit-seeking behaviour, and excessive noisiness).

Organizational issues focus on internal policy and procedures, such as human resource practices, whereas system issues focus on community context and partnerships. Best-practice guidelines can be successfully implemented only with adequate planning, the allocation of required resources, and organizational and administrative support. Organizations implementing recommendations for best practice are advised to consider the means by which the implementation and its impact will be monitored and evaluated.

#### Conclusion

Caring for residents in LTC with mental health problems is often challenging. Concern about the quality of care around the globe led to the recent formation of an International Psychogeriatric Association (IPA) Task Force on Mental Health Services in Residential Care Homes (http://www.ipa-online.org). Early discussions suggest that similar issues are relevant in almost all countries. These issues include inadequate staffing levels, lack of staff training regarding mental health issues, aging and poorly designed LTC homes, failure to identify and assess residents in a timely fashion, inappropriate use of psychotropic medications, and limited availability of mental health consultants.

We hope that these guidelines will prove to be useful to front-line staff, consultants, administrators, accreditation bodies, and others in the service of the residents we care for, as well as their families. We

## Table 5. Recommendations: Organizational andSystems Issues

#### Organizational Issues

- LTC homes should develop the physical and social environment as a therapeutic milieu through the intentional use of design principles. [D]
- LTC homes should have a written protocol in place related to staffing needs specific to the care of older residents with mood and/or behavioural symptoms. [C]
- LTC homes should have an education and training program for staff related to the needs of residents with depression and/or behavioural concerns. Ideally, dedicated internal staff would be available to provide leadership in this area, including the development and delivery of best practices. [C]
- LTC homes should have a written protocol in place related to the administration of medication by paraprofessional staff. [D]
- LTC homes should have a written policy in place regarding the use of restraints. [D]

#### System Issues

- LTC homes should obtain mental health services from local practitioners or multidisciplinary teams, with interest and expertise in geriatric mental health issues. [D]
- Administrators and managers within LTC homes should be prepared to advocate with local, provincial, and national policy makers and funding agencies to promote the health and well-being of older residents. [D]
- LTC homes should have a process in place that ensures adherence to the ethical and legislative rights of the older resident. [D]
- LTC homes should ensure adequate planning, allocation of required resources, and organizational and administrative support for the implementation of best-practice guidelines. [D]
- LTC homes should monitor and evaluate the implementation of bestpractice recommendations. [D]

#### LTC = long-term care.

realize that it may be difficult to implement all of the guidelines given the challenges described in this document, but we hope that each facility will strive to adopt as many as possible.

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A full list of references used in the guideline may be found with the full-text document: Canadian Coalition for Seniors' Mental Health (CCSMH). National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Mental Health Issues in Long Term Care Homes. Toronto: CCSMH; 2006. Available: www.ccsmh.ca.

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## National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide

Marnin J. Heisel, Ph.D, C.Psych; Adrian Grek, M.B, B.Ch, FRCPC; Sharon L. Moore, RN, M.Ed, Ph.D, C.Psych; Fae Jackson, RN Med; Gayle Vincent MA; Faith M. Malach, MHSc, MSW, RSW; Jennifer Mokry, MSW, RSW

#### ABSTRACT

The purpose of the Canadian Coalition for Seniors' Mental Health (CCSMH) practice guideline "The Assessment of Suicide Risk and Prevention of Suicide" 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 are planning it or have recently tried to harm or kill themselves.

Key words: assessment, elderly, guidelines, management, prevention, self-harm, suicide

#### **Background and Significance: Suicide**

Adults 65 years or older have high rates of suicide worldwide.1 Approximately 1.3 seniors die by suicide in Canada every day.<sup>2</sup> Older men are at especially high risk of suicide. The 1997 suicide rate for older Canadian men (23.0 in 100,000) was nearly twice that of the nation as a whole (12.3 in 100,000) and nearly five times that of older Canadian women (4.5 in 100,000).<sup>2</sup> In 2002, 430 Canadians 65 years of age or older (361 men and 69 women) died as a result of "intentional self-harm."2 This is likely a low estimate as it is widely believed that published mortality statistics underestimate the total number of deaths by suicide, owing, in part, to the stigma of suicide and other social pressures that may lead family members and health professionals to avoid labeling deaths as suicides. In equivocal cases, coroners might be less likely to consider the death of an older adult as suicide.3 Approximately 1,000 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 or how many medical admissions are due to unrecognized acts of self-harm. The lethal potential of selfharm behaviour increases with advancing age, partly owing to the lethality of the means used.<sup>1,4</sup> Hanging and firearm use were the most common means of suicide among older men in Canada in 2002.<sup>2</sup> In older women, self-poisoning and hanging were the two most common methods. Other possible contributing factors to the lethality of late-life self-harm behaviour may include lessened physical resiliency and the relative physical or social isolation of older adults who engage in selfharm behaviour. The lethal potential of self-harm behaviour in later life is demonstrated by the ratio of such 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 4 to 1,<sup>56</sup> necessitating clinician vigilance to self-harm behaviour among older adults. As the older population greatly increases over the coming decades in Canada<sup>7</sup> there will likely be a greater number of older lives lost to suicide, necessitating greater understanding of suicide risk assessment and intervention strategies.

#### Suicide Guideline Development: Method

A strategic and comprehensive guideline and literature review was completed on the assessment of late-life suicide risk and treatment of suicidal older adults. A computerized search for relevant evidencebased summaries was conducted by librarian consultants to the National Guidelines Project and Canadian Coalition for Seniors' Mental Health (CCSMH) staff and included guidelines, meta-analysis and literature reviews, and research literature not contained in these source documents. The search strategy was guided by inclusion criteria specifying English-language references, references specifically addressing suicide, guidelines, meta-analyses and reviews dated January 1995 to May 2005, and research articles but not dissertations dated between January 1999 and June 2005.

The initial database search for evidence-based summaries examined Medline, EMBASE, PsycINFO, CINAHL, AgeLine, and the Cochrane Library. The following search terms were used: *suicide, self-harm*,

Marnin J. Heisel, PhD, CPsych: Assistant Professor, Department of Psychiatry and Department of Epidemiology and Biostatistics, Schulich School of Medicine, The University of Western Ontario; Scientist, Lawson Health Research Institute, London, ON, Adjunct Assistant Professor, University of Rochester Center for the Study and Prevention of Suicide, Department of Psychiatry, University of Rochester Medical Center, Rochester, NY; Adrian Grek, MB, BCh, FRCPC. Geriatric Psychiatrist, Mount Sinai Hospital, University of Toronto, Associate Clinical Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, ON; Sharon L. Moore, RN, MEd, PhD, CPsych: Associate Professor, Centre for Nursing and Health Studies, Athabasca University, Athabasca, AB; Adjunct Professor, Faculty of Nursing, University of Alberta, Edmonton, Alberta; Fae Jackson, RN Med, Program Coordinator, Advanced Studies in Mental Health, Mount Royal College, Calgary, AB; Gayle Vincent MA: Manager, Suicide Prevention, Alberta Mental Health Board, Calgary, AB; Faith M. Malach, MHSc, MSW, RSW: Executive Director, Canadian Coalition for Seniors' Mental Health; Adjunct Protessor, Faculty of Nursing, University of Toronto, Toronto, ON; Adjunct Professor, Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto. Toronto, ON; and Jennifer Mokry, MSW, RSW: Project Manager, Canadian Coalition for Seniors' Mental Health, Toronto, ON (since the publication of the Guidelines relocated to the Cardiac Care Network of Ontario, Toronto, ON)

Address for correspondence: Marnin J. Heisel, PhD, CPsych, Department of Psychiatry, London Health Sciences Centre, South Street Hospital, 375 South Street, Room #5054, London, ON, N6A 4G5 Conflict of interest: Details available from the CCSMH. Please contact 416-785-2500, ext. 6331 for more information. *Can J Geriatr* 2006;9(Suppl 2):S65–70.

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) selfharm, practice guideline(s), best-practice guideline(s), and clinical guideline(s). In addition, a list of Web sites was compiled based on evidence-based practice Web sites, known guideline developers, and recommendations from Guideline Development Group members. The search results and dates were noted. The following Web sites 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/
- Centre for Suicide Prevention/Suicide Information & Education Collection (SIEC): http://www.suicideinfo.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/
- 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 20 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 (AGREE) instrument,<sup>8</sup> eight guidelines<sup>9-16</sup> were selected and obtained for inclusion as the literature base for the project.

Of these, the Guideline Development Group determined that the University of Iowa guidelines,<sup>11</sup> in focusing on older adults, were most directly relevant to the current project. These guidelines were thus adopted as an initial template for the CCSMH guidelines, to be adapted, refined, and augmented to include a more complete and updated literature review and discussion of therapeutic interventions and to better represent Canadian aging literature.

The librarian consultant from The Centre for Suicide Prevention (http://www.suicideinfo.ca/) additionally conducted a literature search through their Suicide Information & Education Collection (SIEC) database, a special library and resource centre containing the largest collection of resources related to suicide and suicidal behaviour, with over 36,000 articles, books, and additional resources. A search of the 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 as being related to the assessment and prevention of suicide, and were distributed to group members. As the development of the guideline document progressed, additional summaries and research articles were identified by way of targeted searches and expert knowledge contributions on the part of the Guideline Development Group. The resultant reference base includes over 200 citations.

The selected literature was appraised with the intent of developing evidence-based, clinically sound recommendations to serve as an accessible resource for busy clinicians. Based on relevant expertise and interest, the Guideline Development Group was divided into subgroups and members completed the drafting of recommendations for their particular sections. The process generated several drafts and ultimately a final document containing a parsimonious set of recommendations confirmed by process of consensus. The recommendations are thus based on research evidence, informed by expert opinion.

#### Results

A full-text version of the guideline may be downloaded free of charge from the CCSMH Web site (www.ccsmh.ca). Readers are encouraged to treat the present summary as a companion document to the full guideline. They are strongly discouraged from solely reading this document to the exclusion of the complete guideline. This guideline is not to serve as or replace supervised training and professional education and experience in working with older adults at elevated risk for suicide. The guideline recommendations are provided below, in Tables 1 - 5 followed by a brief discussion.

#### Recommendations: Suicide Risk and Resiliency Factors

Suicide is not a specific disorder but rather is typically an end point to an individual's painful psychological process. Multiple trajectories to suicide thus exist, necessitating an understanding of contributing factors and processes and working knowledge of factors that increase or mitigate suicide risk. Suicide is statistically uncommon. It is thus generally agreed that prediction of suicide is largely impossible; however, risk can be detected. Simple checklist approaches to suicide risk assessment are discouraged. Research on late-life suicide risk is still in an early stage; gaps exist in what is known about risk factors for imminent versus longer-term likelihood of suicide, for self-harm behaviour versus death by suicide, for gender-age-and-culture-specific risk indices, and for resiliency factors that might mitigate self-harm and suicide risk. Continual clinical vigilance is thus strongly advised

#### Table 1. 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]

when suicide risk factors are present. Clinicians should further not disregard any risk factor believing the literature to have greater specificity than it currently has. For example, clinical teams often get caught up in debates over whether an individual has expressed a "wish to die" versus "suicide ideation," erroneously believing the former to hold little risk for suicide. Clinicians, similarly, often debate whether a

#### Table 2.

#### **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]

#### Risk Factor: Personality Factors

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

#### 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]

### 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]

#### Risk Factor: Functional Impairment

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

#### **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 3. Recommendations: Detection, Assessment, and Diagnosis

#### 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]

#### 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]

#### Assessment of Suicide Risk: Process

- Health care 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]

given patient or client behaviour represents "self-harm" versus "suicidal behaviour," erroneously believing the former to hold little risk for suicide. The literature indicates that any expression of a wish to die and any self-harm behaviour increases the risk for death by suicide and so must be regarded seriously. It should also be noted that suicidal intent is not equivalent to the lethality of the means used, necessitating explicit assessment of both intent to die and the lethality of self-harm behaviour.

Although multiple risk factors commonly coexist in suicidal older adults, clinicians should not judge an older adult's suicide risk to be low simply owing to the presence of only one or two risk factors or absence of a specific risk factor. It can be very helpful to contextualize risk factors within the older adult's life experiences when assessing the presence and severity of suicide risk. For example, life transitions that necessitate greater reliance on others might invoke feelings of worthlessness in an achievement-motivated senior and yet be viewed as pleasant opportunities for socializing with caring others by a more interpersonally oriented individual. An identical situation might thus engender elevated suicide risk in some, but not all, older adults.

Assessment of suicide risk requires sensitive and careful evaluation, clinical judgment, and experience and is best conducted in the context of good clinical rapport.<sup>17</sup> Use of well-constructed assessment tools, developed and/or carefully validated among older adult populations, can aid in the detection of suicide risk or resiliency by mental health professionals with appropriate training in the selection, administration, scoring, and interpretation of psychological assessment measures. The full guideline describes measures designed to assess suicidal features (i.e., The Harmful Behaviors Scale, The Reasons for Living Scale Older-Adult Version, and the Geriatric Suicide Ideation Scale) among older adults. The Geriatric Suicide Ideation Scale (GSIS) is a new measure of suicide risk and resiliency developed with

#### Table 4. Recommendations: Treatment and Risk Management

#### Treatment and Management

 Health care providers working with suicidal older adults should ensure that their clients are appropriately assessed and treated for depression. (Refer to the National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression.<sup>22</sup>) [B]

#### 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 help older persons find and maintain meaning and purpose in their lives. [C]

#### Treatment and 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]

### 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 health care 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]

Canadian seniors.<sup>18</sup> Readers should note that older adults may underreport depressive or suicidal symptoms,<sup>19-21</sup> necessitating vigilance when such symptoms are denied in the face of other risk factors. Readers are advised to continually assess suicide risk in older clients as risk factors such as suicidal thoughts may wax and wane. Older adults might downplay thoughts of suicide owing to guilt, stigma, and fear of hospitalization. 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. When assessing the presence of suicidal thoughts and plans it is important not to convey a moralistic attitude or an aversion to suicide as these might encourage concealment of suicide ideation.

Studies of the efficacy of mental health interventions to reduce suicidal ideation and behaviour are quite rare, partly owing to the exclusion of suicidal individuals from clinical trials.<sup>23</sup> However, a recent multi-site trial, the Prevention of Suicide in Primary Care Elderly Collaborative Trial (PROSPECT), found that combined antidepressant (citalopram) and psychotherapeutic treatment (interpersonal psychotherapy) provided in a collaborative care context helped resolve depression and reduce suicide ideation among older primary care patients.<sup>24</sup> Although electroconvulsive therapy (ECT)

#### Table 5. Recommendations: Systems of Care

#### **Collaborative Care**

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

#### 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]

#### 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]

may be of value in treating depressed and suicidal patients, there have been no studies to date of ECT for the amelioration of suicidal ideation or behaviour in older adults. Research has linked late-life suicidal thoughts and behaviour with hopelessness<sup>25,26</sup> and with a lack of perception of meaning and purpose in life.<sup>27–29</sup> Therefore, interventions aimed at increasing recognition of meaning and purpose and engendering hope may help reduce suicide risk. Clinicians are advised to attend to the therapeutic relationship with older adults. They are further advised not to work in isolation as they can greatly benefit from the social support of colleagues and co-workers. Thoughtful risk management strategies, attending to client safety and to the well-being of both clients and providers, may help reduce clients' suicide risk and provider burnout.

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. Research evidence supports collaborative care for depressed and suicidal older adults.<sup>24</sup> Caution is warranted as interventions shown to be efficacious in the controlled environments of clinical trials have yet to be proven effective in socalled "real-world" conditions. Research on knowledge translation is needed. Research studies have suggested that mental health outreach<sup>30</sup> and telephone-based social support services<sup>31</sup> may help reduce the risk for suicide in older adults. Here, too, further research is needed.

#### Conclusion

Suicide among the elderly is a tragedy that should be prevented. The Canadian Association for Suicide Prevention released a blueprint in 2004 calling for the development of a Canadian national strategy for suicide prevention, attending to risk factors and prevention opportunities specific to different age and cultural groups and geographic regions<sup>32</sup>. The CCSMH national guideline "The

Assessment of Suicide Risk and Prevention of Suicide" is consistent with this call. This guideline provides an overview of the epidemiology of late-life suicide and highlights associated risk and resiliency factors, assessment, treatment, and risk management practices. It additionally provides an overview of systems of care, mental health outreach, education, and medico-legal issues related to ethics, privacy, and confidentiality. This guideline represents the work of an interdisciplinary team dedicated to improving systems of risk detection and prevention of suicide among older adults, drawing on the best available evidence at the time of writing. Many of the recommendations in the guideline have relatively low levels of evidentiary strength (i.e., primarily C- and D-level recommendations<sup>33</sup>), representing the paucity of controlled intervention trials with at-risk older adults currently available in the literature. Similar gaps exist in the literature regarding resiliency factors, mental health promotion, suicide risk detection, assessment instruments and techniques, and the effectiveness of public health education programs and prevention efforts among older adults<sup>34</sup>. These guidelines are thus 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 existing knowledge regarding this critical tragic public health problem.

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A full list of the references used in the guideline may be found with the full-text document: Canadian Coalition for Seniors' Mental Health (CCSMH). National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide. Toronto: CCSMH; 2006. Available: www.ccsmh.ca.

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