Assessing and Responding to Suicide Risk in Older Adults

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Learning objectives:

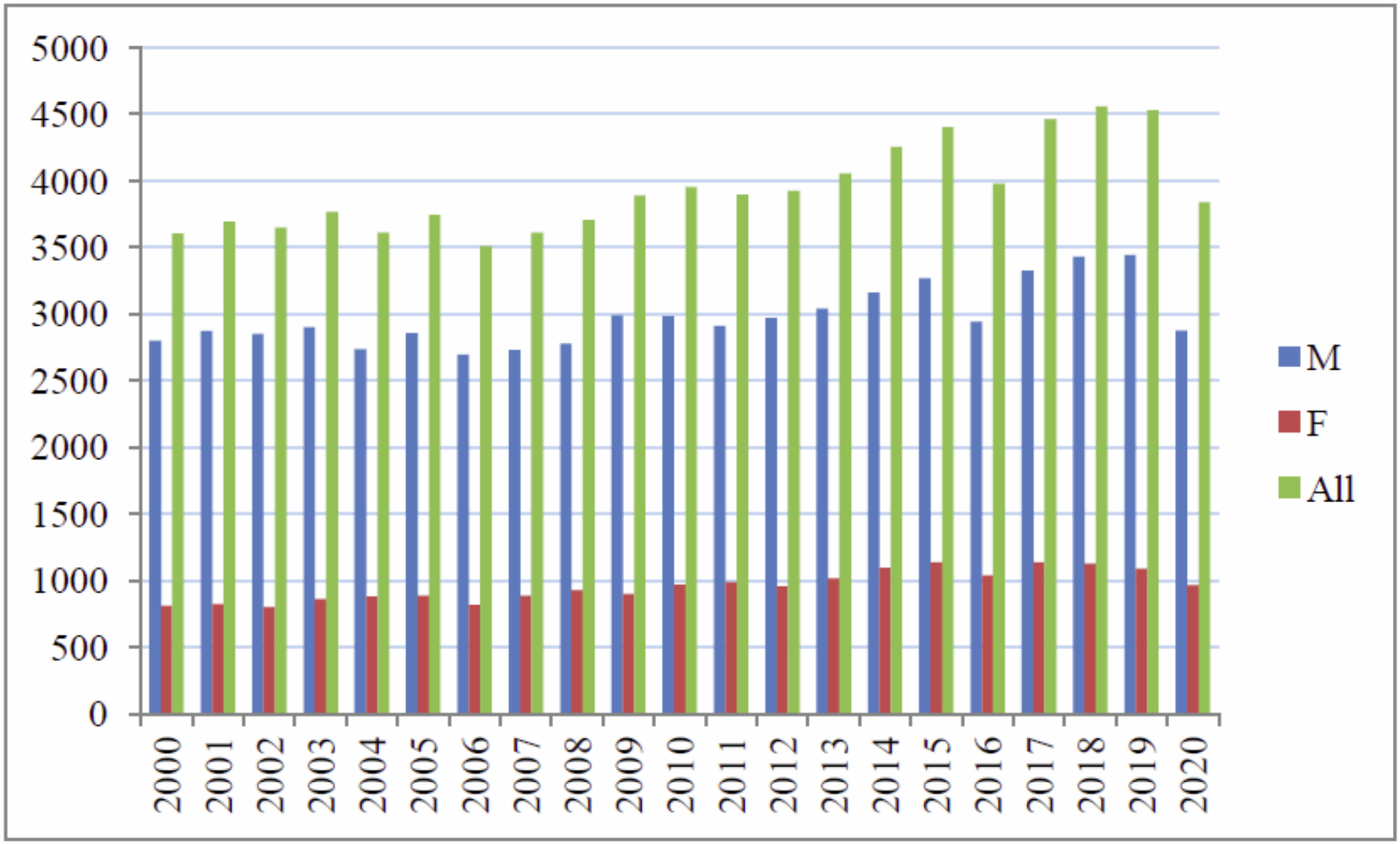
By the end of this presentation, you will be able to:

1. Discuss the prevalence, correlates, risk and protective factors associated with suicide among older adults;
2. Consider the critical role of routine suicide risk detection and response among older adults receiving community support and healthcare services; and
3. Demonstrate familiarity with validated tools and approaches for detecting suicide risk among older adults.

The Epidemiology of Suicide, Worldwide

- According to a 2021 WHO report, suicide accounts for roughly 1% of deaths worldwide, or 703,000 lives lost every year.
- This number is extremely high, and yet it reflects a recent worldwide reduction in deaths by suicide, supportive of suicide prevention efforts.
- In 2014, the WHO reported over 800,000 annual deaths to suicide worldwide; in earlier years, the figure exceeded 1,000,000 lives lost to suicide.
- However, suicide rates increased in the Americas over the past 20 years; this, in part, seems to be associated with shifting population demographics.

Number of Deaths by Suicide in Canada, from 2000-2020, Overall and by Sex



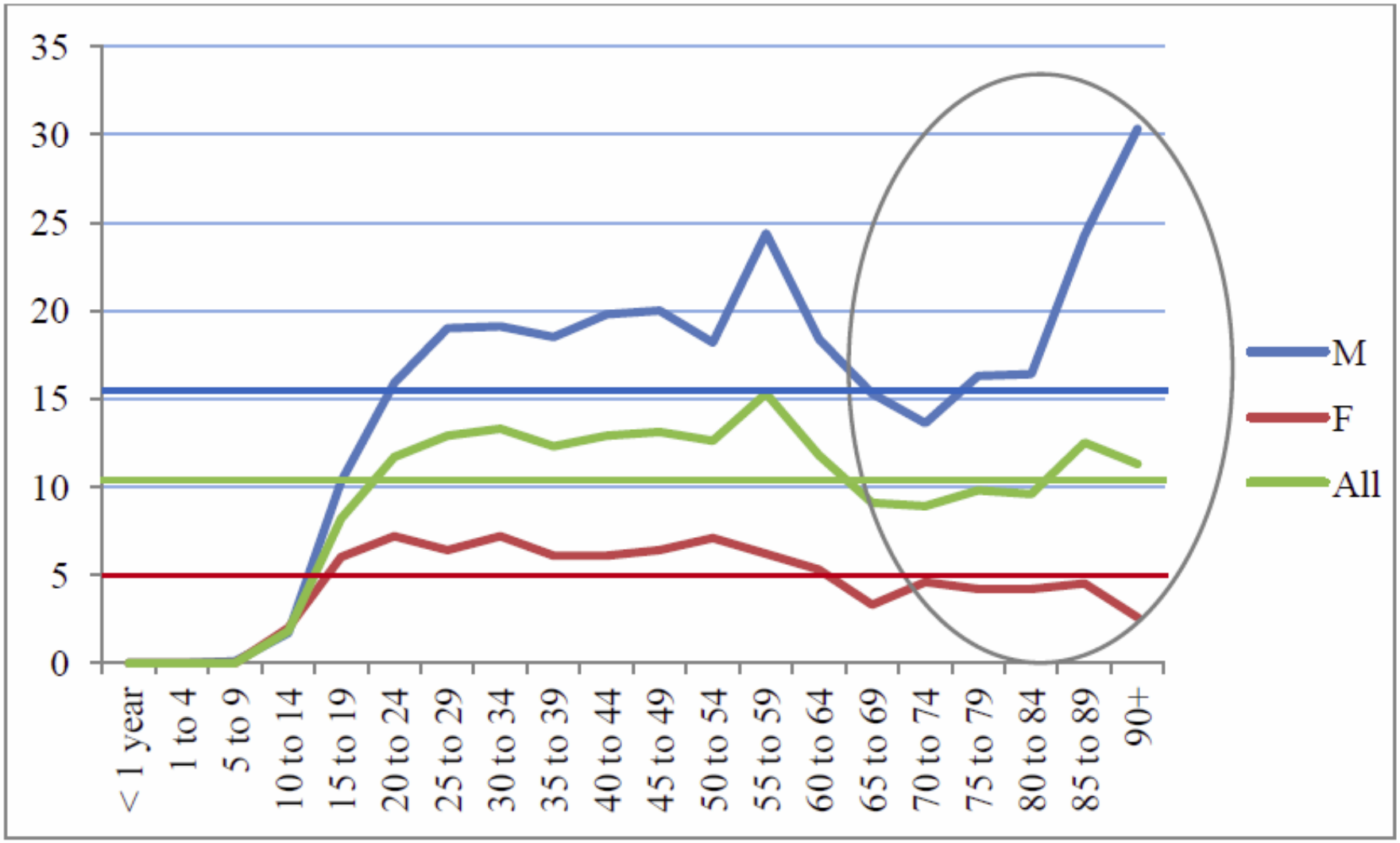
Source: Statistics Canada. Table: 13-10-0392-01 Deaths and Age-Specific Mortality Rates, by Selected Grouped Causes

Focusing on High-Risk Demographics

- Sex and age are two of the most common demographic variables associated with risk for suicide, at the aggregate level.
- Older adults, and older men in particular, have the highest suicide rates in Canada, and in most countries worldwide.
- Older adults typically use highly lethal means of suicide; men over 60 accounted for nearly 40% of firearm-related deaths by suicide in Canada.

- 2020 North American mortality data indicate:
  - 45,979 people died by suicide in the U.S.A., including 36,551 men or boys (M: 79.5%) and 9,428 women or girls (F: 20.5%), for a national suicide rate of 13.95/100,000 overall, 22.5/100K for M, & 5.6/100K for F (U.S. CDC; WISQARS).
  - 3,839 people died by "suicide" in Canada, including 2,874 men or boys (M: 75%) and 965 women or girls (F: 25%) for a national suicide rate of 10.1/100,000 overall, or 15.2/100K for M and 5.0/100K for F (Statistics Canada).

Canadian Suicide Rates by Sex and Age for 2020



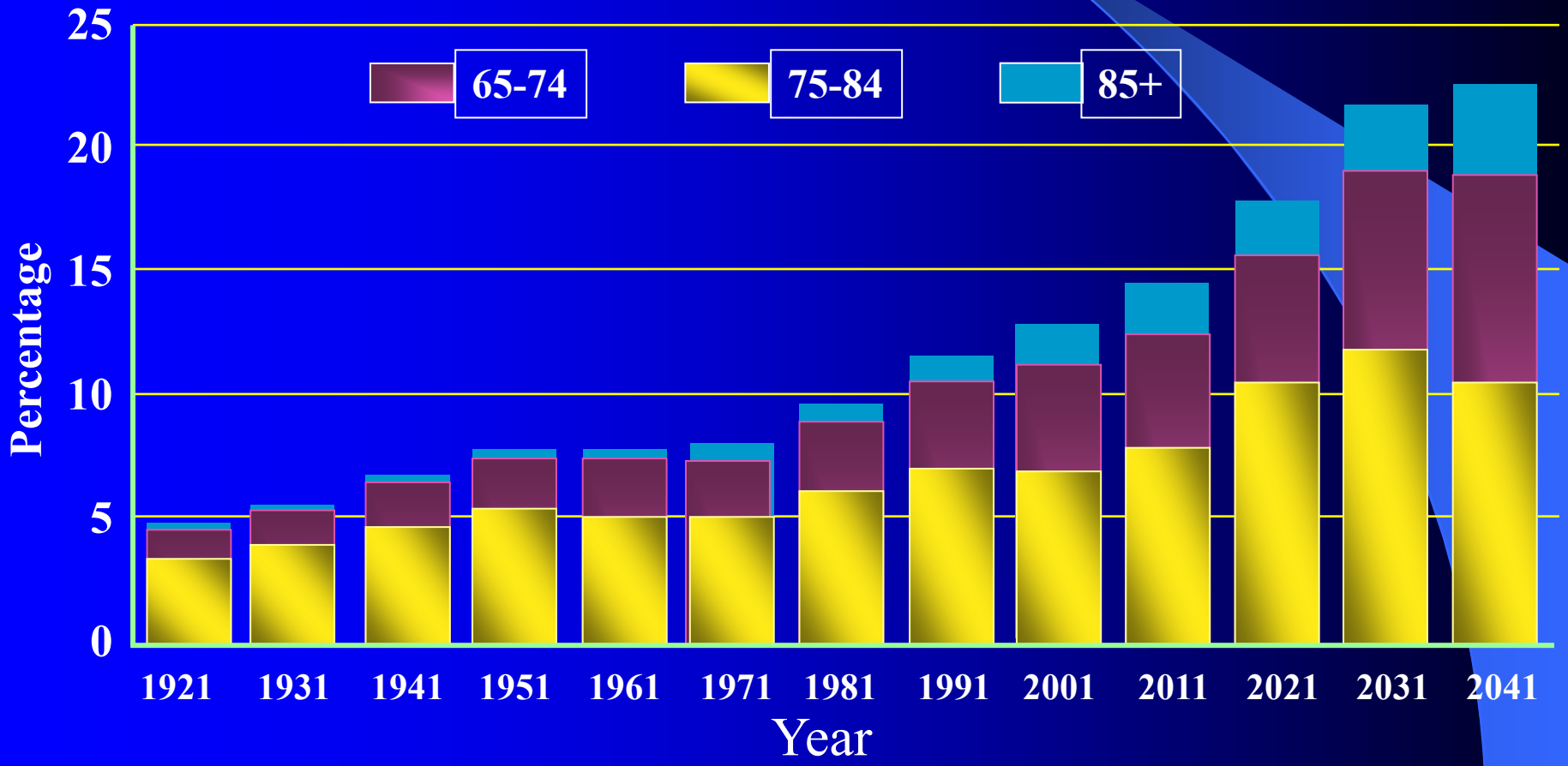
Note: Lifetime suicide rates: 10.1 overall; 15.2 Males; 5.0 Females

Source: Statistics Canada. Table: 13-10-0392-01 Deaths and Age-Specific Mortality Rates, by Selected Grouped Causes

- The burden of older adult suicide is increasing, coincident with the growth of this demographic.
- Baby-boomers (DOB: 1946-1964) have high rates of suicide as compared with earlier cohorts.
- More than 9,500 North Americans over 65 die by suicide annually or more than 18,000 over 55; this number is growing (CDC, StatsCan).

Older Adults (by age sub-groups) as % of the Total Population

Canada, 1921-2041

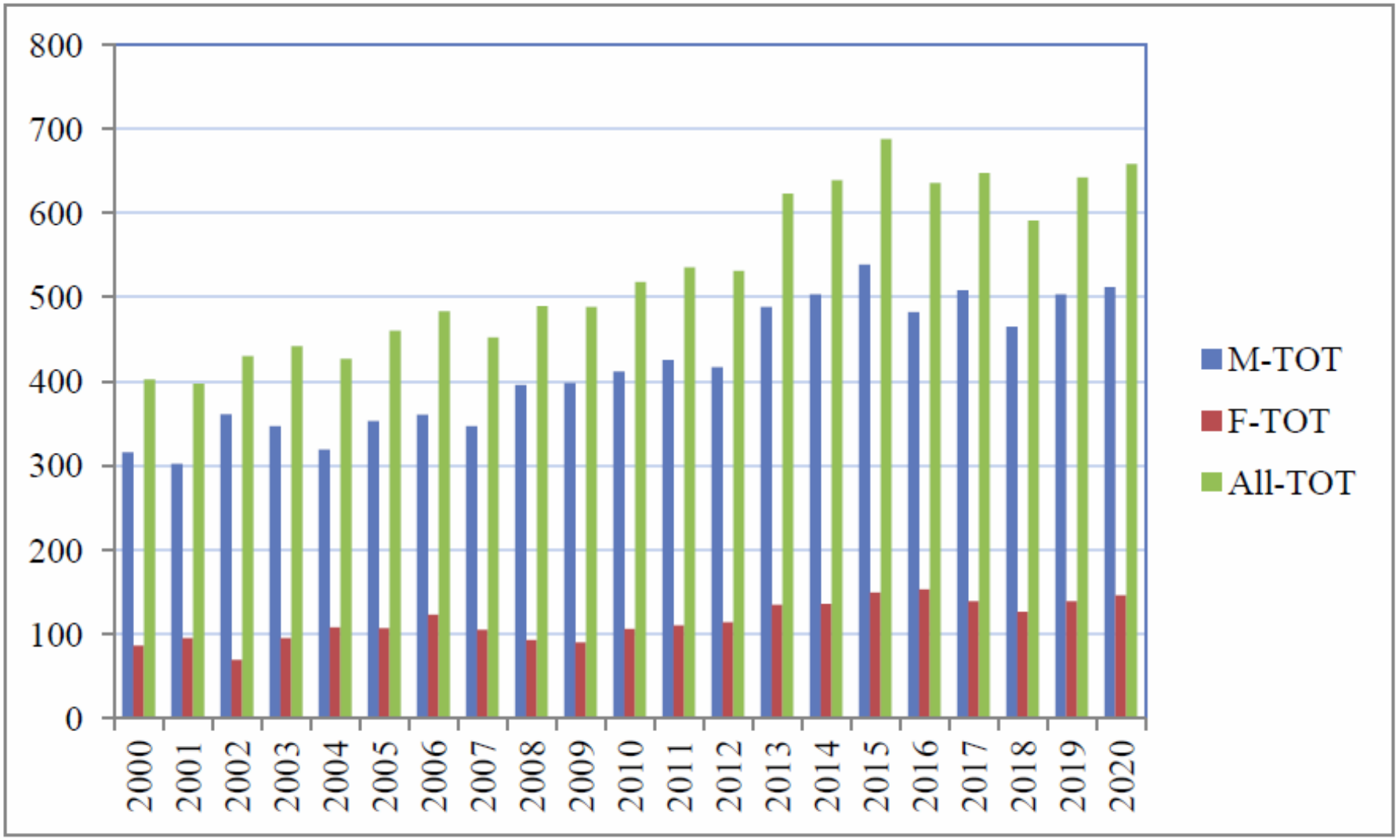


Source: The Canadian Coalition for Seniors' Mental Health

- 3,606 individuals died by suicide in Canada in 2000; by 2019, this figure increased 11% to 4,012.

- 402 older adults died by suicide in Canada in 2000; by 2019, this figure increased by 60% to 642.

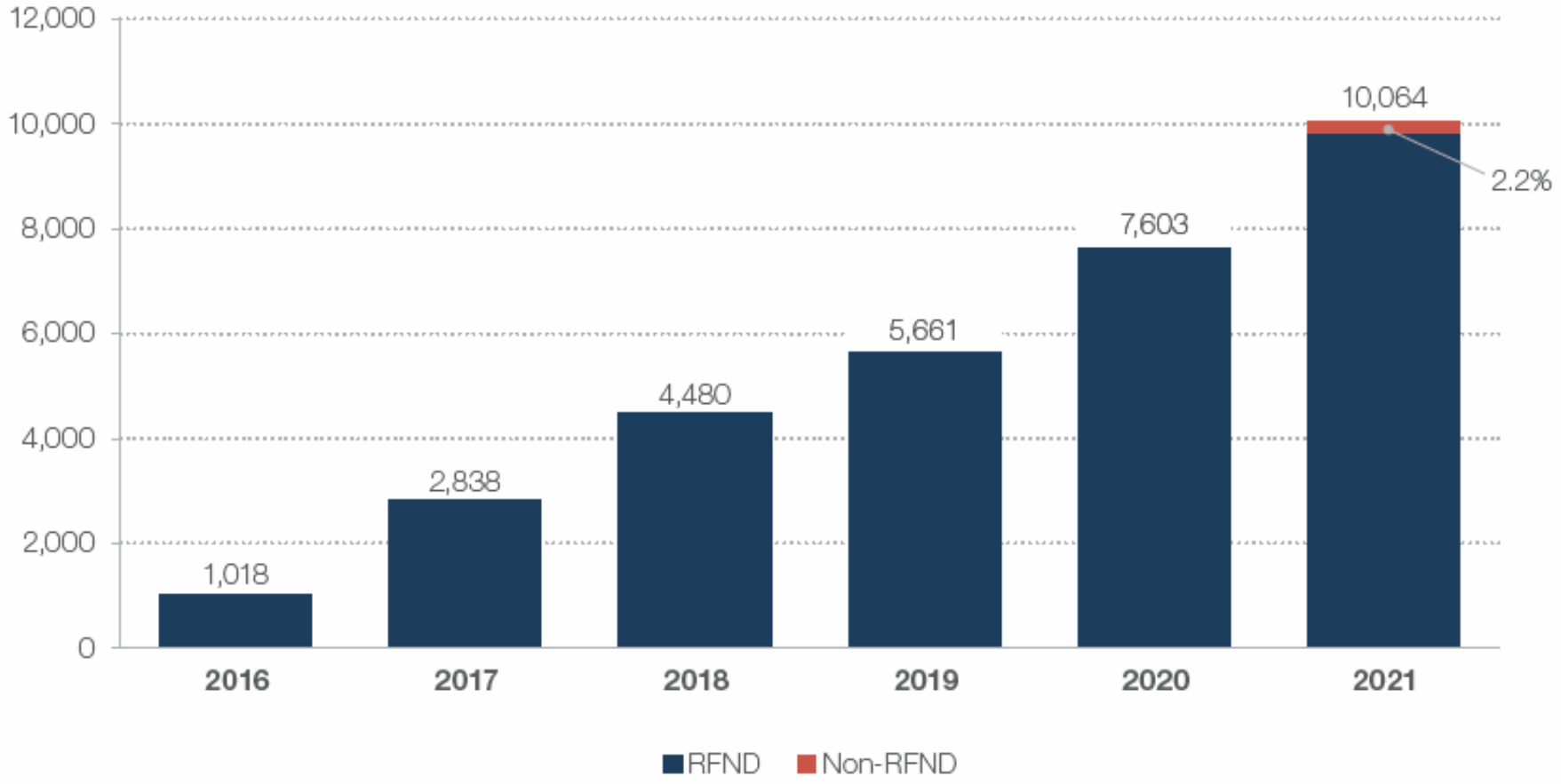
Number of Deaths by Suicide among Adults 65+ in Canada (2000-2020)



Source: Statistics Canada. Table: 13-10-0392-01 Deaths and Age-Specific Mortality Rates, by Selected Grouped Causes

- These figures do not include Medical Assistance in Dying; there was a 34% increase in MAID from 2019 to 2020, and a further 32% increase from 2020- 2021.
- 10,064 Canadians died by MAID in 2021.
- The average age of Canadians who accessed MAID in 2021 was 76.3 years.
- Men accounted for roughly 52% of deaths by MAID, as compared to roughly 76% of deaths by suicide.
- Women accounted for over 61% of individuals over the age of 90 who accessed MAID.

Chart 3.1: Total MAID Deaths in Canada, 2016 to 2021

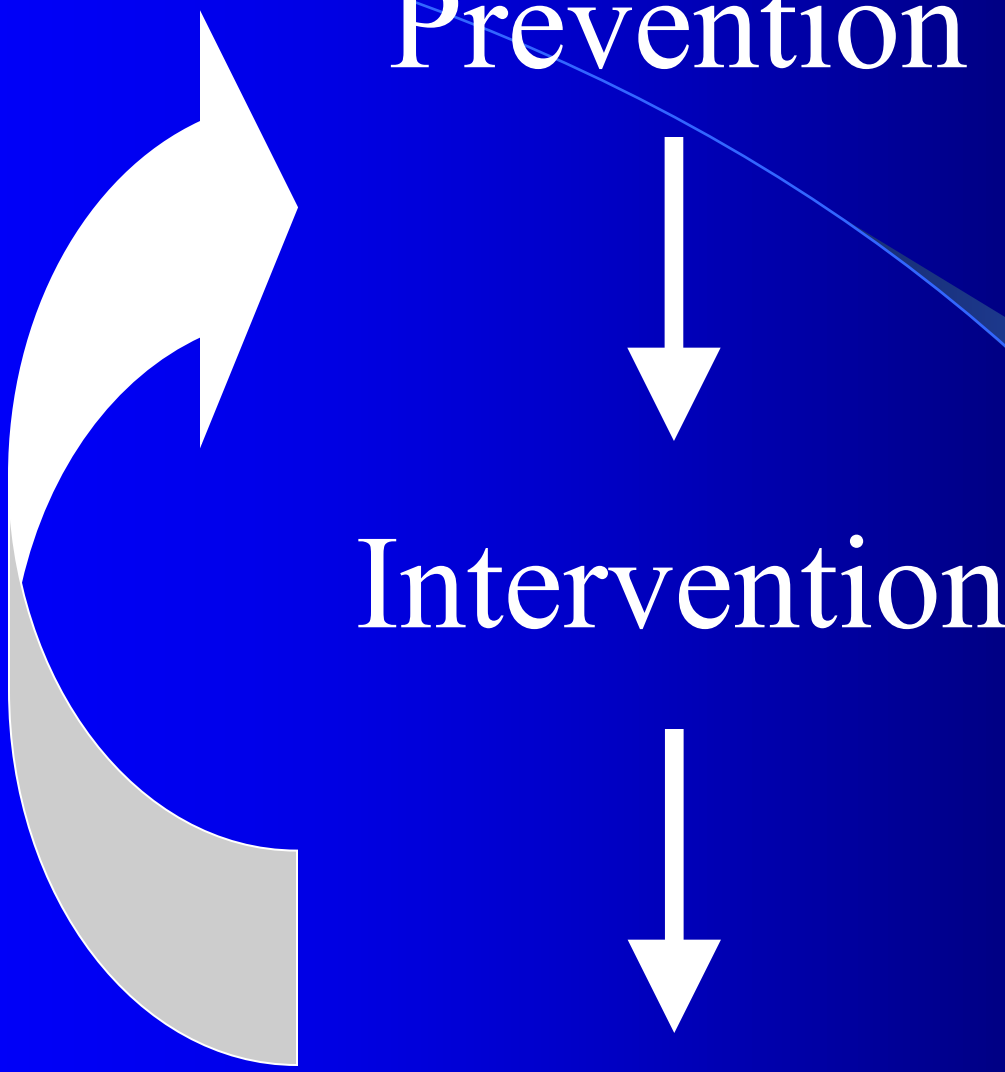


EXPLANATORY NOTES:

1. MAID cases are counted in the calendar year in which the death occurred (i.e., January 1 to December 31), and are not related to the date of receipt of the written request.
2. For 2016 – Québec data begins December 10, 2015 when its provincial Act respecting end-of-life care came into force. Data for the rest of Canada begins June 17, 2016.
3. Previous years' reporting has been revised to include corrections and additional reports.
4. This chart represents MAID deaths where a report was received by Health Canada by January 31, 2022 (9,950 deaths) as well as additional MAID deaths reported by the jurisdictions (114 deaths) where the report was not yet received by Health Canada, for a total of 10,064 MAID deaths in 2021.
5. Cases of self-administered MAID are included in this chart. They are not identified by year or jurisdiction in order to protect confidentiality.
6. Cases of non-RFND MAID (15 cases in 2020 in Quebec and 219 cases in 2021 in Canada) are included in this chart. They are not identified by year or jurisdiction in order to protect confidentiality.

Source: Health Canada, 2022

Suicide can be prevented!


Prevention
Intervention
Postvention

What Works?

- Mann et al., (2005) conducted a large-scale review of the suicide prevention literature investigating publications from 1966-2005

- They identified 5,020 articles and evaluated:
  - Meta-analyses and systematic reviews
  - Quantitative studies (trials or cohort studies)
  - Ecological or population-based studies

- Their outcomes of interest were:
  - Death by suicide
  - Suicide behaviour
  - Suicide ideation

Their Findings of Areas of Promise

- Increasing Awareness and Education, among:
  - The General Public
  - Primary Care Physicians/General Practitioners
  - Gatekeepers
- Screening Approaches
- Treatment Interventions:
  - Pharmacotherapy
  - Psychotherapy
  - Follow-up Care Following Suicide Behaviour
- Restriction of Suicide Means
- Working with the Media

What Works? (2.0)

- Zalsman et al., (2016) have updated this review, (using PubMed and Cochrane databases) for the period extending from 2005-2014

- They assessed the following interventions:
  - public and physician education
  - media guidelines and strategies
  - screening
  - lethal means-restriction
  - treatments
  - Internet or hotline support

- They identified 1,797 articles and reviewed:
  - 12 meta-analyses
  - 40 RCTs
  - 67 cohort trials
  - 22 ecological or population-based studies

- Their outcomes of interest were:
  - Death by suicide
  - Suicide behaviour
  - Suicide ideation
  - Intermediate/secondary outcomes (treatment-seeking, risk-identification, antidepressant prescription and/or use, and referrals for care)

Their Main Findings: Effectiveness

- Restriction of Suicide Means
  - Evidence is stronger (especially re: analgesics and jumping from “hot spots”)
- Increasing Awareness and Education:
  - School-based programs can effectively reduce suicide ideation and behaviour
- Interventions:
  - Pharmacotherapy (Clozapine & Lithium are effective but apparently less specific than previously thought)
  - Psychotherapy + pharmacotherapy for depression

Insufficient Evidence

- Screening Approaches:
  - Primary care
  - Public Education
- Media Guidelines

More Research is Needed:

- Gatekeeper Training
- Physician Education
- Internet and Helpline Support

Some Systemic Limitations

- There is an insufficient number of providers trained in working with suicidal older adults; this is not a typical focus of clinical training
- At-risk older adults often seek care from primary healthcare providers; yet, the demand on family physician time is great
- Approximately 45% of people who die by suicide visited a primary care provider in the month prior to death, this figure exceeds 70% for older adults (Luoma, Martin, & Pearson, 2002)
- The primary care system was not designed for assessment and treatment of mental health issues
- Enhanced detection and referral to clinical MH-care is critical as are outreach and community-based care

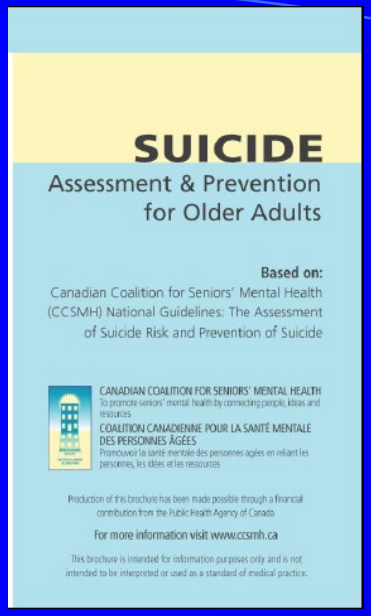
Clinical Implications/Opportunities

- Innovative models of outreach and health service delivery and training are needed:
  - Collaborative/shared care
  - Use of non-provincially-funded providers
  - Use of social service providers and peer supports
  - Telecare and distress/crisis services
  - Local providers and distant consultants
  - Innovative educational programs and scholarships
  - Distance learning, webinars, and conferences
  - Knowledge Translation (KT) to reduce the lag time between dissemination of new clinical findings and implementation in frontline care

Setting the Context: Review of CCSMH Guideline Project: Guideline Topics

- Assessment & Treatment of **Delirium**
- Assessment & Treatment of **Depression**
- Assessment & Treatment of **Mental Health** Issues in LTC (with a focus on mood & behaviour)
- Assessment and Prevention of **Suicide**

- These have been widely disseminated
- Additional funding by the PHAC and a CIHR KT Award supported development of additional KT tools (available online at www.ccsmh.ca):
  - A quick reference clinician pocket-card
  - Interactive case-based DVD
  - A facilitator's manual
  - A guide for family members
- A CIHR-funded KT study assessed the impact of training workshops on provide knowledge and attitudes (M.J. Heisel and S.L. Moore, co-Pis)


SUICIDE
Assessment & Prevention
for Older Adults
Based on:
Canadian Coalition for Seniors' Mental Health
(CCSMH) National Guidelines: The Assessment
of Suicide Risk and Prevention of Suicide
CANADIAN COALITION FOR SENIORS' MENTAL HEALTH
COALITION CANADIENNE POUR LA SANTÉ MENTALE
DES PERSONNES ÂGÉES
Production of this brochure has been made possible through a financial contribution from the Public Health Agency of Canada
For more information visit www.ccsmh.ca
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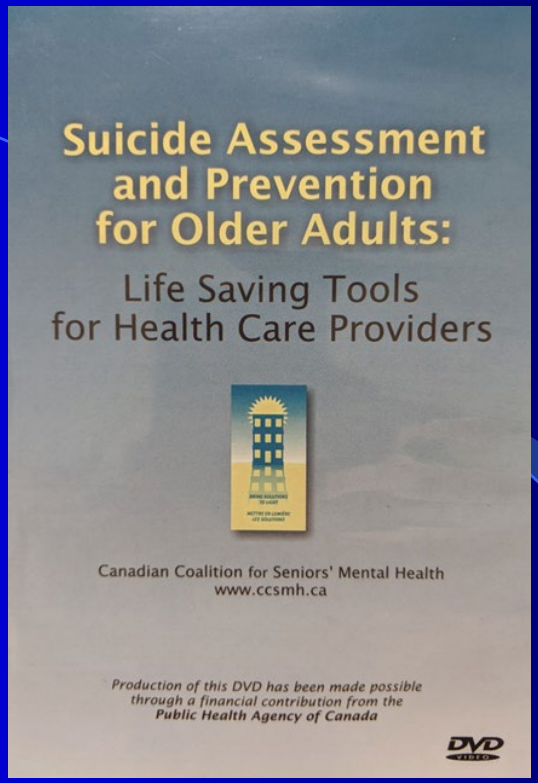
Suicide Assessment
and Prevention
for Older Adults:
Life Saving Tools
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Canadian Coalition for Seniors' Mental Health
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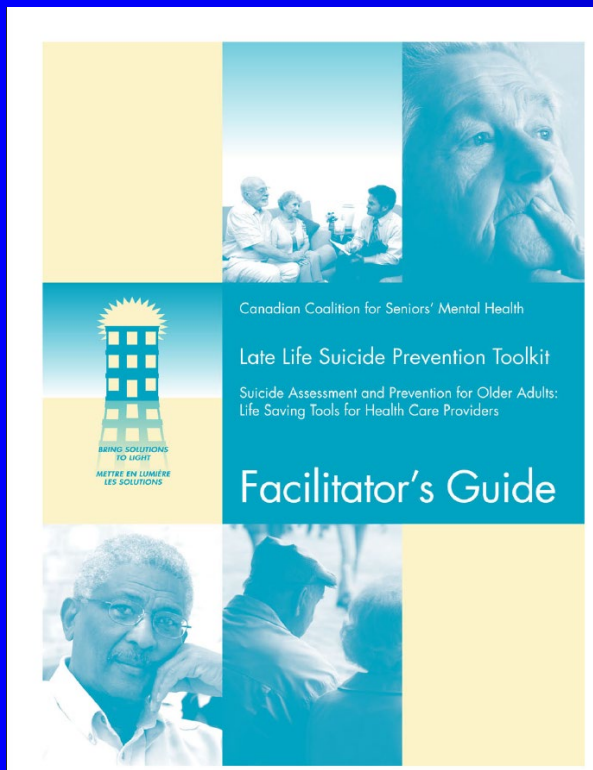
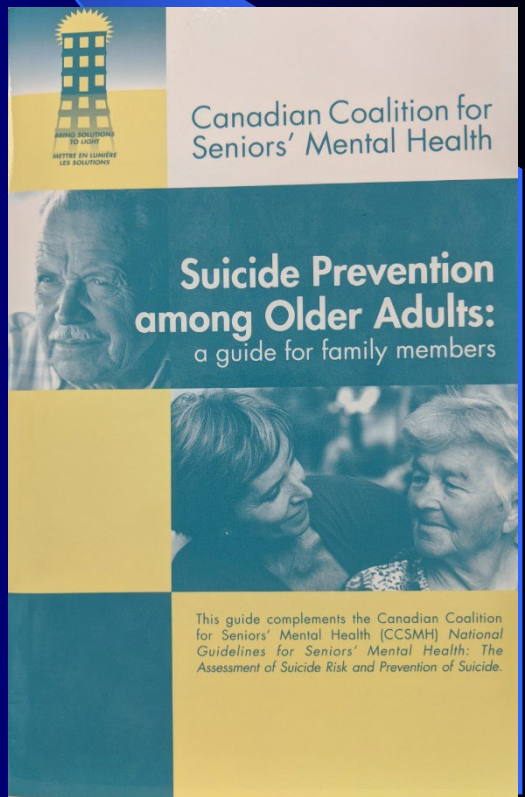
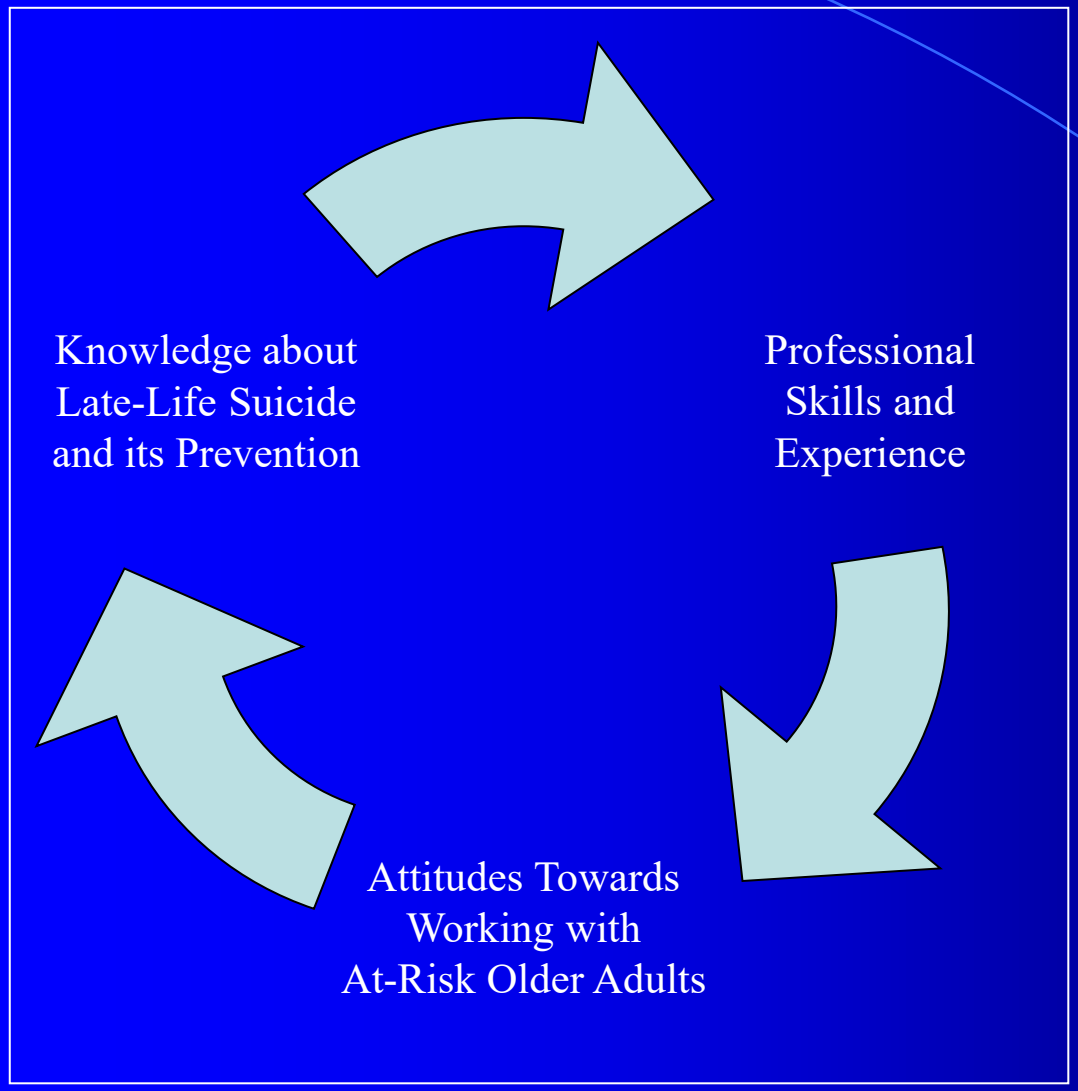

Canadian Coalition for Seniors' Mental Health
Late Life Suicide Prevention Toolkit
Suicide Assessment and Prevention for Older Adults:
Life Saving Tools for Health Care Providers
Facilitator's Guide
BRING SOLUTIONS TO LIGHT
METTRE EN LUMIÈRE LES SOLUTIONS


Canadian Coalition for
Seniors' Mental Health
Suicide Prevention
among Older Adults:
a guide for family members
This guide complements the Canadian Coalition
for Seniors' Mental Health (CCSMH) National
Guidelines for Seniors' Mental Health: The
Assessment of Suicide Risk and Prevention of Suicide.

Our Model



Enhanced competency in assessing suicide risk and providing care for at-risk older adults

Suicide Assessment & Prevention for Older Adults
Clinician Pocket-Card

KEY MESSAGES:

1. Be aware of suicide warning signs: **IS PATH WARM.**
2. Be aware of the risk factors for suicide.
3. Be vigilant to the presence of suicide risk factors in older patients presenting for care, even if they do not express mental health complaints. Episodes of suicide ideation may come and go. Ongoing assessment is necessary.
4. Screen for suicide risk factors in high-risk individuals, especially those emerging from depression. Be aware of those who have risk factors but no presentation of suicidal ideation. An improvement in mood doesn't necessarily mean a decrease in suicide risk.

KEY MESSAGES (Cont.):

5. Take any threat of suicide or wish to die seriously.

6. Talking about suicide **DOES NOT** make someone suicidal. Create a safe environment to talk about suicide.

7. Be prepared. Create crisis/risk management plans before a crisis occurs.

8. Suicide prevention is everyone's business. You're not alone. Learn about available community resources and develop relationships in your community.

Other Guidelines/Resources

- The CCSMH guideline format was based loosely on a guidelines from the University of Iowa Gerontological Nursing Interventions Research Center (Holkup et al., 2002). The Iowa guidelines focused on assessment and not intervention, and are currently being updated.
- Additional guidelines include the American Psychiatric Association's (2003) "Practice guideline for the assessment and treatment of patients with suicidal behaviors." These are not specific to older adults.
- SAMHSA (2011) "Promoting emotional health and preventing suicide: A toolkit for senior living communities (SPARK kit)."
- The U.S. Veterans Administration has also recently developed a set of KT tools.

Suicide Risk Assessment

- Depressed older adults often downplay psychological symptoms (Duberstein et al., 1999).
- With older adults, we initially need to gently approach the issue of suicide; however, we must ask the question, even if risk is not apparent.
- Consider use of collateral source information (Heisel, Conwell, Pisani, & Duberstein, 2011).
- Suicide risk assessment must be carried out in a sensitive fashion, in the context of a trusting therapeutic relationship.

Approaches to Detecting Suicide Risk

- Risk Factors
- Protective/Resiliency Factors
- Assessment Tools/Interview
- Warning Signs

Suicide risk and resiliency factors

- Suicide is a complex phenomenon with multiple determinants and contributing factors
- Identification of suicide risk factors may aid in the detection of those at risk and inform intervention
- Common risk factors (age, sex, and ethnicity) are non-modifiable; therapeutics need to focus on modifiable factors, such as reducing suicide ideation, treating psychological and physical symptoms, providing support, and enhancing well-being
- We also need to focus on resiliency and protective factors (Heisel, 2006)

Suicide Assessment & Prevention for Older Adults Clinician Pocket-Card

RISK FACTORS:

1. Suicidal Ideation and/or Behaviour

- Prior suicidal behaviour (including suicide attempt), prior self-harm behaviour, previous expression of suicide ideation
- Feels tired of living and/or wishes to die
- Thinks about suicide, has suicidal wishes and/or desires
- Has a suicide plan/note
- Access to a firearm or other means of suicide

2. Family History

- Family history of suicide, suicide ideation, mental illness

RISK FACTORS (Cont.):

3. Mental Illness (can include)

- Any mental disorder, co-morbidity
- Major depressive disorder
- Any mood disorder
- Psychotic disorder
- Substance misuse disorder/addictions

4. Personality Factors

- Personality disorders
- Emotional instability
- Rigid personality
- Poor coping skills, introversion

- Kleespies et al. (2000) reported that 30-40% of U.S. older adults who died by suicide were medically ill at the time, yet only 2-3% were terminally ill
- Most suicidal older adults are not terminally ill
- Most terminally ill older adults are not suicidal
- Nevertheless, receiving a terminal prognosis can be psychologically overwhelming and temporarily induce suicide ideation (Silverman, 2000).
- These thoughts subside quickly for most; however, some terminally ill older adults with depression, despair, or poor end-of-life care experience an on-going desire to hasten death (DHD), increasing risk (Chochinov, 2006; Waern et al., 1999).

- Suicide among older adults does not typically occur in the context of terminal illness, but rather in the context of depression and/or other mental disorders and losses or other life transitions and stressors

- The lay public believes that suicidal older adults are terminally ill; this is generally wrong

- Many providers believe that terminally ill older adults are not suicidal; this, too, can be wrong

- Therefore, we should carefully assess suicidal intent in those expressing a wish to hasten death (King, Heisel, & Lyness, 2005)

- Be vigilant to excess need for perceived autonomy and self-determination and be aware of high-risk periods, including after communication of a frightening diagnosis or a terminal prognosis

RISK FACTORS (Cont.):

5. Medical Illness

- Pain, chronic illness
- Sensory impairment
- Perceived or anticipated/feared illness or decline

6. Negative Life Events and Transitions

- Family discord, separation, death or other losses
- Financial or legal difficulties
- Employment/retirement difficulties
- Relocation stresses

7. Functional Impairment

- Loss of independence
- Problems with activities of daily living

Suicide Assessment & Prevention for Older Adults
Clinician Pocket-Card

RESILIENCY FACTORS:

1. Religious (or spiritual) practice.

2. Sense of meaning and purpose in life.

3. Sense of hope or optimism.

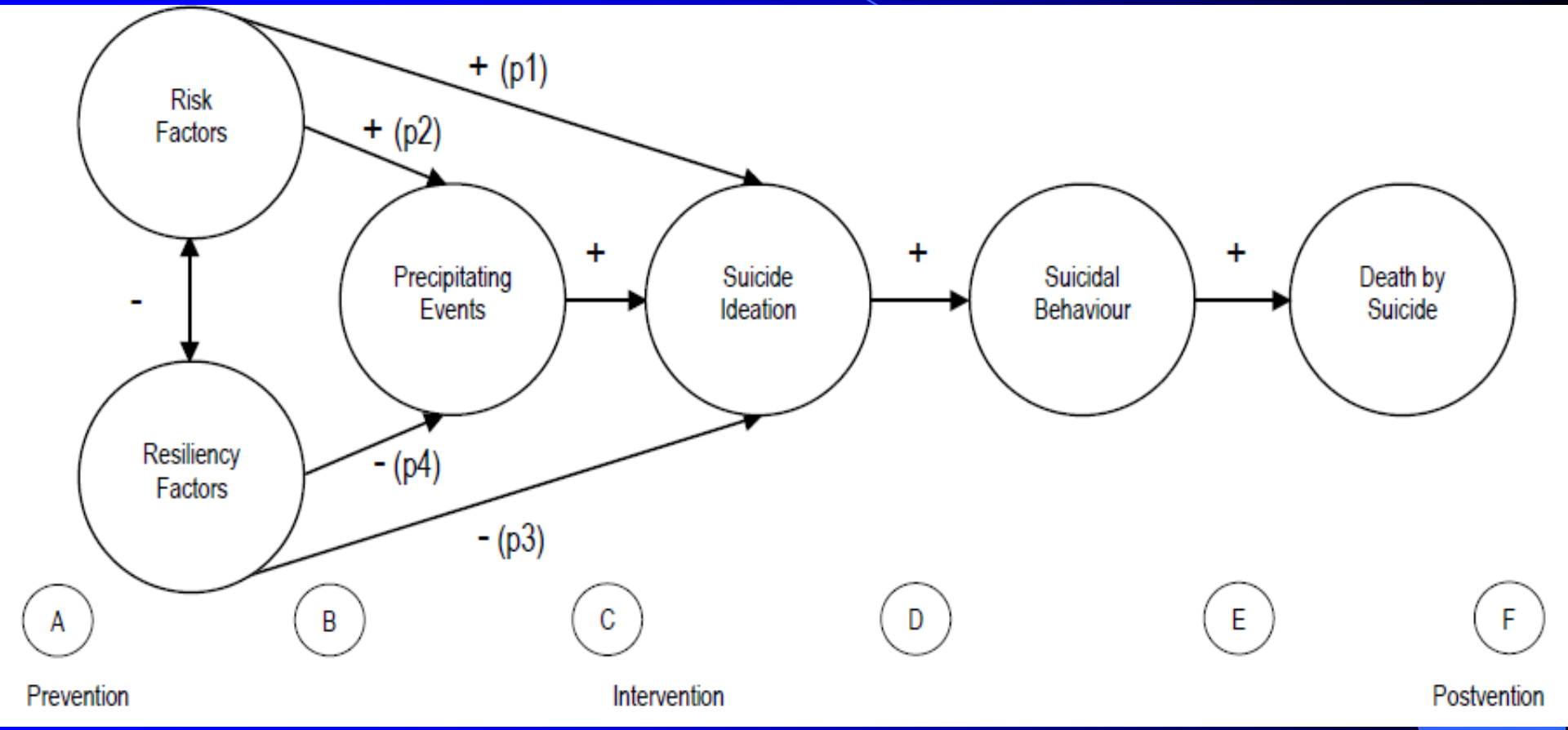
4. Active social networks and support from family and friends.

5. Good health care practices.

6. Positive help-seeking behaviours.

7. Engagement in activities of personal interest.

Our Conceptual Framework (e.g., Heisel & Flett, 2014)



Risk Assessment Tools

- Rating scales and other measures can be helpful for diagnostic clarification, symptom ratings, and standardization, but are insufficient to assess risk

- Be aware of validity issues; don't just take self-reports at "face value"-at least a rudimentary rapport is required when using assessment tools

- Work within your skill-set and competencies; use of validated scales requires appropriate training

- There is no such thing as a "best" screening or assessment tool; rather certain tools are more appropriate in particular contexts and populations

- Suicide risk assessment must be carried out in a sensitive fashion, in the context of a trusting therapeutic relationship
- Clumsy assessment of suicide ideation may be worse than not asking the question at all
- The same can be true of use of non-validated assessment instruments
- Busch and colleagues (2003) noted that roughly three-quarters of current or recently-discharged mental health patients who died by suicide denied suicide ideation as a last communication before death; some as little as 5-10 minutes beforehand

- Evidence for public health screening for SI is mixed

- The U.S. Preventive Services Task Force concluded that evidence is insufficient to recommend for or against routine screening for suicide risk by primary care providers

- A growing body of research supports screening for depression and suicide ideation:

    - Teaching GPs to screen for and treat depression reduced the suicide rate in Gotland (Rutz et al., 1980).

    - Community outreach education, depression screening, and counseling reduced deaths by suicide in Japan (Oyama et al., 2004, 2005, 2006).

- Although measures developed with adults can often be used with older adults, provided validation data exist, these measures may not be as relevant to the experiences or reporting styles of older adults.
- We found that a 5-item screen derived from the GDS identified older primary care patients with suicide ideation (Heisel et al., JABFM, 2010).
- Professional geropsychology guidelines recommend use of age-specific measures developed and/or validated with older adults (APA, 2004).
- We saw the need for a tool to specifically assess older adult suicide risk and resiliency, and developed the Geriatric Suicide Ideation Scale to meet this need.

The Development and Initial Validation of the Geriatric Suicide Ideation Scale

Marnin J. Heisel, Ph.D.
Gordon L. Flett, Ph.D.

Objective: *The authors report on the development and initial validation of the Geriatric Suicide Ideation Scale (GSIS), a new multidimensional measure of suicide ideation and related factors in older adults.* **Methods:** *Study 1 involved development of an initial 66-item measure, administration to a heterogeneous sample of 172 adults 65 years or older, assessment of the measure's factor structure, and subsequent scale reduction and correlation with social desirability. Study 2 involved validation of the reduced scale with a new sample of 107 older adults and psychometric assessment of the measure's reliability and initial validity.* **Results:** *Factor analysis indicated a four-factor structure for the GSIS, with subscales assessing Suicide Ideation, Death Ideation, Loss of Personal and Social Worth, and Perceived Meaning in Life. Psychometric analyses with a new sample indicated strong internal consistency and test–retest reliability. Construct and criterion validity for the GSIS and its subscales were demonstrated by positive associations with measures of depression, hopelessness, and self-reported health problems, and negative associations with life satisfaction and psychological well-being. The 10-item Suicide Ideation subscale also differentiated psychiatric patients from nonpatients.* **Conclusions:** *The GSIS is a psychometrically sound measure of late-life suicide ideation. Findings support the use of its subscales as standalone measures of late-life suicide risk and psychological resilience.* (Am J Geriatr Psychiatry 2006; 14:742–751)

Key Words: Suicide ideation, suicide, GSIS, older adults, assessment

The American Journal of Geriatric Psychiatry, 14, 742-751, 2006

The GSIS Sample Items

- **Suicide Ideation** (10 items):
  "*I want to end my life*"
- **Death Ideation** (5 items):
  "*I often wish that I would pass away in my sleep*"
- **Loss of personal and social worth** (7 items):
  "*I generally feel pretty worthless*"
- **Perceived Meaning in Life** (8 items):
  "*I feel that my life is meaningful*"

Reliability Estimates

	Internal Consistency[a]	*Temporal Stability*[b]
GSIS Total Scale	α = .93	r = .86**
Suicide Ideation	α = .82	r = .78**
Death Ideation	α = .84	r = .76**
Loss of Worth	α = .82	r = .77**
Meaning in Life	α = .81	r = .75**

a Validation sample (n = 107)

b 1-2 month test-retest period (n = 32)

** p<0.001

Validity

- Convergence
- Suicide Ideation
- Suicidal Behaviour
- Depression
- Hopelessness
- Social Hopelessness
- # of physical complaints
- Self-reported health ratings
- Attitudes toward hastened death

- Non-Convergence
- Meaning in life
- Purpose in life
- Psychological well-being
- Satisfaction with life
- Adaptiveness in coping
- Religiosity/religious commitment
- Reasons for living

Other Findings

- The GSIS has shown strong temporal consistency over a 1-2 year period in community-residing older adults.
- It has shown sensitivity to clinical change in our trial of IPT with suicidal older adults (Heisel et al., 2009), and in a trial of cognitive therapy for adults 60+ with Generalized Anxiety Disorder (Dr. J. Mohlman, P.I.).
- Research use in Canada (Neufeld & O'Rourke, 2009), the U.S. (Marty & Segal, 2010) and China (Chou et al., 2005).
- The GSIS has recently been included in a resource guide published by the Ontario Hospital Association among 15 recommended assessment tools
- Feedback from colleagues has been very positive.
- However, 31 items is long; we have thus developed abbreviated versions of the GSIS

The Brief GSIS (BGSIS)

- Developed a 10-item version, given the perceived need for a brief tool for busy clinical services

- We began by listing "critical items" from the GSIS based on our decade+ of experience administering the scale to older adults across the gamut of risk (wellness group members to suicidal inpatients)

- We assessed each item's response characteristics, central tendency, dispersion, normality, factor loadings, contribution to internal consistency, and associations with suicide ideation, behaviour, plans, resiliency, and setting

- Our rationale was to reflect the measure's multidimensional item content

- We wanted the measure to:
  - be brief (no more than 10 items)
  - demonstrate internal consistency
  - demonstrate test-retest reliability
  - demonstrate predictive, construct, & criterion validity
  - reflect the best features of the GSIS, to be used in conjunction with it, but not replace it
  - assess theoretically important constructs
  - be face valid and user-friendly

The GSIS-Screen

- Developed for use in community and other health screenings, large-scale epidemiologic studies, and for possible assessment of study inclusion criterion
- We retained a single item from each of the GSIS subscales retaining its multidimensional focus
- 4 items overlap with the BGSIS; however, unlike the BGSIS, we retained an item inquiring into past suicidal behaviour to better differentiate those with vs. without histories of suicidal behaviour
- We have recently developed a user's guide for the GSIS-Screen

GSIS-Screen

The Geriatric Suicide Ideation Scale-Screen

A User's Guide

Marnin J. Heisel, Ph.D., C.Psych.

&

Gordon L. Flett, Ph.D.

The GSIS Screen

1. I feel that my life is meaningful.
2. I generally feel pretty worthless.
3. I often wish that I would pass away in my sleep.
4. I want to end my life.
5. I have tried ending my life in the past.

GSIS-Screen

Listed below are a number of statements concerning your feelings and beliefs about your life. Please read each statement carefully, and decide whether you agree or disagree with it, and to what extent, as indicated below. Please be completely honest in your responses, and try to respond to every statement. Do not circle more than one number for each statement.

1	2	3	4	5
Strongly Disagree	**Disagree**	**Neither Agree Nor Disagree**	**Agree**	**Strongly Agree**

1. I feel that my life is meaningful.	1 2 3 4 5
2. I generally feel pretty worthless.	1 2 3 4 5
3. I often wish that I would pass away in my sleep.	1 2 3 4 5
4. I want to end my life.	1 2 3 4 5
5. I have tried ending my life in the past.	1 2 3 4 5

Findings with Combined Older Adult Sample (Three Studies; N=305)

- Findings demonstrated acceptable internal consistency (α = .82; n=298) and 1 month test-retest reliability (r=.83, ICC=.91, p<0.0001, n=190)

- The GSIS screen was significantly correlated with:
  - Corrected GSIS totals: r =.83, p<0.0001
  - Corrected GSIS-SI: r =.91, p<0.0001
  - Corrected GSIS-DI: r =.83, p<0.0001
  - Corrected GSIS-LOSS: r =.79, p<0.0001
  - Corrected GSIS-MIL: r =.69, p<0.0001
  - Corrected BGSIS totals: r =.87, p<0.0001

- The GSIS-screen significantly differentiated among settings ($F_{(4,293)} = 53.2$, $p<0.0001$).

Setting	M	SD	n
Psychogeriatric	13.05	4.38	42
Hospital	7.80	2.22	25
Nursing Home	9.63	3.37	41
Retirement Home	7.56	2.46	9
Community	6.57	2.01	181

Note: Psychogeriatric patient scores were significantly higher than all other participants; Community participant scores were significantly lower than Nursing Home residents.

- The GSIS-screen differentiated community-residing older adults with vs. without a history of suicidal behaviour ($t_{(8)} = -5.06$, $p<0.001$):

Group	M	SD	n
Hx of SB	10.6	2.5	9
No SB	6.3	1.6	162

Construct Validity (Resiliency Study; n=171)

Variable	Measure	r
Depression	GDS	.38***
Social Hopelessness	SHQ	.32***
Loneliness	UCLA	.33***
Anxiety	GAI	.30***
Psychological Well-Being	PWB	-.45***
Meaning in Life	EMIL-TOT	-.34***
Purpose in Life	PIL Test	-.38***
Life Satisfaction	SWLS	-.26***
Perceived Social Support	DUKE-PSS	-.15*

Note: **p<0.01 ***p<0.001.

Predictive Validity

- The GSIS-screen also predicted corrected total GSIS scores:
  - After 2-4 weeks $r = .53$, $p < 0.0001$ ($n = 137$)
  - After 6-12 months $r = .45$, $p < 0.0001$ ($n = 124$)

So Why Use the Longer Scales?

- We conducted a hierarchical regression analysis, predicting Time 2 SSI-C scores (Resiliency study; n=128) with the GSIS scales
- The GSIS Screen predicted Time 2 SSI-C scores (R^2=.06; $F_{(1,127)}$=8.22, p<0.01)
- Corrected BGSIS scores explained unique variance (ΔR^2=.03; $\Delta F_{(1,126)}$=4.64, p<0.05)
- Corrected GSIS-TOT further explained unique variance (ΔR^2=.03; $\Delta F_{(1,125)}$=4.49, p<0.05)
- Longer scales are generally more reliable

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Screening for suicide risk among older adults: assessing preliminary psychometric properties of the Brief Geriatric Suicide Ideation Scale (BGSIS) and the GSIS-Screen

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ABSTRACT

Objectives: To initially assess psychometric properties of two abbreviated versions of the Geriatric Suicide Ideation Scale (GSIS): a 10-item Brief Geriatric Suicide Ideation Scale (BGSIS), and a 5-item Geriatric Suicide Ideation Scale-Screen (GSIS-Screen).

Methods: A series of psychometric analyses was conducted, assessing the internal consistency, test–retest reliability, construct and predictive validity of the abbreviated GSIS scales. This was done by selecting-out GSIS items from a combined dataset of studies on suicide ideation in older adults: 1) The GSIS scale development study ($n = 107$); 2) A clinical trial of Interpersonal Psychotherapy (IPT) modified for suicidal older adults($n = 25$); 3) A longitudinal study of risk and resiliency to suicide ideation in community-residing older adults ($n = 173$).

Results: Overall findings demonstrated strong internal consistency, test–retest reliability, concurrent and predictive validity for the BGSIS and GSIS-Screen with older adults across community, clinical, and residential settings.

Conclusion: Study findings support the use of the abbreviated GSIS scales when conducting research on suicide risk identification among older adults. Future research is recommended testing these scales prospectively in public health, residential, and clinical settings, in research and healthcare delivery contexts.

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KEYWORDS
Suicide ideation; screening; assessment; resiliency; risk; older adults; GSIS; BGSIS; GSIS-Screen; suicide prevention

Additional Tools

- Harmful Behaviors Scale (HBS; Draper et al., 2002), a 20-item, 5-point, Likert-scored, observer rating scale for nursing home residents.

- Reasons for Living Scale-Older Adults Version (RFL-OA*; Edelstein et al., 2009), a 69-item Likert-scored measure of reasons for not killing one's self when feeling suicidal.

- Suicidal Older Adult Protocol (SOAP; Fremouw et al.), an 18-item clinical interview measure assessing static (demographic and historical variables) and dynamic factors (clinical, contextual, & protective variables).

- Suicidal Behaviors Questionnaire (SBQ*; Linehan, 1996), a 90-item measure of current, past, and anticipated suicide thoughts, plans, and behaviour.

* Abbreviated versions exist for older adults.

Limitation/Implication

- No measure does anything on its own
- Trained individuals are needed to select, administer, score, and interpret the results of any assessment tool, together with complementary approaches (e.g., clinical, interview, collateral informants, etc.)
- Clinical services must also be available to meet the need identified by screening and/or assessment tools
- These tools appear quite promising in helping to identify older adults at-risk for suicide
- Consider use of collateral sources of information (Heisel, Conwell, Pisani, & Duberstein, 2011).

Screening for Suicide Risk among Older Adults in Ontario Long-Term Care Homes: Assessing the Prevalence and Correlates of Suicide Ideation in a Vulnerable Demographic

Funding for this project has been provided by the Canadian Institutes of Health Research

CCSMH Suicide Assessment & Prevention for Older Adults Clinician Pocket-Card

Assessment Process:

1. Establish rapport and assess for suicide risk in a sensitive and respectful fashion.

2. Respect the dignity of older adults. Acknowledge their experiences and validate their feelings.

3. Assess for suicide risk factors.

4. Assess for psychological resiliency.

5. Assess for suicide warning signs IS PATH WARM.

- Remember "IS PATH WARM?"
  - I Ideation
  - S Substance Abuse
  - P Purposelessness
  - A Anxiety
  - T Trapped
  - H Hopelessness
  - W Withdrawal
  - A Anger
  - R Recklessness
  - M Mood Change

From the American Association of Suicidology (AAS) website (www.suicidology.org).

Assessment Process (Cont.):

6. Where appropriate, access collateral information (medical chart, family members, other providers).

7. Be mindful of ambivalent wishes to live and to die.

8. Develop a risk management/action plan.

9. Seek consultation and/or assistance if you do not have specialized training in mental health or in suicide prevention.

Suicide Assessment & Prevention for Older Adults Clinician Pocket-Card

KEY QUESTIONS:

1. Ask about their feelings

- Do you feel tired of living?
- Have you been thinking about suicide?

2. Ask about a suicide plan

- Have you made any specific plans or preparations (giving away possessions, tying up 'loose ends')?
- Do you have access to lethal means like a gun or other implements?

3. Ask about their reasons to live

- Who or what makes life so worth living that you would not harm yourself?

Intervention

Empirically-Supported Initiatives

- Public health initiatives (Universal)
  - Means restriction (medication packaging, CO, bridge barriers, firearms, media guidelines)
  - Clinician education (screening & intervention)
  - Suicide prevention strategies/treatment guidelines
- Community initiatives (Selected)
  - Gatekeeper training and response/referral
  - Community outreach/support (DeLeo et al., Oyama et al.)
- Clinical initiatives (Indicated)
  - Psychotherapy (+ medication, and possibly ECT)
  - Emergency Cards and caring letters
  - Organizational change

Recommendation: Treatment and Management:

- 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.

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

- Health care providers should explore strategies to assist older persons find and maintain meaning and purpose in their lives.

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Meaning-Centered Men's Groups: Initial Findings of an Intervention to Enhance Resiliency and Reduce Suicide Risk in Men Facing Retirement

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ABSTRACT

Objectives: To assess the preliminary effectiveness of Meaning-Centered Men's Groups (MCMG), a 12-session existentially-oriented, community-based, psychological group intervention designed to enhance psychological resiliency and prevent the onset or exacerbation of suicide ideation among men who are concerned about or struggling with the transition to retirement.

Methods: We recruited 30 men (n= 10 per group), 55 years and older (M= 63.7, SD= 4.1) from community settings to participate in a course of MCMG to be delivered in a community center. Participants completed eligibility, pre-, mid-, and post-group assessments of suicide ideation and psychological risk and resiliency factors.

Results: Participants experienced significant increases in attitudinal sources of meaning in life, psychological well-being, life satisfaction, retirement satisfaction, and general health, and decreases in depression, hopelessness, loneliness, and suicide ideation.

Conclusions: Preliminary findings suggest that MCMG is a novel men's mental health intervention that may help to enhance psychological well-being and potentially reduce the severity or prevent the onset of symptoms of depression, hopelessness, and suicide ideation.

Clinical Implications: Upstream psychological interventions may serve an important role in mental health promotion and suicide prevention with potentially vulnerable individuals facing challenging life transitions.

KEYWORDS

Meaning in life; suicide prevention; psychological resiliency; men's groups; older adults; geropsychology

Testing Online Meaning-Centered Men's Groups to Promote Psychological Well-Being and Reduce Despair in the Face of the COVID-19 Pandemic

Funding for this study was provided by the Lawson Health Research Institute

Testing Online Meaning-Centered Groups in Promoting Psychological Well-Being and Reducing Distress in Ontario Retirement Home Residents

Project support for this study was provided in part by SPARK-ON funding from the Centre for Aging and Brain Health Innovation and by a New Horizons for Seniors Program grant by Employment and Social Development Canada

Promoting Psychological Resiliency among Veterans and First Responders in Career Transition: Implementing and Evaluating Meaning-Centered Men's Groups in Key Sectors at Elevated Risk for Suicide

Project support for this study was provided in part by Movember's Men's Mental Health Grant for Veterans and First-Responders (VFR)

Risk Management

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RISK MANAGEMENT STRATEGIES:

Help the older adult connect with a team of supports: other medical and/or mental health care providers, social service providers, clergy, family members, friends, and/or other community members.

Immediate Risk Management

1. Do not leave the person alone until you have arranged for the involvement of another appropriate care provider or source of protection

2. Establish an immediate safety plan that includes:

- family support; 24-hour (or in-home) care providers
- police intervention (if needed)

3. Consider care needs:

- emergency services
- Telephone and/or in-person distress/support services
- mental health services
- medical services
- social service providers, community supports

4. Ensure that follow-up care is arranged.

5. Where possible, restrict access to lethal means.

Ongoing Risk Management

1. Address underlying issues:
   - medical, psychological, social, and environmental
2. Continually assess suicide risk, resiliency, & warning signs
3. Continue to build and sustain the therapeutic relationship.
4. Foster hope and enhance a sense of meaning in life.
5. Develop a safety plan that includes after-hours support.
6. Read and review CCSMH and other treatment guidelines.
7. Work within a culturally competent model of care.
8. Work in an inter-disciplinary care model where possible:
   - Develop relationships with mental health teams for support and on-going follow-up.
   - Be aware of community resources and referral sites/processes.

What should providers do?

- Be willing to sit and listen, non-judgmentally
- Be interested, supportive, and approachable
- Find out about situational/interpersonal issues
- Don't assume all is well…QUESTION!
- Listen to your gut (or little voice in your head), and follow-up on dropped comments/hints
- Involve others!!!
- Document

- Keep detailed notes; documentation is critical
- But avoid "no-harm contracts"(Lewis, 2007)
- Contracts do not decrease risk for suicide; Kroll (2000) reported that 41% of psychiatrists who used no harm contracts lost a patient to suicide while on a contract
- Moreover, calling it a contract raises the legal bar, and the consequent risk of a lawsuit
- Develop a "safety plan" instead (Brown et al., 2005)
- Provide follow-up and supportive aftercare

Know your clients/patients

- The relationship is crucial
- Learn about the person's personal and family medical and mental health history
- Cookie cutter approaches do not work here
- Get to understand the context of his/her life
- Be vigilant to worries, concerns, problems
- Be aware of pending challenges and losses
- Be kind and empathic and retain your objectivity

Treatment Implications

- We cannot predict who will die by suicide; however, we can and must assess suicide risk (and resiliency)
- Outreach is critical for detecting at-risk individuals; don't forget to follow-through
- Make suicide risk assessment part of usual practice, even when you don't think it's present
- Routinely assess access to firearms and other lethal means
- Assess history of suicidal behaviour; one of the strongest risk factors for death by suicide
- Be open to discussions of suicide-it takes time and should
- Consider use of rating scales
- Work in teams wherever possible
- Communication among providers is absolutely critical

Summary

- Suicide is a significant problem in our society; societal responses are desperately needed!
- Older adults have high rates of suicide
- The population is growing; increasing numbers of older adults are dying by suicide (and MAID)
- Guidelines and other KT resources now exist for assessment and intervention with at-risk older adults
- Suicide risk and resiliency must be assessed
- Use of validated measures and approaches can help

- Promising clinical & community interventions exist; more are desperately needed, especially with cut-backs in and ineffectiveness of hospital-based care
- Enhanced healthcare services are needed
- Mental healthcare is still inaccessible for many
- Collaborative care is strongly encouraged
- Outreach approaches can help and are needed
- Ensure that you have supports in place; this work can be both challenging and highly rewarding

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- This is a free webinar series, taking place on roughly a monthly basis, focusing on suicide and its prevention. Everyone is welcome.
- Feel free to e-mail me to ask for your e-mail to be added to our distribution list: Marnin.Heisel@lhsc.on.ca