A Guide
to Promoting Emotional Health and Preventing Suicide in Senior Living Communities

Contents:

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- Tools for Implementing Action Steps

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Table of Contents

Getting Started

Overview of the Guide

A Guide to Promoting Emotional Health and Preventing Suicide in Senior Living Communities is written for administrators and managers of departments of nursing, social work, pastoral care, wellness, and staff development in senior living communities. Senior living communities include nursing homes, assisted living facilities, independent living facilities, and continuing care retirement communities. Too often, staff in senior living communities do not think about suicide prevention until a suicide attempt or death occurs. This Guide will help you be proactive by implementing policies, protocols, programs, and activities that will improve all residents' quality of life, while also helping protect vulnerable members of the community from suicide and related emotional health problems.

The Guide contains the following components:

- **Getting Started:** Includes background information on suicide and suicide prevention, directions for using the Guide, a Sample Policy, and a Facility Assessment Checklist
- **Goals and Action Steps:** Includes sections addressing each of the three essential approaches to suicide prevention in a senior living community:
  - Section 1. Whole Population Approach: Discusses strategies to promote the emotional health of all residents, regardless of their risk for suicide
  - Section 2. At-Risk Approach: Discusses how to identify and assist residents who are at a particularly high risk for suicide and related emotional health problems
  - Section 3. Crisis Response Approach: Focuses on what senior living communities should do after suicide deaths and attempts

  Each section has background information, goals relevant to the approach, and action steps your staff can take to meet those goals.
- **Tools for Implementing Action Steps:** Includes worksheets, fact sheets, and program descriptions to help you create and implement the policies, protocols, programs, and activities discussed in the Goals and Action Steps component of the Guide
- **References**

While implementing all the protocols, policies, programs, and activities outlined in this Guide would create a comprehensive suicide prevention and emotional health prevention program, most senior living communities will not have the time and resources to systematically do everything suggested in this Guide. You may also find you have already implemented many of the strategies recommended in this Guide. For these reasons, the Guide is designed to help you quickly select goals and implement action steps of the most relevance and importance to your senior living community.

Background on the Topic of Suicide

Suicide Definitions

Suicidal behavior is a spectrum of activities that includes the following (DHHS, 2001, p. 203):

- Suicide—A death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the death.
- Suicide attempt—Potentially self-injurious behavior with a non-fatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.
- Suicidal ideation—Self-reported thoughts about engaging in suicide-related behaviors.

Passive suicide (also called indirect suicide) includes behavior that occurs over time and can reasonably be expected to result in death. This can include refusing to eat, drink, take medication, or follow other treatment plans, or taking unnecessary risks. Passive suicide is likely to occur among older adults in settings such as nursing homes where they have limited control over their lives and limited access to lethal means (Reiss & Tishler, Part II, 2008). It is important to note that passive or indirect suicide is different from an end-of-life decision made by a terminally ill older adult, in which a health care team supports a rationally thought-out decision by the individual to have treatment and medication withheld or withdrawn.

Suicide in Senior Living Communities

Suicide rates are higher among older adults than the national average (CDC WISQARS, 2006). It is unclear whether suicide death and attempt rates are higher among older adults living in senior living communities or those not in these facilities. Several studies have shown that suicidal thoughts (ideation) and depression are more common among nursing home residents than among those who are not in nursing homes. This is particularly true for adults recently admitted to a nursing home (Reiss & Tishler, Part I, 2008).

The most common method of suicide among older adults, in general, is firearms (CDC, 2006). However, the most common means of suicide in nursing homes (in which access to firearms is very limited) are jumping from high places, hanging, taking overdoses of medication, and cutting (Abrams et al., 1988; Osgood, 1990; Scocco et al., 2006; Suominen et al., 2003). Passive suicide, such as refusing to eat, drink, take medications, or follow other treatment plans, and taking unnecessary risks, are also used as a means of suicide in these situations (Conn & Kaye, 2007; Nelson & Farberow, 1980).

In the general population of older adults, suicide attempts are much more likely to result in death than among younger adults: 1 of every 4 older adults who attempt suicide dies, compared to 1 of every 100–200 young people who attempt suicide (American Association of Suicidology, 2009). There are several reasons for this difference (Conwell, 1997):

- Older adults plan carefully and use more deadly methods (such as guns). Suicide attempts by younger people are more impulsive. They are less likely to use firearms.
- Older adults are less likely to be discovered and rescued than younger people.
- Many older adults are physically frail. They are less likely to recover from a suicide attempt than younger people.

Risk Factors for Suicide

Risk factors for suicide are personal characteristics, life circumstances, and situations that lead to, or are associated with, suicide. People with one or more of these risk factors have a greater potential for suicidal behavior (DHHS, 2001, p. 34). Some risk factors cannot be changed—such as a previous suicide attempt—but they can help identify someone who may be vulnerable to suicide. The impact of other risk factors can definitely be reduced with appropriate care, support, and action by staff, residents, and family members. Risk factors that are relevant for older adults in senior living communities include the following (Beeston, 2006; DHHS, 2001; Reed, 2007; Wojnar et al., 2009):

Mental illness

- Major depression
- Other mood disorders
- Psychotic disorders

Substance misuse and abuse

- Alcohol
- Prescription and over-the-counter (OTC) medication

Physical illness, disability, and pain

- Poor physical health
- Functional impairments
- Pain
- Side effects of some medications
- Insomnia

Personal and family history of suicide

- Previous suicide attempt
- A family member who has died by suicide

Current life circumstances

- Social isolation
- Major life transitions, such as moving to a new setting
- Family conflict and loss
- Financial problems
- Lack of a sense of safety
- Losing autonomy, respect, supportive relationships, and participation in civic and social life
- Other people having lower expectations for them

Personal characteristics

- Inability to adjust to change
- Low rating of their own health
- Low self-esteem
- Hopelessness
- Impulsive or aggressive behavior
- Cultural or religious beliefs favorable to suicide, especially among older people

Access to means of suicide

Most common means of suicide in nursing homes include:

- Jumping from buildings
- Hanging
- Cutting
- Taking an overdose of medication

Older adults can also harm themselves by refusing to eat, drink, take medication, or follow other treatment, and by taking unnecessary risks.

Protective Factors that Can Help Prevent Suicide

Protective factors are a person's attitudinal and behavioral characteristics, life circumstances, and attributes of the environment that reduce the likelihood of suicide. "They enhance resilience and may serve to counterbalance risk factors" (DHHS 2001, p. 34). Actions that enhance protective factors are essential to preventing suicide. Some actions can be taken by staff in senior living communities and some by friends, family members, and residents themselves. The following are protective factors for suicide for older adults in senior living communities (Beeston, 2006; DHHS, 2001; Reed, 2007):

Health care and emotional health care

- Treatment for depression and other mental health issues
- Substance abuse treatment
- Treatment for physical illnesses and disabilities
- Promotion of health and wellness

Personal characteristics

- Resilience and perseverance
- Openness to experience
- Sense of meaning and purpose/Hope
- Self-esteem
- Skills in coping, problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Positive health practices and help-seeking behavior

Living situation

- Positive, pleasant, and homelike physical environment
- Accessible environment for residents with physical disabilities
- Restricted access to highly lethal means of suicide

Relationships

- Strong connections with family, friends, and the larger community
- Engagement in purposeful activities, including recreational, social, spiritual, intellectual, and creative—designed around the likes and needs of the residents
- Strong connections with staff and volunteers

Recognizing and reducing risk factors and increasing protective factors, both for individuals and groups, is at the heart of this Guide's approach to preventing suicide.

How to Use the Guide

There is no universal set of strategies that is appropriate for all senior living communities. Each senior living community needs to tailor its emotional health and suicide prevention activities to its own needs, residents, culture, and available resources. This Guide presents a wide range of policies, protocols, programs, and activities from which you can choose. You will probably not use all of these activities nor implement the activities in the order they are presented in the Guide. We recommend the following process:

1. **Review the Sample Policy** included in this section. This document provides a concise yet comprehensive picture of the type of senior living community that promotes emotional health and seeks to prevent suicide.
2. **Complete the Facility Assessment Checklist** in this section. This simple two-page checklist will help you identify programs and policies that you may need to implement or strengthen. The checklist will also point you to the goals and action steps in the Guide related to these areas of need.
3. **Review the goals** in the Guide indicated in your completed Facility Assessment Checklist. Read the background information, action steps, and supplemental information for each goal. The information is drawn from research on what works as well as from the experiences of staff in senior living communities around the country.
4. **Develop a plan for implementing the action steps:**
   - ◊ Consider which of the action steps might be possible for your senior living community, and then of these, the most important and most appropriate, given your organization, existing efforts, culture, and resources available in your senior living community.
   - ◊ Use the tools referred to in many of the action steps. These tools include worksheets, guidelines, templates for protocols, model policies, and other resources. They are located in the Tools for Implementing Action Steps section of the Guide.
   - ◊ Convene the necessary staff to help put actions into place.
   - ◊ Use *Tool 4.a: Planning Worksheet Example and Template*. This tool will help you create a realistic timeline and ensure that you consider staffing and resource needs. The tool has a template you can use and an example of how to fill it in.
5. **Use the Trainer's Manual** to deliver workshops to your staff and your residents and their families to enable them to be effective partners in the implementation of the emotional health promotion and suicide prevention plans that you have developed using this Guide.

Sample Policy

Senior Living Community Policy on Emotional Health Issues, including Suicide

At _____, we believe that emotional health is inseparable from physical health. Our person-centered model demonstrates our commitment to creating a home in which every resident's experience is meaningful, dignified, and satisfying. Our programs are designed to ensure that our staff and environment promote our residents' health and well-being, prevent illness and injury when possible, and provide or ensure provision of high-quality treatment when needed. We have multiple programs and activities aimed at enriching our residents' lives and promoting their emotional health, whether they reside in our independent living, assisted living, skilled nursing care, or special care facilities for people with memory loss. Especially helpful are those activities that help residents establish and enhance social networks with other residents, family members, friends, volunteers, and staff. In addition, we have professional staff who are trained to screen and treat residents in need of emotional health care or to refer them to providers in the nearby community.

We are especially concerned about the safety of our residents, and we know that, in the United States, older adults have one of the highest rates of death by suicide of any age group. At _____, we are committed to preventing suicide. All of our staff members know how to identify warning signs in a resident who is contemplating suicide, and we have written protocols to prevent an emotional health concern from becoming a tragedy. As much as possible, we limit the residents' access to methods of self-harm, such as toxic chemicals and unprotected rooftops. We also provide facility-wide well-being campaigns to increase our residents' knowledge and comfort in seeking help if and when they need it.

In the unlikely event that a resident makes an attempt to end his or her life, we have protocols for an effective response and follow-up plan to ensure the resident gets the best available treatment and care.

We also know that each suicide death leaves behind "survivors," (i.e., friends and family of the deceased), and survivors are often devastated by the loss. In a senior living community, survivors also include staff, volunteers, and residents who were close to the person who died. We have protocols in place to help these survivors in the immediate aftermath, as well as over the long term.

Professional and paraprofessional, clinical and nonclinical staff all have distinct and important roles to play in implementing this policy.

If you have any questions about this policy, please do not hesitate to contact _____ _____ **[insert name]**.

Facility Assessment Checklist

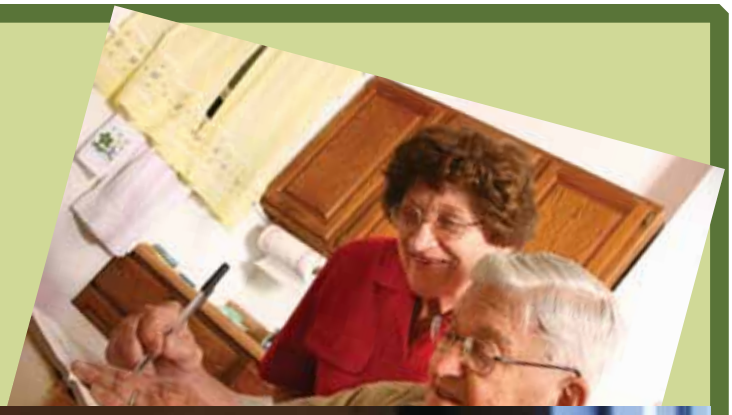
For Emotional Health Promotion and Suicide Prevention in Your Senior Living Community

Whole Population Approach Questions	If you answer No or Don't Know, consider implementing the steps in:	
Do you have a variety of activities that promote intellectual, creative, spiritual, and physical well-being?	__ Yes __ No __ Don't Know	Goal 1.1: Activities
Do you have programs and support services for residents that help them cope with loss?	__ Yes __ No __ Don't Know	Goal 1.1: Activities
Have your staff received training on the value of engaging residents in intellectual, social, physical, and creative activities?	__ Yes __ No __ Don't Know	Goal 1.1: Activities
Do you have programs that are designed to promote social networks and community building among your residents?	__ Yes __ No __ Don't Know	Goal 1.2: Social networks
Are you familiar with initiatives recommending improvements in the social and physical environment of a senior living community to increase resident well-being and satisfaction?	__ Yes __ No __ Don't Know	Goal 1.3: Environment
Do you have policies related to resident access to lethal means, (i.e., weapons and other methods they could use to harm themselves), as well as building design and security standards that restrict or minimize the potential for individuals to access areas that could lead to a fatal act?	__ Yes __ No __ Don't Know	Goal 1.4: Lethal means

At-Risk Approach Questions	If you answer No or Don't Know, consider implementing the steps in:	
Have all your staff received training on how to recognize warning signs of suicide, and how to respond if they see these signs?	__ Yes __ No __ Don't Know	Goal 2.1: Warning Signs
Have relevant staff received training on how to effectively manage the treatment of a resident determined to be at risk of suicide?	__ Yes __ No __ Don't Know	Goal 2.1: Warning Signs
Does your staff know what factors in the lives of your residents put them at risk of suicide?	__ Yes __ No __ Don't Know	Goal 2.2: Risk Factors
Does your staff know how to screen for and identify the symptoms of depression?	__ Yes __ No __ Don't Know	Goal 2.3: Depression
Are all relevant staff familiar with effective treatments for depression among older adults?	__ Yes __ No __ Don't Know	Goal 2.3: Depression
Are you familiar with comprehensive programs that have been shown to be effective in reducing depression among older adults (e.g., PEARLS, Healthy IDEAS)?	__ Yes __ No __ Don't Know	Goal 2.3: Depression
Can your staff recognize and screen for alcohol problems among your residents?	__ Yes __ No __ Don't Know	Goal 2.4: Substance abuse
Is your staff familiar with effective ways to treat alcohol and medication misuse problems?	__ Yes __ No __ Don't Know	Goal 2.4: Substance abuse
Do you have a list of the mental health contacts in your community, and what help and resources they provide?	__ Yes __ No __ Don't Know	Goal 2.5: Community connections
Are your residents provided with information and resources to encourage them to seek help for depression, substance abuse, and suicidal thoughts?	__ Yes __ No __ Don't Know	Goal 2.6: Help seeking

Crisis Response Approach Questions	If you answer No or Don't Know, consider implementing the steps in:	
Do you have a protocol for what to do in the event a resident attempts suicide?	__ Yes __ No __ Don't Know	Goal 3.1: Immediate response
Do you have a protocol for what to do in the immediate aftermath of a suicide death in your senior living community?	__ Yes __ No __ Don't Know	Goal 3.1: Immediate response
Do you have a plan and the resources in place to help survivors after a suicide death or attempt, including family and close friends, the resident community at large, and staff?	__ Yes __ No __ Don't Know	Goal 3.2: Postvention

Goals and Action Steps



Section 1

Whole Population Approach

Goals

Goal 1.1: Activities	Residents have access to activities that promote their emotional health and well-being.
Goal 1.2: Social networks	Social networks are established among residents.
Goal 1.3: Environment	The physical and social environment promotes emotional health and well-being.
Goal 1.4: Lethal means	Residents' access to methods of self-harm is limited.
Goal 1.5: Staff training	Staff receive training and support for their roles in promoting the emotional health of residents.

This section of the Guide discusses how you can promote emotional health and prevent suicide among all residents of your senior living community, regardless of their individual risk for emotional health problems or suicide. Any comprehensive approach to these issues begins with implementing policies and activities to promote the emotional health and well-being of all residents. Activities in support of these goals work to strengthen the protective factors that promote emotional health and prevent suicide, as well as affect the physical, intellectual, emotional, social, and spiritual well-being of residents. Examples of strengthening protective factors include obtaining needed medical and emotional health care; strengthening personal characteristics such as hope, sense of meaning in life, and coping skills; and developing positive living environments and relationships with other people.

The goals in this section are consistent with the philosophy of the nursing home *culture change movement*, which is led by organizations such as the Eden Alternative, Pioneer Network, and National Alliance of Small Houses. They are also consistent with the recommendations for improving the environments in nursing homes put forth by several professional and advocacy organizations, including the Canadian Coalition for Seniors' Mental Health, American Geriatrics Society, and American Association for Geriatric Psychiatry.

Although the culture change movement focuses on nursing homes, many of its principles and guidelines are also relevant for assisted living and independent living facilities. To obtain information on these organizations and recommendations and how they can help you, see *Tool 4.b: Resources List, Section III. Information about the Physical and Social Environment.*

Culture Change

Culture change is the name of the national movement for the transformation of older adult services, including long-term care, where the voices of older adults and those working with them are considered and respected. Culture change transformation may involve changes in organization practices, physical environments, relationships at all levels and workforce models to lead to better outcomes for consumers and direct care workers (Pioneer Movement, 2009).

Goal 1.1 Activities:
Residents have access to activities that promote their emotional health and well-being.

Activities and programs that promote the emotional health and well-being of residents build and strengthen the protective factors associated with personal characteristics and coping skills (see the Getting Started section for more information).

The types of activities that promote emotional health and well-being include the following[1]:

- Health and wellness activities, such as exercise classes or interactive games; walking and gardening; and classes in relaxation, breathing techniques, yoga, Quigong, or Tai Chi
- Disease and injury prevention and chronic disease management classes that promote an ability to take care of one's health
- Intellectual activities, such as book and current events discussions, to stimulate cognitive functioning and enhance self-esteem
- Arts activities, such as creative writing, arts and crafts, music, drama, and dance, to promote creativity, imagination, and self-expression
- Skill-building activities, such as classes in computers, carpentry, cooking, sewing, gardening, financial management, and grandparenting, to increase self-esteem and a sense of competence
- Coping support programs for groups and individuals, including classes and workshops, to help residents face personal issues, such as loss and bereavement, caring for a spouse or partner, interpersonal communication, and problem solving
- Spiritual activities, such as religious services, celebrations of religious holidays, prayer groups, and meditation classes, to help residents find meaning, purpose, and value in life
- Volunteer and mentoring activities, such as welcoming and engaging new residents, and intergenerational activities with children, teens, and younger adults, which provide a sense of purpose and meaningful connections with others

[1] Project staff contacted a number of senior living communities by phone and e-mail to solicit suggestions and learn about their experiences. The information and suggestions provided here are a compilation of these discussions.

Action Steps for Goal 1.1

1. **Gather information.**
   - ◊ Survey current and future residents about their interests to find out what activities are most likely to engage them.
   - ◊ Consult with staff to learn what current activities and programs are most popular with the residents.
2. **Look at the programs and policy statements in** *Tool 4.b: Resources List, Section III. Information about the Physical and Social Environment.*
3. **Select activities and make a plan** to implement them. Assess which of your existing activities can be enhanced and which new activities can be implemented, then decide who will take the lead and how to implement them. Using *Tool 1.a: Activities to Promote Emotional Health and Well-Being* will help by providing additional ideas for activities. Accessibility factors must be clearly addressed in the plan to ensure that any barriers to participation are explored and effectively accommodated.
4. **Implement the new activities** or enhance existing activities.
5. **Deliver Staff Workshops 1 and 2.** *Staff Workshop 1: Understanding Suicide Prevention in Senior Living Communities* and *Staff Workshop 2: Implementing Strategies to Prevent Suicide in Senior Living Communities* introduce staff to the Whole Population Approach and provide opportunities for staff to develop plans to improve activities that promote emotional health and well-being.
6. **Deliver the Family and Resident Workshop.** *Family and Resident Workshop: Promoting the Emotional Well-Being of Residents in Senior Living Communities* emphasizes the value of resident participation in activities offered by the senior living community. Also distribute the fact sheet, *Look Out for the Well-Being of Yourself and Others,* which reinforces this information.

Chronic Disease Self-Management Program

The Chronic Disease Self-Management Program, developed and tested by Stanford University, is a six-week education program that teaches practical skills to manage chronic health problems. Adults with a variety of chronic health problems attend the same classes; family members and caregivers can also participate. The classes are highly participatory with a focus on mutual support. Topics covered include (1) techniques to deal with problems such as frustration, fatigue, pain, and isolation; (2) appropriate exercise; (3) appropriate use of medications; (4) communicating effectively with family, friends, and health professionals; (5) nutrition; and (6) how to evaluate new treatments. This program has been scientifically evaluated and is commonly used in community settings across the United States, as well as in some senior living communities. For more information, see http://patienteducation.stanford.edu/programs/cdsmp.html.

Linking Older Adults with Medication, Alcohol, and Mental Health Resources

Getting Connected: Linking Older Adults with Medication, Alcohol, and Mental Health Resources is a toolkit designed to enable service providers of older adults to conduct health promotion and prevention education, as well as provide screening and referral for mental health problems and the misuse of alcohol and medications. The kit includes a coordinator's guide and program support materials, such as education curricula, fact sheets, handouts, forms, and resources. The kit has been used in a senior living community in Maryland. For more information, see https://ncadistore.samhsa.gov/catalog/ProductDetails.aspx?ProductID=16523.

ElderVention Program

The ElderVention program targets risk factors for depression and suicide and aims to increase protective factors such as coping skills, resilience, and socialization. It can be implemented in both senior living communities and community settings. The program includes classes on a range of behavioral health prevention topics, including loss, grief, anxiety, and stress, and workshops to help build coping skills and resilience to deal with major life transitions, such as the death of a spouse, health problems, retirement, and relocation (Maier et al., 2006). For more information on ElderVention, go to http://www.aaaphx.org/ELDERVENTION.

Activities to Engage Men

At one assisted living facility, staff noticed a lack of involvement in activities among the men, so they started offering a monthly breakfast for men, during which health care professionals speak on topics of special interest to men, such as heart disease and prostate cancer. The presentation is followed by a discussion to encourage the men to interact. This senior living community also encourages men to participate in activities in the fitness center and in games of pool, poker, and bridge. They also have a fantasy baseball league, which has sharpened the residents' strategic planning skills and their competitive spirit.

Continuing Education

The continuing care retirement community, Asbury Methodist Village, has a school of continuing education that is *fully* staffed and administered by residents. Resident experts, as well as academics and other experts from the surrounding community, serve as lecturers and class leaders. The school serves a number of functions, including education, social networking, and meaningful volunteer activity. It also serves as a logical kind of activity for retired academics as they transition into life in a senior living community. For more information, contact the current dean, Murray Schulman (m-mschulman@comcast.net).

Peer Counseling Program

Consider developing a Senior Peer Counseling Program based on the program at the Center for Successful Aging. Peer counselors, all age 50 and over, provide individual counseling and support groups for older adults who are experiencing a variety of problems related to aging, such as the stresses of illness, loss of spouse or friends, isolation from family and friends, and other life changes. An essential component of this program is that volunteer counselors are carefully screened, undergo an intensive 60-hour training, and are carefully and regularly supervised by a clinical psychologist. For more information, see http://www.csasb.org.

Health Promotion and Disease Prevention Programs

For information on evidence-based health promotion, and disease and disability prevention programs, see the Center for Healthy Aging Web site of the National Council on Aging at http://www.healthyagingprograms.org.

Goal 1.2 Social networks:
Social networks are established among residents.

Strategies that promote social networks among residents build and strengthen protective factors that are associated with relationships.

Social isolation and loneliness can have significant negative effects on emotional health. It is crucial for residents to have a variety of ways to connect with other people, develop social relationships, and receive the emotional support they need. Creating opportunities for social networking among residents can help buffer the isolation that can exist in senior living communities (especially nursing homes), as residents are removed from day-to-day contact with their family and friends. Building connections between residents and staff is also important. Staff can be engaging and empathetic with residents while maintaining appropriate professional boundaries.

Types of strategies that establish social networks among residents include the following[2]:

- Activities and opportunities for individuals to feel welcomed and accepted into the community. Examples include welcoming rituals and events, buddy systems, and "friendship tables" in the dining room, which are designed to encourage singles and couples just beginning to form their network of friends to eat with others. Other activities engage people who are preparing to move to the senior living community, so they can establish social networks before entering the facility and ease their transition to a new living situation.
- Caring neighbor activities, in which resident volunteers reach out to other residents. These can include telephone outreach programs, in which residents make calls to other residents to check on how they are doing and to offer support.
- Programs or committees where staff partner with residents to assist in building social networks.
- Programs that involve residents in the decision-making processes of the senior living community. These can include activities that encourage residents to participate on the resident council, resident committees, or other advisory, governing, or planning bodies. Being involved in decision making that affects the senior living community helps build social networks for both individuals and the community as a whole.

[2] Project staff contacted a number of senior living communities by phone and e-mail to solicit suggestions and learn about their experiences. The information and suggestions provided here are a compilation of these discussions.

Action Steps for Goal 1.2

1. **Select strategies.** Determine which strategies you can implement, who will have the lead, and what resources are needed by using *Tool 1.b: Strategies to Establish Social Networks.*
2. **Implement the new strategies.**
3. **Deliver Staff Workshops 1 and 2,** as described in Goal 1.1, as they reinforce the value of building social networks and provide opportunities to strengthen these in the senior living community.
4. **Deliver the Family and Resident Workshop,** as described in Goal 1.1, as it also describes the value of enhancing social connections in the senior living community.

Increasing Mealtime Socialization

Two activities to increase residents' mealtime socialization opportunities are included in the best practices reported by the Lexington, Kentucky, Long-Term Care Ombudsman Program (http://www.ltcombudsman.org/ombpublic/49_352_1004.cfm).

Silver Spoons (Dining with Dignity)

This program matches volunteers with residents for mealtime socialization and assistance. Occupational therapy students and professors at a local university provide special training to volunteers as part of their curriculum. The volunteers sit with a resident during a meal, assist with feeding, bring in special foods, have pot luck dinners, and take residents out to lunch. Although volunteers are initially paired with only one resident, they usually take on the entire table of residents as their focus. Residents who are unable to go to the dining room may have a volunteer join them in their rooms for meals. If a volunteer observes a problem, he or she reports it to the facility ombudsman.

Resident Celebrations

These celebrations are special luncheons for residents held in church recreation halls or local restaurants. Grants and donations are obtained to host a catered lunch, complete with decorations by local garden clubs, door prizes, music, and entertainment. Volunteers are recruited to assist residents, and each senior living community provides staff for its residents.

Eden Alternative Mentors

Eden Alternative provides resources and ideas, primarily through training Eden Mentors and Associates, to help change the culture of senior living communities to one that includes social connections among residents and between residents and others (including children and pets). Eden Alternative offers a wide range of activities that can promote protective factors in senior living communities. For more information, see *Tool 4.b: Resources List, Section III. Information about the Physical and Social Environment.*

Goal 1.3 Environment:
The physical and social environment promotes emotional health and well-being.

Having a physical and social environment that promotes emotional health and well-being builds and strengthens protective factors associated with a living situation.

A positive environment includes appreciating and actively engaging all residents in the life of the community. The environment should be welcoming to residents with various physical abilities and to those from a variety of ethnic, racial, and economic backgrounds. It should also ensure that residents are protected from possible abuse or violence from other residents or family members.

A physical and social environment that is homelike, comfortable, practical, clean, safe, and aesthetically pleasing can have a profound effect on the emotional and physical health of residents. It can provide opportunities for socializing and meaningful activities, enhance both independence and privacy, and support the abilities of residents to accomplish the tasks of daily living. Additionally, the physical and social environment can have powerful protective effects on residents, both directly by affecting their mood and emotional health and indirectly by encouraging social connections and physical activity. It also helps residents feel a sense of belonging if they are consulted about the décor and furniture arrangements and are given alternatives to choose from.

Creating a physical and social environment that helps protect residents from suicide does not have to be expensive. There are a number of reasonably priced ways to make changes in the environment that can enhance the emotional health and functioning of residents. These include the following (Bergman-Evans, 2004; Canadian Coalition for Seniors' Mental Health, 2006; Eden Alternative Web site; Osgood, 1990):

- Ensure your senior living community compensates for physical impairments and other accessibility-related factors, including handrails in hallways, large print on signs and menus, and minimal background noise to make conversations easier.
- Store institutional equipment, such as medicine carts and housekeeping carts, out of sight; remove nurses' stations from resident areas; and make space for residents' personal objects and furniture.
- Install indoor plants, artworks, and attractive landscaping and gardens with appropriately designed walking paths, shaded areas, and seating to rest and socialize.

- Provide gathering areas for group conversations and activities; arrange dining areas and common spaces to allow small-group interactions.
- Provide opportunities to develop intergenerational connections, such as bringing children and teens into the senior living community for different activities.
- Foster an environment that is welcoming and inclusive of people of different cultural and ethnic groups.

Action Steps for Goal 1.3

1. **Select activities.** Assess the status of the physical and social environment, choose ways to change the environment, determine who will have the lead, and identify how it will be done by using *Tool 1.c: Changes in the Physical and Social Environment that Can Promote Emotional Health and Prevent Suicide.* Also see the resources listed in *Tool 4.b: Resources List, Section III. Information about the Physical and Social Environment.*
2. **Plan for and obtain the resources** needed and implement the environmental changes.

Physical Design Principles

The Canadian Coalition for Seniors' Mental Health's publication *Design Principles: Supportive Physical Design Principles for Long-Term Care Settings* is a useful resource for making modifications to the physical environment that enhance protective factors. A link to this publication is provided in *Tool 4.b: Resources List, Section III. Information about the Physical and Social Environment.*

Residents' Vegetable Garden

At a continuing care retirement community (CCRC) that has a number of residents from the same ethnic background, several residents asked if they could have a garden to grow vegetables and herbs native to their culture. The garden was established and provided both physical activity and an opportunity to develop closer social connections. These residents then requested that some of their vegetables and herbs be used in the meals provided by the CCRC to make some dishes from their culture. Their request was accepted, and the head cook was glad to use some of their recipes. Many other residents also enjoyed the diversity they found in their meals.

Goal 1.4 Lethal means:
Residents' access to methods of self-harm is limited.

An environment in which one has limited access to methods of self-harm has been shown to prevent suicide. Research has shown that having easy access to a lethal means at the time when a person has an impulse to harm or kill himself or herself significantly increases the likelihood that the person will attempt suicide (Nordentoft et al., 2007; Beautrais et al., 2007). In addition, when older adults attempt suicide, they are much more likely than people of other ages to die, in part because they use more lethal means (CDC, 2006).

Although residents without access to items such as guns and knives can harm themselves by refusing food and medicine, passive (or indirect) suicide takes much longer to result in significant harm, which allows more time for discovery and treatment.

The ability of a senior living community to restrict access to lethal means varies. It is easier to implement restrictions in more structured facilities, such as nursing homes. It is more difficult when residents have their own apartments or homes, as in assisted living and independent living. However, it is usually possible to implement some restrictions on lethal means, such as the following[3]:

- Restrict access through policies and procedures—Examples include prohibiting the possession of weapons, including firearms, by residents (in any type of senior living community) and monitoring medications taken by, and in the possession of, residents (more likely in nursing homes and assisted living). Staff, residents, and their families need to be informed about the new restrictions and the reasons for them, as well as the consequences of violating the restrictions.
- Restrict access through physical barriers—Examples include keeping facility cleaning supplies in locked cabinets and locking access to areas such as rooftops and unprotected stairwells (which are common locations for suicide attempts in senior living communities because of their relative isolation).

Again, not all of these strategies are appropriate for all senior living communities. However, in independent living communities where it may not be possible to control medications or cleaning supplies, another way to address the issues might be to provide education periodically on safety issues and on the side effects of medications.

[3] Project staff contacted a number of senior living communities by phone and e-mail to solicit suggestions and learn about their experiences. The information and suggestions provided here are a compilation of these discussions.

Action Steps for Goal 1.4

1. **Select activities.** Assess which restrictions can and should be implemented by using *Tool 1.d: Restricting Access to Lethal Means.*
2. **Implement and document the new restrictions,** including notifying staff, residents, and their families about any new policies, the reason for these policies, and the consequences of violating the policies.

Goal 1.5 Staff training:
Staff receive training and support for their roles in promoting the emotional health of residents.

Working toward the goals outlined in this Guide may require staff members to learn new ways of working and relating to residents. It is essential to provide staff members with the training and information that help them understand the reasons for the new ways of working, as well as the skills needed to effectively work in these new ways.

Training in senior living communities often focuses on physical health needs. However, it is essential to provide training to *all* staff on the aging process; risk and protective factors for suicide; the Whole Population Approach; and emotional health issues, particularly depression, substance abuse, and suicide.

Nursing assistants (also called certified nurse aides, nurse aides, geriatric nurse aides, personal care assistants, or direct care workers, depending on the State and the senior living community) are the primary caregivers in nursing homes and assisted living facilities. As a result, training nursing assistants to provide consistent and high-quality care is crucial to residents' well-being and has a significant impact on improving emotional health and decreasing suicide risk (Osgood, 1990). Professional staff may need additional training in how activities in their areas of responsibility can promote emotional health and well-being and prevent suicide.

Training on interpersonal skills, including communication and conflict resolution; team building; attitudes toward depression, substance abuse, and suicide; treating residents with respect; prevention of elder abuse; and self-care, including stress management and coping strategies, may also enhance staff members' ability to work well with residents and other staff.

When staff members are given the support they need, consistent assignment to the same residents, and generally positive working conditions, their morale is better, and there is less absenteeism and turnover (Doty et al., 2008). Low staff turnover and better staff-resident connections both help promote emotional health and prevent suicide (Osgood, 1990).

Action Steps for Goal 1.5

1. **Deliver Staff Workshops 1 and 2.** *Staff Workshop 1: Understanding Suicide Prevention in Senior Living Communities* and *Staff Workshop 2: Implementing Strategies to Prevent Suicide in Senior Living Communities.*
2. **Consider providing additional training.** Some of the training programs described in *Tool 4.b: Resources List, Section II. Curricula and Training Tools* have information relevant to the Whole Population Approach.
3. **Provide ongoing opportunities for staff to discuss resident and staff needs** and to share ideas on how to work most effectively. These can include regular staff meetings, one-to-one supervision, case conferences, or support groups.
4. **Consider implementing additional methods of staff support,** such as through supervision, support groups, mentoring relationships, or regular team meetings that combine business and training.
5. **Add to the orientation for new staff** some training on emotional health promotion and suicide prevention.
6. **Make staff aware of the resources** listed in *Tool 4.b: Resources List, Section I. Fact Sheets and Overviews for Professionals.*

Training Requirements for Nurse Aides

The U.S. Centers for Medicare and Medicaid Services has issued requirements for training nurse aides in nursing homes. They can be found online at: http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf. Sections 483.75 (e) and (f) address Required Training and Proficiency for Nurse Aides.

In addition, the staff workshops in the Trainer's Manual, which is part of this Toolkit, are designed to be one hour long and to help you meet your training requirements.

Section 2

At-Risk Approach

Goals

Goal 2.1: Warning signs	All staff are able to identify and respond to warning signs for suicide. Designated staff are able to screen individual residents for suicide risk and ensure that the appropriate action is taken when a resident may be at risk.
Goal 2.2: Risk Factors	All staff are able to identify risk and protective factors for suicide.
Goal 2.3: Depression	All staff are able to recognize symptoms of depression. Appropriately designated staff are able to screen individual residents for depression and ensure that residents who are depressed receive treatment.
Goal 2.4: Substance abuse	All staff are able to recognize symptoms of alcohol abuse and medication misuse. Appropriately designated staff are able to screen individual residents for these conditions and ensure that residents with substance abuse problems receive treatment.
Goal 2.5: Community connections	Appropriately designated staff establish effective connections in the community to support emotional health of residents.
Goal 2.6: Help seeking	Residents are knowledgeable about and comfortable seeking help for emotional health problems, including suicidal ideation, depression, and substance abuse.

This section of the Guide discusses how staff and residents can recognize and respond to residents of senior living communities who are at risk of suicide, because they are showing warning signs of suicide or have other risk factors, especially depression or substance abuse.

The goals in this section address the following actions:

- The senior living community develops protocols prescribing the actions that different staff should take and trains all staff in the use of these protocols.

- Staff members other than mental health professionals who see warning signs of imminent risk of suicide follow the protocol for an immediate contact with a mental health provider, or if necessary, dial 911.
- If staff members identify less immediate warning signs and risk factors for suicide and/or symptoms of depression or substance abuse, they follow the protocol that will lead to the resident's being referred to a designated mental health professional in the senior living community or in the community.
- The mental health professional screens the resident, determines whether a referral for treatment is appropriate, and if so, facilitates the resident's getting into treatment whenever possible.
- The protocol may also contain steps for residents to follow if they are concerned about themselves or another resident.

All Staff Have an Essential Role

The goals in Section 2. At-Risk Approach are based on the philosophy that every staff member in a senior living community has an essential role to play in protecting residents who may be at risk for suicide. Everyone on staff, including the executive director; administrators; department managers and supervisors; medical director; professional clinical staff; clergy; nursing assistants; and activities/wellness, dietary, housekeeping, transportation, maintenance, grounds, and security staff, should know how—and be willing—to recognize and respond to the warning signs of suicide. Appropriately designated professional staff should know how to screen for suicide risk and related emotional health issues and refer patients for appropriate forms of care. Administrative staff should know how to support all of these efforts. And residents should be willing and able to seek help for any emotional health problems they may experience.

National Suicide Prevention Lifeline

The **National Suicide Prevention Lifeline** is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. **If you need help, please call 1-800-273-TALK (8255).** You will be routed to the closest possible crisis center in your area. With more than 130 crisis centers across the country, the Lifeline's mission is to provide immediate assistance to anyone seeking mental health services. Call for yourself or for someone you care about. Your call is free and confidential. http://www.suicidepreventionlifeline.org/default.aspx.

Goal 2.1 Warning signs:
All staff are able to identify and respond to warning signs for suicide. Designated staff are able to screen individual residents for suicide risk and ensure that the appropriate action is taken when a resident may be at risk.

An expert panel has identified warning signs that indicate that someone may be in **immediate danger** of suicide (Rudd et al., 2006). These warning signs are:

- Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Someone talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person

Every staff member in a senior living community should be able to recognize and know how to respond immediately if a resident displays any of these warning signs. Every senior living community should have a formal, written protocol in place that outlines a clear process for immediately responding to these warning signs. The protocol should involve seeking immediate help from the person on staff with responsibility for the emotional health of the residents, or contacting 911.

The same expert panel identified other warning signs that show a person may be considering suicide in the very near future. These warning signs are:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped, like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family, and society
- Anxiety, agitation, unable to sleep, or sleeping all the time
- Dramatic mood changes
- No reason for living, no sense of purpose in life

Every staff member in a senior living community should be able to recognize and know how to respond if a resident displays any of these nine warning signs. Every senior living community should have a formal protocol in place that outlines a clear

process for responding to these nine warning signs. This process should include referral to the person on staff with responsibility for the emotional health of the residents.

All staff members are not expected to respond with the same actions. For example, a resident might reveal his or her feelings of despair and hopelessness to a nursing assistant or a housekeeping staff person, but these staff members would not be expected to do a detailed screening for suicidal intent. Rather, they would inform the person designated in the senior living community's protocol, who in turn would know what steps he or she should take to ensure the resident's safety. It is important for all staff to communicate compassion and concern to residents who raise difficult issues, but they also need to know that they should not try to address such issues alone.

Once a person has been referred for either immediate risk of suicide or for considering suicide, the senior living community's protocol should include timely screening for suicidal intent by appropriate professional staff and referral to professional care if indicated. This care is likely to be provided by either a mental health professional who is on staff, serves as a consultant to the senior living community, or is in the community. Professional staff, including nurses and social workers, should have a basic understanding of the most effective ways to manage suicide risk, so they can monitor and support the treatment being provided.

Action Steps for Goal 2.1

1. **Develop a formal, written protocol** for immediately responding to a resident who may be at imminent risk of suicide. Identify the person(s) that each staff member should contact if he or she thinks someone is in immediate danger of suicide, and the person(s) he or she should contact if he or she thinks someone is considering suicide. Use this protocol to complete the Warning Signs section of *Tool 2.a: Recognizing and Responding to the Warning Signs of Suicide.*
2. **Distribute to all staff** *Tool 2.a: Recognizing and Responding to the Warning Signs of Suicide* and the *National Suicide Prevention Lifeline* brochure or wallet card (available at http://www.suicideprevention-lifeline.org/campaign/promotional.aspx). Also post copies in strategic locations, such as nurses' stations.

3. **Develop a plan for training your staff** in recognizing and responding to the warning signs of suicide. Options include:
   - ◊ Deliver *Staff Workshop 1: Understanding Suicide Prevention in Senior Living Communities* to all staff. This workshop teaches staff to recognize and respond to the warning signs of suicide and can be adapted for your protocol.
   - ◊ Deliver *Staff Workshop 2: Implementing Strategies to Prevent Suicide in Senior Living Communities* to nurses, social workers, and other appropriate staff members. This workshop includes more detailed information about assessing and referring residents who may be at risk of suicide.
   - ◊ Consider providing suicide-prevention gatekeeper training programs to your staff. *Tool 4.b: Resources List, Section II. Curricula and Training Tools* has descriptions of these programs and how you can implement them.
4. **Encourage or require the use of suicide screening tools** by appropriate staff members and/or mental health consultants. Share with your mental health providers *Tool 2.b: Suicide Screening Tools for Older Adults.*
5. **Encourage or require training on managing suicide risk** for appropriate professional staff. See the descriptions of available trainings in *Tool 4.b: Resources List, Section II. Curricula and Training Tools.*
6. **Make sure the mental health staff have the appropriate** tools to use in managing a resident who is suicidal. *Tool 4.b: Resources List, Section IV. Mental Health Treatment Guidelines.*
7. **Make sure residents do not have access to lethal means,** especially if they at risk for suicide. For guidance, see *Tool 1.d: Restricting Access to Lethal Means.*

Defining Gatekeeper

In the field of suicide prevention, *gatekeepers* are people who are trained to recognize the warning signs for suicide. They do not need to have special training in screening or treating mental illnesses. Rather, they need to know how to relate to someone who may be contemplating suicide, the questions to ask the person, and how to make an effective referral to a mental health professional.

Assessing and Managing Suicide Risk Curriculum

Assessing and Managing Suicide Risk is a curriculum to train mental health clinicians developed by the Suicide Prevention Resource Center in collaboration with the American Association for Suicidology. It contains a number of recommendations to ensure that clinicians use a culturally competent approach. Suggestions include the following (SPRC, 2008):

"There should always be a genuine effort to understand the individual's identities—including race, ethnicity, religion, sexual orientation, and cultural identities and related beliefs. It is important to understand how suicide is viewed by the individual and his or her cultural community and how members of the community generally respond when someone dies by suicide."

"It is important to understand the culture in which the client lives and what events may trigger shame, humiliation, or despair."

"Be aware that a mental health provider in another culture may be someone you do not consider a colleague but nevertheless is a 'provider' for your client, for example tribal elders and pastors. Be prepared to work collaboratively with them."

Gatekeeper Training for Senior Living Community Staff

Karl Rosston, Suicide Prevention Coordinator for the Montana Department of Health and Human Services, described his use of QPR, a suicide gatekeeping program.

QPR has been a good choice for most staff in our residential facilities for older adults. Teaching QPR takes only 1 to 2 hours, and staff members come away with the core knowledge of warning signs and what to do, as well as what *not* to do. There is a tremendous need for universal training in facilities for older adults, and QPR can provide that. It is critical to have ***every*** staff member trained. Many residents have relationships with personnel other than the nurses or nursing assistants. Janitorial, kitchen, and transportation staff often have a great deal of interaction with residents and may see warning signs that other people would miss. We also encourage training any volunteers who spend time with older adults.

—Karl Rosston (personal communication, 2009)

Another widely used suicide gatekeeping program is ASIST. Information on both programs can be found in Gatekeeper Training Programs in *Tool 4.b: Resources List, Section II. Curricula and Training Tools.*

Common Thoughts about Death and Dying vs. Suicide Risk

It is not unusual for older adults, residents of senior living communities, and seriously or chronically ill older adults, to talk about death and dying. There is virtually no research that provides substantial direction about how to distinguish normal or healthy talk about death and dying from talk that might indicate suicidal intent. Below, Ruth Kent, Chaplain at Ingleside at Rock Creek (a continuing care retirement community) describes how she tries to address this issue.

Many older adults talk fairly casually about suicide as a possible escape from the possibility of losing physical and mental functioning and experiencing severe pain. Most of what we hear—or hear about—seems to be in the nature of exploring the ***idea*** of suicide, ethical questions, and practical questions. Many older adults who enter into such discussions and examine suicide as an option will not take their own lives, ask anyone else to do so, nor assist a spouse or other person in suicide.

In a focus group, we asked whether the participants knew of any residents who had considered suicide. One response we heard was, "Who hasn't thought about it?" The majority nodded in agreement. Yet we do not have suicides happening here all the time. The comment reflects common thoughts and feelings, not common intentions. Older people may discuss their death in the same way they discuss their medical care, their day's activities, or current events. Thoughts and conversations about suicide or assisted suicide are often within the normal/common category for older adults. This makes it hard to determine who is seriously considering suicide and who is just having a dinner conversation.

To understand who is at risk, it may be helpful to ask about the ***conditions*** that people fear, and people's responses to them, at times of ***crisis*** or ***transition*** when they are feeling losses most keenly and have not developed a sense of well-being and what remains to them in life. For example, when one is first becoming aware of encroaching dementia in oneself or a spouse, that may be a time when an escape route is frantically sought as a way to avoid a long, slow decline. The same may be true after a stroke or other dramatic change in physical functioning, or after a diagnosis of terminal cancer or other condition that people associate with pain. The loss of a spouse, especially if ***either*** the deceased spouse or the survivor was a caregiver to the other, can create a crisis of care (for the receiver) or of meaning (for the giver). Any of these changes in oneself or in a loved one can create panic and a sense of being trapped by circumstances.

For someone in one of these transitions, the first clue that there may be a real problem may be a ***change*** in the frequency or intensity of common/normal conversations about dying and/or suicide. We need to ask ourselves if the resident has ever had this conversation before—or is it a new topic for them. Or have they always joined the conversation at a casual level but now seem more intense—focusing more on practical questions of how to take one's own life rather than the philosophical questions? On the other hand, it is possible that those most at-risk may be the most secretive. In this case, those who have always joined the conversation before might suddenly ***not*** want to talk about it and might clam up or get up and walk away.

Active intervention at these transition stages to uncover suicidal intention would include inquiring closely about emotional resources, support systems, respite care for caregivers, and what survives of hope, interest, and unfinished business. The more trapped older people feel, the more they are open to death as a way out. They may think, "It's coming before long anyway, so why not just speed it along a bit and avoid all this pain and difficulty?"

The first step in preventing a painful life change from developing into a suicidal crisis is to maintain communication with and observe people during these critical transitions. Once changes in behavior or conversation have been observed, the technique for evaluating their risk of suicide would be fairly straightforward, such as asking if the person is thinking about ending his or her life or whether the person has actually thought about how he or she would do this."

—Ruth Kent (personal communication, 2009)

Goal 2.2 Risk factors:
All staff are able to identify risk and protective factors for suicide.

Being able to identify risk and protective factors for suicide may help your staff recognize and refer residents who may be at risk for suicide long before they exhibit warning signs.

Risk factors are medical and emotional health conditions, personal characteristics, life circumstances, and situations that increase a person's risk for suicide. Examples of risk factors include depression, substance abuse, physical illness, disability, pain, and isolation (Reed, 2007; DHHS, 2001; Beeston, 2006). No single risk factor alone means that a person will try to take his or her life. But risk factors can provide more information about whether the person may be in trouble. *Tool 2.c: Risk Factors for Suicide* provides a detailed list of risk factors.

Protective factors are personal characteristics, life circumstances, and situations that have been shown to have a positive effect on specific medical or psychological problems and that decrease the risk for suicide. They include factors such as good problem-solving skills, strong connections with other people, and access to high-quality health care. *Tool 2.d: Protective Factors for Suicide* provides a detailed list. Protective factors, and how they can be used to prevent suicide and promote emotional health, are discussed both at the beginning of this Guide in "Background on the Topic of Suicide" and in Section 1.

Action Steps for Goal 2.2

1. **Make a plan for training your staff** about risk and protective factors. Options include:
   - ◊ Provide all staff with copies of *Tool 2.c: Risk Factors for Suicide* and *Tool 2.d: Protective Factors for Suicide.*
   - ◊ Deliver *Staff Workshop 2: Implementing Strategies to Prevent Suicide in Senior Living Communities* to nurses, social workers, clergy, and staff responsible for the emotional health of residents. This workshop includes guidance on how to consider warning signs in the context of a resident's possible risk factors.
   - ◊ Encourage clinical staff to take advantage of one of the trainings described in *Tool 4.b: Resources List, Section II. Curricula and Training Tools,* many of which address risk and protective factors.
2. **Implement some of the activities described in Section 1,** Whole Population Approaches. These activities help strengthen factors that protect residents from suicide and related problems.

Goal 2.3 Depression:
All staff are able to recognize symptoms of depression. Appropriately designated staff are able to screen individual residents for depression and ensure that residents who are depressed receive treatment.

Depression is a major risk factor for suicide. In a review of studies of depression rates in older adults the following was found (Hybels & Blazer, 2003):

- Symptoms of major depression were present in less than 1–5 percent of older adults residing in the community and in 4–15 percent of residents in nursing homes.
- Other clinically significant depressive symptoms were present in 3–26 percent of older adults residing in the community and in 17–31 percent of residents in nursing homes.

Yet in many nursing homes, rates of correct diagnosis by nursing home staff are low (Teresi et al., 2001). Residents who are newly admitted to nursing homes are especially vulnerable to depression, yet there is a low rate of diagnosis of depression among them by nursing home staff as well (Bagley et al., 2000). These findings suggest a strong need for more training for nursing home staff in recognizing depression and referring residents for treatment.

Many people with dementia become depressed as their ability to remember and accomplish the functions of everyday life diminish. Dementia itself can lead to symptoms commonly associated with depression, such as apathy, loss of interest in activities, and social withdrawal. Up to 40 percent of people with Alzheimer's disease suffer from significant depression (Alzheimer's Association, http://www.alz.org/living_with_alzheimers_depression.asp).

Key Symptoms of Depression in Older Adults include:

- Depressed mood most of the time, sad or "empty" feelings
- Loss of interest or pleasure in activities
- Disturbed sleep (sleeping too much or too little)
- Weight loss or gain (changes in appetite)
- Fatigue or lack of energy
- Feelings of worthlessness or extreme guilt
- Difficulties with concentration or decision making
- Noticeable restlessness (agitation) or slow movement
- Frequent thoughts of death or suicide, or a suicide attempt

Adapted from American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (DSM-IV-TR) (4th ed.). Washington, D.C.: Author.

It is common for someone to experience one or more symptoms of depression following the loss of a loved one. However, if the symptoms persist for more than two months, the diagnosis of major depression would be made and the person treated accordingly (APA, 2000).

It is essential that all staff know that depression is a treatable illness, not a normal part of aging (NIMH, 2007; Geriatric Mental Health Foundation, n.d.). Senior living communities should have a protocol in place so that staff know how to identify someone at risk of depression, the appropriate referral, who will screen, and who will treat the resident.

Action Steps for Goal 2.3

1. **Review** *Tool 2.e: Principles of the American Geriatrics Society and American Association for Geriatric Psychiatry's Expert Panel on Quality Mental Health Care in Nursing Homes.*
2. **Provide and discuss with all staff** *Tool 2.f: Key Symptoms of Depression*

3. **Encourage or require the appropriate use of depression screening tools** for older adults by appropriate staff members and/or mental health consultants. This requires training and administrative support. *Tool 2.g: Screening Older Adults for Depression* provides more information on depression screening tools for older adults.
4. **Encourage or require training** on managing or coordinating the appropriate treatment for depression for appropriate professional staff. *Tool 2.h: Treatment for Depression* provides more information on this subject.
5. **Ensure that appropriate staff members monitor and support patients** who are receiving medication or therapy for depression.
6. **Consider adapting and implementing programs to manage and treat depression** from programs used in other senior living communities or in community-based settings. *Tool 2.i: Programs for Managing and Treating Depression in Older Adults* provides guidance in planning.

Goal 2.4 Substance abuse:

All staff are able to recognize symptoms of alcohol abuse and medication misuse. Appropriately designated staff are able to screen individual residents for these conditions and ensure that residents with substance abuse problems receive treatment.

Substance abuse is a major risk factor for depression and suicide, and alcohol abuse and medication misuse are growing problems among older Americans (Blow et al., n.d.). (Medication misuse includes the abuse and misuse of both prescription and OTC medications.) The number of adults aged 50 or older with substance use disorder is projected to double, from 2.8 million (annual average) during 2002–2006 to 5.7 million in 2020 (Han et al., 2009). Illegal drug use tends not to be a major issue among current residents of senior living communities, but this could change in the future.

Other than depression, alcohol abuse and dependence are the most common disorders associated with suicide among older adults. Thirty-five percent of older men and 18 percent of older women who die by suicide were involved in alcohol abuse or dependence (Waern, 2003). Alcohol can also exacerbate other risk factors for suicide, including depression, medical illnesses, and low social support (Blow, 2004).

Alcohol is especially problematic for older adults. It can accelerate normal declines in functioning due to aging; increase the risk of falls, injuries, and disability; and trigger or complicate many medical and mental conditions, including diabetes, depression, and anxiety (SAMHSA, 2003a). Alcohol can also interfere with the intended effect of medications (SAMHSA, 2003a).

Diagnosing alcohol and medication misuse among older adults can be difficult. The symptoms (such as cognitive and sensory impairments) are similar to those of other conditions common among older adults (SAMHSA, 2003a). In addition, many people do not know that sensible drinking limits are different for older adults compared to those for younger people.

Action Steps for Goal 2.4

1. **Provide all staff** with *Tool 2.j: Recognizing and Responding to Substance Abuse Problems*. This tool includes information on the following:
   - ◊ How to recognize alcohol abuse and medication misuse
   - ◊ Risk factors for alcohol and medication misuse
   - ◊ Barriers to recognizing alcohol abuse and medication misuse
   - ◊ How to talk with older adults about alcohol and/or medication problems
2. **Encourage or require the appropriate use of alcohol abuse screening tools** for older adults by appropriate staff members and/or mental health consultants. This requires training and administrative support. *Tool 2.k: Screening Older Adults for Alcohol Abuse* provides more information on alcohol abuse screening tools for older adults.
3. **Encourage or require appropriate professional staff to receive training** on treating older adults with alcohol abuse problems or referring these residents for treatment. Additional information on these topics can be found in *Tool 2.l: Treatment for Alcohol Abuse.*
4. **Consider sponsoring substance abuse support groups.** A number of senior living communities have AA and Al Anon groups.

Recommended Drinking Limits for Older Adults

- Older adults can drink low amounts of alcohol and drink infrequently and still experience problems.
- For adults over 65, both men and women, recommended drinking means no more than one alcoholic drink a day.

Who Should Never Drink Alcohol?

Older adults who have:

- Prescription pain medication
- Prescription sleeping pills or over-the-counter drugs for sleep troubles
- Prescription drugs to treat anxiety or depression
- Memory problems
- A history of falls or unsteady walking

Source: SAMHSA, 2003a.

Sedatives and Hypnotics Increase Suicide Risk in Older Adults

According to a recent study in Sweden (Carlsten & Waern, 2009), sedative and hypnotic medications significantly increase the risk for suicide in older adults. These medications are commonly prescribed for older adults with symptoms of depression, anxiety, and sleep disturbance. Consequently, older adults should be carefully evaluated for suicide risk before being prescribed these medications.

Alcoholism Screening Tool for Older Adults

The only brief alcohol screening tool developed specifically for older adults is the Short Michigan Alcoholism Screening Test—Geriatric Version, also known as SMAST-G. It is used widely and has been validated in research studies. A longer alcohol screening tool designed for older adults is the Alcohol Related Problems Survey (ARPS). For more information on these tools, see *Tool 2.k: Screening Older Adults for Alcohol Abuse.*

Screening and Brief Intervention Program for Older Adults

The Florida Brief Intervention and Treatment for Elders (BRITE) program provides screening and two kinds of brief treatment with education and counseling for older adults who misuse or abuse alcohol, illicit drugs, and prescription and OTC medications. It also addresses related depression and suicide risk. It provides outreach and services to older adults where they live as well as in health care and aging services sites. In three years, this program tripled the number of older adults served in Florida and significantly decreased depression, alcohol and drug abuse, and medication misuse (Schonfeld et al., 2009).

Goal 2.5 Community connections:
Appropriately designated staff establish effective connections in the community to support emotional health of residents.

It is essential that professional staff form relationships with mental health providers before residents need them. Establishing these connections will increase providers' awareness of your residents' needs and their levels of risk. Most importantly, a strong relationship between a senior living community and local mental health providers will increase residents' access to appropriate services when they are needed. Although the professional staff member will make the referral, a trusted non-professional staff member can be extremely helpful in encouraging the resident to accept treatment.

Mental health providers may also be valuable resources for consultation and training for your staff.

Action Steps for Goal 2.5

1. **Compile a directory of mental health care providers** in your community using *Tool 2.m: Emotional Health Resources in the Community.*
2. **Contact these providers and establish a personal connection.** Find out about the types of services each provider can provide to your residents. *Tool 2.m: Emotional Health Resources in the Community* includes a list of questions to ask mental health care providers about their services.
3. **Disseminate the information** gathered about mental health care providers to the appropriate professional staff who may need to make referrals to providers outside your senior living community. Present an overview of the information, including how to use it, at a staff meeting and/or as an information sheet. Encourage staff to familiarize themselves with this information.

Working with Providers in the Community

The Christian Health Care Center's (CHCC) senior living programs share a campus in Wyckoff, New Jersey, with a psychiatric hospital and mental health providers. The hospital and providers have Affiliation Agreements with many senior living programs in surrounding communities through which they provide inpatient psychiatric care, outpatient counseling, partial hospitalization, and community education for older adults.

Goal 2.6 Help seeking:
Residents are knowledgeable about and comfortable seeking help for emotional health problems, including suicidal ideation, depression, and substance abuse.

One study found that 77 percent of people over the age of 55 who died by suicide had contact with a primary care provider within one year prior to their suicide. Fifty-eight percent had contact with a primary care provider within a month prior to their death. Yet, only 8.5 percent had contact with mental health services within the previous year (Luoma et al., 2002).

Cultural stigma, personal embarrassment about mental illness, and lack of help-seeking behaviors may prevent residents from seeking the help and treatment they need for emotional health problems such as suicidal ideation, depression, and substance abuse. Many people, of all ages, are not comfortable seeking treatment for health conditions, including those related to emotional health. In addition, many older adults are not well-informed about emotional health issues, and they may consider these conditions to be signs of character weaknesses rather than treatable illnesses. They are likely to have difficulty, and be somewhat resistant to, talking about conditions such as depression, alcoholism, medication mismanagement, and suicide. The feelings of hopelessness and helplessness associated with both suicidal ideation and depression can also be a barrier to seeking treatment (SAMHSA, 2003a).

It is essential for staff of your senior living community to help residents achieve a level of comfort in seeking help with emotional health issues and thus contribute to their own recovery.

Action Steps for Goal 2.6

1. **Provide residents, family members, and caregivers with copies of fact sheets** to educate them about suicide, emotional health issues, substance abuse, and treatment and referral options. The fact sheet *Know the Warning Signs of Suicide* is in this Toolkit. *Tool 4.b: Resources List, Section VI. Fact Sheets for Consumers* lists other fact sheets for consumers.

2. **Have a nurse or social worker explain to residents what happens in a counseling session** and how useful it can be to talk with a mental health professional about life issues that make them feel sad, depressed, or anxious. Explain that clinicians are bound by rules of confidentiality that they may break only in cases where the client or someone else is in danger.
3. **Offer to families and residents** the *Family and Resident Workshop: Promoting the Emotional Well-Being of Residents in Senior Living Communities.* The Trainer's Manual for this workshop is in this Toolkit.
4. **Decrease barriers to help seeking** by ensuring that all residents know to whom they can turn if they feel they need help. You can adapt the information you have gathered to complete *Tool 2.m: Emotional Health Resources in the Community* and use it as a resource for your residents and their families.
5. **Implement efforts to reduce stigma and normalize help seeking** in your senior living community. Work to address feelings of shame and failure that may be associated with mental health disorders and treatment. The SAMHSA resource described in the sidebar provides additional guidance.

Reducing Stigma

The SAMHSA Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center) provides helpful information about reducing the stigma associated with mental health problems among older adults (http://www.promoteacceptance.samhsa.gov/audience/adults/default.aspx). The ADS Center also provides information on an anti-stigma campaign on depression created specifically for older adults (http://promoteacceptance.samhsa.gov/campaigns/Program_Details.aspx?ID=164).

Section 3

Crisis Response Approach

Goals

Goal 3.1: Immediate response	Policies and protocols for systematic and effective responses to suicide attempts and deaths are created. Staff are trained in these policies and protocols and their responsibilities in the event of a suicide crisis.
Goal 3.2: Postvention	Plans for postvention to support residents, families, and staff after a suicide crisis are developed.

This section of the Guide explores responding to suicide deaths and attempts in senior living communities. It includes information on creating and implementing crisis response policies and protocols and a plan to provide support for residents, their families, volunteers, the staff, and others who are affected by a suicide death or attempt.

It is essential for senior living communities to be prepared to respond immediately to suicide deaths and attempts that do occur. A prompt response to a suicide attempt can mean the difference between life and death.

Suicide deaths and attempts also have a profound emotional impact upon other residents, their families, volunteers, and the staff. Attempt survivors and their families can be severely traumatized. Both attempts and deaths can elevate the suicide risk of other vulnerable residents. Therefore, responding to suicide deaths and attempts in an appropriate way can help alleviate the pain caused by these incidents and can prevent a similar attempt by other residents who may be at an increased risk of suicide. The activities discussed under Goal 3.1 will prepare a senior living community to respond appropriately in the immediate aftermath of a suicide attempt or death. The activities discussed under Goal 3.2 will prepare a senior living community to engage in postvention, that is, implement activities that address the emotional impact on family, friends, staff, and others affected by a suicide death or attempt.

Goal 3.1 Immediate response:
Policies and protocols for systematic and effective responses to suicide attempts and deaths are created. Staff are trained in these policies and protocols and their responsibilities in the event of a suicide crisis.

Staff should be prepared to respond to a suicide death or attempt, just as they are prepared to respond to a fire or a medical emergency, such as a heart attack. Developing a set of policies about suicide deaths and attempts and educating staff about these policies and protocols is an essential part of being prepared before a crisis occurs. While key administrators and staff and persons with special expertise should be involved in developing these policies and protocols, it is helpful to have the perspective of every group that will be involved in a crisis.

Action Steps for Goal 3.1

1. **Develop policies and protocols for responding** to a suicide death or attempt. *Tool 3.a: Protocols for Responding to a Suicide Attempt* and *Tool 3.b: Protocols for Responding to a Suicide Death* will help guide this process.
2. **Develop policies and protocols for providing information** on a suicide death or attempt to residents, their families, staff, and the media using *Tool 3.c: Communicating with Residents, Families, Staff, and the Media.*
3. **Develop policies and protocols for the return of a resident** who has attempted suicide using *Tool 3.d: Protocols for a Resident Returning after a Suicide Attempt.* These policies and protocols should define the conditions under which the resident can continue to live at the senior living community and who will make the final decision about when and if the resident can return.
4. **Disseminate, and train staff on, these policies and protocols.** The training should explain why the policies and protocols were developed and how they will benefit the staff, as well as residents and their families.

Media Coverage

Media attention to a suicide death or attempt in a senior living community can complicate the efforts of staff members to address the problem and protect other vulnerable members of the community. On the other hand, responsible media coverage of a suicide can help residents, family members, and the community understand the events, and it can be a valuable way to educate the public about suicide and suicide prevention. When working with the media after a suicide death or attempt, it may be helpful to provide them with a copy of **The Role of the Media in Preventing Suicide**, found at http://www.sprc.org/featured_resources/customized/pdf/media.pdf.

Goal 3.2 Postvention:
Plans for postvention to support residents, families, and staff after a suicide crisis are developed.

Every person who dies by suicide leaves behind survivors—family, friends, neighbors, and coworkers—who are profoundly affected by the suicide. Survivors often experience complex reactions, which may include feelings of grief, guilt, shame, and embarrassment.

Knowing someone who has died by suicide is a risk factor for suicide (as is being part of a family in which someone has died by suicide). A suicide death or attempt can raise the risk of suicide for other people who are vulnerable.

Dr. Edwin Shneidman, founder of the American Association of Suicidology, coined the term *postvention* to refer to programs and interventions for survivors following a death by suicide. Postvention helps alleviate the suffering of suicide survivors and helps prevent an attempt by those at an elevated risk of suicide.

Postvention should follow any suicide death or attempt in a senior living community. The type of support may vary for each of the three categories of survivor: family, close friends, and neighbors of the resident; the senior living community at large; and staff.

Action Steps for Goal 3.2

1. **Develop a protocol for postvention** for survivors after a suicide death or attempt. The protocol should contain the following elements:
   - ◊ The lead person for postvention support
   - ◊ Who are considered survivors
   - ◊ How to support survivors immediately after the suicide death or attempt
   - ◊ How to assess survivors for levels of trauma and risk
   - ◊ Type of support to be offered or provided to all survivors
   - ◊ How to discourage imitative suicides

   See *Tool 3.e: Protocols for Postvention after Suicide Deaths and Attempts* to help guide this process.

2. **Disseminate this protocol to all staff** and explain why the policies and protocols were developed and how they will benefit the staff, as well as residents and their families.
3. **Consider contacting an organization that provides postvention support** to arrange for their help in the event of a suicide death or attempt.
4. **Consider holding a community support meeting** for all residents, staff, and possibly family members. *Tool 3.f: Community Support Meetings for Senior Living Communities* provides a facilitator guide for conducting this type of meeting.
5. **Disseminate to residents the fact sheet** *After a Suicide: What to Expect and How to Help,* which is in this Toolkit.

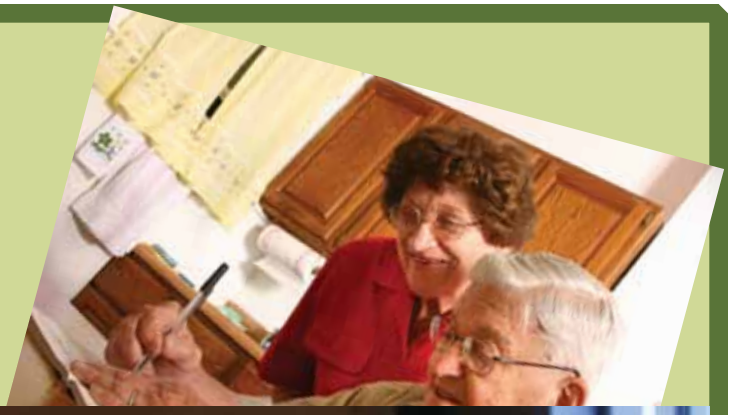
LOSS Team Services for Survivors

The LOSS (Local Outreach to Suicide Survivors) Team was created in 1997 in Baton Rouge, Louisiana, to help suicide survivors get the services they need. The LOSS team is made up of trained suicide survivors and staff from the Baton Rouge Crisis Intervention Center (BRCIC). Teams go to the scene of a suicide as soon as possible following a death to comfort survivors and let them know about postvention resources. LOSS can be used as a model for the types of postvention services that should be available in the event of a suicide crisis. For more information about LOSS and other postvention programs, see http://www.brcic.org/programs/crisisresponse.

After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances

The Suicide Prevention Resource Center has a guide to help community and faith leaders plan memorial observances and provide support for individuals after the loss of a loved one to suicide. Available at: http://www.sprc.org/library/aftersuicide.pdf.

Tools for Implementing Action Steps



Section 1

Tools for the Whole Population Approach

Tool 1.a: Activities to Promote Emotional Health and Well-Being

Tool 1.a

Use with Goal 1.1

Review the list of activities below. These ideas were collected from senior living communities across the United States.[4] Contact the organizations in *Tool 4.b: Resources List, Section III. Information about the Physical and Social Environment* for additional background and ideas. Consider the activities you already have in place and which new ones you want to consider implementing. For those you want to adopt, use *Tool 4.a: Planning Worksheet Example and Template* to help guide your planning process.

Activity Ideas

Social activities: Social activities fill many functions, including preventing and coping with loneliness, enhancing emotional support, and developing relationships. Some examples are group trips to social, sporting, and cultural events; parties to celebrate holidays, birthdays, and other special occasions; and a hospitality room where coffee is served every morning or tea every afternoon. Many of the other ideas below also involve social contact.

It is especially important to provide activities aimed at drawing men, since men are less likely than women to reach out socially. Engage others by example by having men lead these activities, which might include games such as pool, poker, and bridge; fitness center activities; breakfasts or lunches specifically for men that sometimes include a speaker (from outside or inside the senior living community) on an issue of interest to men; and resident-led discussions on topics of interest to men.

Health and wellness: Group exercise classes and interactive games increase physical activity, balance, circulation, and flexibility. Walking and gardening provide physical activity and opportunities to get outdoors. Classes in relaxation, breathing techniques, yoga, Quigong, Tai Chi, etc., may help with stress reduction and overall wellness. Group games, such as health education bingo, and presentations

[4] Project staff contacted a number of senior living communities by phone and e-mail to solicit suggestions and learn about their experiences. The information and suggestions provided here are a compilation of these discussions.

with discussions can be used to convey health information. Caring for pets may help cope with loneliness and provide stress reduction, a sense of purpose, and, in some cases, an opportunity to get physical activity and be outdoors.

Disease and injury prevention and chronic disease management: Classes on topics such as nutrition and preventing falls, or managing chronic diseases, such as heart disease and diabetes, can help residents take better care of their own health.

Intellectual activities: Encourage residents to present on topics of interest. Book and current events discussions, presentations, seminars, workshops, learning a new language, and interactive gaming may stimulate cognitive functioning and enhance self-esteem.

Arts activities: Activities such as creative writing, poetry readings, arts and crafts, photography, music, drama, and dance can promote creativity, imagination, and self-expression.

Skills-building: Classes in building skills, such as computers, carpentry, cooking, sewing, gardening, financial management, and grandparenting, may increase a sense of competence and self-esteem.

Coping skills: Classes or groups on coping skills can help residents better deal with personal issues, such as loss and bereavement, aging, living with specific health conditions, sexuality, caring for a spouse or partner, stress, interpersonal communication, problem solving, financial issues, and organizing paperwork.

Spiritual connection: Religious services, celebration of religious holidays, prayer groups, meditation classes, and taking personal time for contemplation may help residents find meaning, purpose, and value in life.

Positive life review: Also called reminiscence, this activity involves going back through one's life and putting together scrapbooks, journaling, and/or writing life stories. It can be very helpful in the process of putting one's life in perspective and finding meaning, and it is also a form of creative expression. It can be done in groups, alone, or with another person as a guide, such as a student, a professional, or a friend.

Volunteer and mentoring: Helping others may provide a sense of purpose or meaning in residents' lives. For example:

- Residents can participate in finding ways to welcome new residents and engage other residents in contributing skills they have, either within the senior living community or in other settings.

- Within the senior living community, residents can help organize and run events; develop and manage a newsletter; help other residents with household tasks, shopping, getting to appointments, and taking walks outside; or plant and maintain a community garden. Residents can also organize and run fundraisers to raise money for other senior living community activities.
- Residents can teach or tutor children, teens, adults, and other residents, as well as tutor senior living community staff members who are learning English as a Second Language.
- Outside the senior living community, residents can volunteer for community organizations, such as ethnic and religious groups and the Service Corps of Retired Executives.
- Intergenerational activities can be effective in bringing young energy to older adults and enabling them to contribute to young people's lives. These activities can range from care of preschool children to tutoring or mentoring school-age children.

Tool 1.b

Use with Goal 1.2

Tool 1.b: Strategies to Establish Social Networks

Review the list of strategies below. These ideas were collected from senior living communities across the United States.[5] Contact the organizations in *Tool 4.b: Resources List, Section III. Information about the Physical and Social Environment* for additional background and ideas. Consider the activities you already have in place and which new ones you want to consider implementing. For those you want to adopt, use *Tool 4.a: Planning Worksheet Example and Template* to help guide your planning process.

Welcoming New Residents

1. Hold events specifically to welcome new residents where they can meet other residents and the community leadership.
2. Set up your new resident orientation as a welcoming ritual to bring new residents into the social fabric of the community rather than just being an informational session.
3. Establish a buddy and/or a mentor system, especially for new residents, in which residents regularly check in with each other.
4. Provide information to all new residents on all the forms of social connection and support available in the senior living community.
5. Have events, buddy systems, and information in continuing care retirement communities to welcome and help residents who are moving to new levels of care.
6. Invite people on the waiting list for the senior living community to participate in your facility's activities. This will help them get to know residents and facilitate a smooth transition when they do move in.

Resident Volunteer Outreach

1. Implement a telephone outreach program, in which residents are engaged to make calls to other residents to check on how they are doing and offer support. Predetermined times can be set for the calls. If an individual does not respond to daily calls made at set times, the caller alerts a designated emergency contact.
2. Train one resident on each floor to be aware of other residents and reach out to them. For example, a resident on each floor might volunteer to do things

[5] Project staff contacted a number of senior living communities by phone and e-mail to solicit suggestions and learn about their experiences. The information and suggestions provided here are a compilation of these discussions.

to help others, such as taking a new resident to dinner, providing support if a spouse dies, and making hospital visits.

3. Provide training on signs and symptoms of suicide and listening skills to residents who will take on an outreach role.

Involvement in Senior Living Community Decision Making

Encourage participation on the resident council, committees, or other senior living community governing or planning bodies. Being involved in decision making that affects the senior living community may help build social networks not only for individuals but also for the community as a whole. It also gives residents a role in which they can contribute and gain respect, as well as have input into decisions that affect their lives.

Tool 1.c

Use with Goal 1.3

Tool 1.c: Changes in the Physical and Social Environment that Can Promote Emotional Health and Prevent Suicide

Review the list of actions below (Bergman-Evans, 2004; Canadian Coalition for Seniors' Mental Health, 2006; Eden Alternative Web site; Osgood, 1990). Use the information in *Tool 4.b: Resources List, Section III. Information about the Physical and Social Environment* for additional background and ideas. Consider the activities you already have in place and which new ones you want to consider implementing. For those you want to adopt, use *Tool 4.a: Planning Worksheet Example and Template* to help guide your planning process.

Changes to Compensate for Impairments

- ***To increase safety, mobility, and accessibility:*** Add physical aids and safety features, such as handrails in hallways and nonslip flooring. Keep hallways and open areas free of clutter.
- ***To help with visual impairments:*** Adjust lighting and glare for both daytime and nighttime. Use large print on signs and menus.
- ***To compensate for hearing changes:*** Minimize background noise to make conversation easier. Do not use public address systems. Use wall hangings to absorb sound. Provide equipment or a sound system for lectures, programs, etc., that can compensate for hearing impairments.
- ***To make the environment easier to understand:*** Put up easy-to-read signs, painted arrows and icons, communication boards, and large-faced clocks.

Changes to Enhance the Interior and Exterior Environments

- ***To make the environment more comfortable:*** Control air temperature and quality. Eliminate drafts. Provide furniture that is comfortable for the physical needs of older people. Play soothing music.
- ***To make the environment more homelike:*** Keep institutional equipment, such as laundry, medicine, and housekeeping carts or mechanical lifts, stored out of sight. Remove the nurses' stations from the resident areas, and have staff meet and do work in a separate room. Make space for residents' personal objects and furniture.

- ***To make the interior environment more aesthetically pleasing:*** Add plants, pictures, artwork, and homey lighting. Pictures and artwork could be items that residents own or make, as well as items that the senior living community acquires.
- ***To make the exterior environment more inviting:*** Put in gardens or other landscaping to make the grounds more aesthetically pleasing. Build walkways to encourage physical activity. Consider building a nonthreatening skills path or par course into the walkways. Build gathering areas with benches to encourage social interaction.

Changes to Improve the Social Environment

- ***To increase social contact and interaction:*** Provide multiple spaces for group conversation and activities. Provide opportunities to develop intergenerational connections, such as bringing children and teens into the senior living community for different activities. Foster an environment that is welcoming to people of different cultural and ethnic groups. Bring pets into the senior living community.
- ***To improve the integration of various categories of residents:*** For senior living communities that have younger mentally ill residents as well as older adults, provide staff the opportunity to share strategies for creating an environment that is inclusive of and comfortable for everyone.
- ***To enhance privacy:*** Place curtains between beds in shared rooms. Arrange dining areas and furniture in other common spaces to allow for small-group interaction.

Tool 1.d

Use with Goals 1.4 and 2.1

Tool 1.d: Restricting Access to Lethal Means

Review the list of policies, procedures, and strategies below. These ideas were collected from senior living communities across the United States.[6] Consider the activities you already have in place and which new ones you want to consider implementing. Keep in mind that different policies, procedures, and strategies will be appropriate for different types of senior living communities. For those you want to adopt, use *Tool 4.a: Planning Worksheet Example and Template* to help guide your planning process.

Policies and Procedures

- Review and update policies and procedures periodically.
- Inform staff, residents, and their families about any new restrictions and the reasons for them, as well as the consequences of violating the restrictions.

Limitations on Possession of Methods of Self-Harm

The more structured the senior living community (e.g., nursing homes compared to independent living), the easier it is to implement restrictions on methods of self-harm.

- ***Firearms (includes handguns, shotguns, hunting rifles, etc.):*** Do not allow possession of firearms by residents. (Applicable to any type of senior living community.)
- ***Other weapons (such as hunting knives, decorative swords):*** Do not allow possession of any other weapon by residents. (Applicable to any type of senior living community.)
- ***Prescription and OTC medications:*** Closely monitor the medications taken by residents and in the possession of residents. Watch for stockpiling. (Easiest in nursing homes, possible in assisted living. May not be possible in independent living.)
- ***Illegal drugs:*** Do not allow possession of illegal drugs by residents. (Applicable to any type of senior living community.)

[6] Project staff contacted a number of senior living communities by phone and e-mail to solicit suggestions and learn about their experiences. The information and suggestions provided here are a compilation of these discussions.

- ***Chemicals (such as toxic cleaning supplies), kitchen knives, and rope:***
  - Limit possession in personal living spaces. (Most possible in nursing homes, more difficult in assisted living, and not possible in independent living, where these things are needed by people who live there.)
  - Lock up supplies needed by staff to maintain the facility or keep them under the watchful eye of those who are using them. (Applicable to any type of senior living community.)
  - Tell staff not to give these items to residents. (Applicable in nursing homes and maybe in assisted living.)

Locking and Monitoring Risky Locations and Supplies

- Lock facility garages when not in active use. Garages are a common place for suicide deaths and attempts in senior living communities because of their relative isolation and remoteness.
- Lock all areas where chemicals (including cleaning supplies), knives, and ropes are stored when they are not in active use.
- Have staff monitor risky locations and supplies to be sure they are kept locked. Document their monitoring efforts in a log.

Physical Changes to a Senior Living Community that Can Reduce the Risk of Self-Harm

- Limit residents' access to unprotected stairwells in isolated areas and to high places where they do not need to go, such as roofs. Or, install railings or fences around the perimeters on high places.
- Make any necessary changes to ensure safety on high places, such as balconies and porches above ground level where residents have regular access.
- Place window guards on windows or limit the size of openings.

Section 2

Tools for the At-Risk Approach

Tool 2.a

Use with Goal 2.1

Tool 2.a: Recognizing and Responding to the Warning Signs of Suicide

Warning Signs for Suicide Prevention

The *Warning Signs for Suicide Prevention* was developed by an expert working group brought together by the American Association of Suicidology. The working group presented the warning signs organized by degree of risk and emphasized the importance of including clear and specific directions about what to do if someone shows warning signs.

Warning Signs of Suicide: Emergency Response

- Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Someone talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person

If you hear or see any of the behaviors above in _____ [facility], you should do the following:

- Do not leave the resident alone
- **Call 911 or Contact _____ [mental health contact in facility or local community]**
- Call the resident's emergency contact: _____
- Other: _____

Warning Signs of Suicide: Mental Health Referral

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped—like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family, and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living, no sense of purpose in life

If you hear or see anyone showing any one or more of the behaviors above in _____ **[facility]**, you should do the following:

- **Contact _____ [mental health contact in facility or local community]**
- Other: _____

You can also call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

Source: Rudd, M.D. et al. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior, 36*(3), 255–262. (http://www.atypon-link.com/GPI/doi/abs/10.1521/suli.2006.36.3.255)

Statements and Behaviors that May be a Warning Sign

People manifest warning signs for suicide risk in a variety of ways. It is important to be attentive to things residents may say or do. The following lists some statements or behaviors that may be a warning sign (adapted from Beeston, 2006).

Warning sign: Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself

- Direct statements, such as:
  - "I'm going to kill myself, end it all."
  - "Goodbye. I won't be seeing you again."
  - "I'm tired of living. I just want to die."
- Indirect statements about a future event they will not be around to see, such as:
  - "I won't make it to Christmas."
  - "You won't have to worry about me much longer."
  - "I can't take this any longer. I'd be better off dead. All I do is mess things up."
  - "My family would be better off without me. Soon I won't be around."
- Guarded answers to questions especially related to suicidal thoughts or plans

Warning sign: Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means

- Purchase of a gun or storage of a loaded gun
- Hoarding medication
- Failure to thrive: Self-neglect, including not eating, drinking, or taking medication or other medical treatment

Warning sign: Someone talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person

- "Death would solve all my problems."
- "Death seems like the only way out."

Note: As people get older, they think more about death and dying. Sometimes they talk more about death and dying. Talking about death and dying can be healthy for older adults. Obsessing about death is not healthy.

Warning sign: Hopelessness, no reason for living

- "There's no reason for me to go on."
- "I'm no good to anyone anymore."

Warning sign: Withdrawing from friends, family, and society

- Lack of interest in household or social tasks
- Refusal to participate in activities that had previously been of interest

Warning sign: Anxiety, agitation, unable to sleep, or sleeping all the time

- Depression accompanied by anxiety
- Changes in sleeping and eating habits

A cluster of symptoms, such as:

- Tension, agitation, guilt, and dependency
- Rigidity, impulsiveness, and isolation
- Sudden shift from deep depression and thoughts of death to cheerfulness or peace

Probes for More Information

The importance of residents' relationships with staff members cannot be overstated. Simply by being warm, caring, and interested in what the resident is saying or doing, staff members create vital protective factors.

We all know that ***how*** you ask a question is as important as ***what*** you ask. It is important not to challenge the resident in any way. He or she will know if you are sincere or if you are "just doing your job." A warm, friendly, but matter-of-fact tone of voice and manner work best. And, be sure you have enough time to listen to the person's responses (Assisted Living Concepts, 2008).

Examples of *inappropriate responses* to individuals who express a wish to die or show other warning signs include (Assisted Living Concepts, 2008):

- "Oh, don't talk like that. You're one of our favorites."
- "Look on the bright side."
- "Now don't talk such foolishness. You're doing just fine."
- "I know you're probably not, but I just want to check—are you thinking about suicide?"

Examples of appropriate responses to someone who may be suicidal are (Assisted Living Concepts, 2008):

- How are you doing?
- What are you thinking?
- Do you feel like talking about how you feel?
- Tell me more about how you feel.
- How long have you felt this way?
- Are you thinking about doing something to harm yourself?
- Do you have thoughts about suicide?
- Are you thinking about ending your life?
- Do you believe you would be better off dead?
- What are you planning to do?

Tool 2.b: Suicide Screening Tools for Older Adults

Tool 2.b

Use with Goal 2.1

Most suicide assessment measures have been developed for child, adolescent, college student or young adult populations (Goldston, 2000). In contrast, there are very few measures that have been specifically designed for elderly populations (Gallo et al., 1998; Szanto et al., 1996). Although there have been efforts in recent years to modify standard tools for use with older adults, these are not yet fully evaluated and are limited in their availability (Brown, 2002; Charney et al., 2003).

Scale for Suicide Ideation (SSI)

The SSI is one of the most widely used measures to assist mental health clinicians in assessing suicide risk. In addition to items that measure suicide ideation (thoughts of wanting to kill oneself), it includes an item that assesses the frequency of previous suicide attempts and the degree of intent to kill oneself during the last suicide attempt. The SSI is one of the few suicide assessment instruments to have documented the predictive validity for completed suicide (Brown, 2002).

The Paykel Suicide Questions

The Paykel Suicide Questions tool provides practitioners with a quick assessment to determine if suicidal thoughts are present. It contains five interviewer-administered questions with increasing levels of intent (Paykel et al., 1974). Although not tested specifically with older adults, it has been used with them (Skoog et al., 1996). The reliability of this measure needs to be established, and further studies are needed to investigate its validity (Brown, 2002).

The Paykel Suicide Questions are:

1. “Has there been a time in the last year when you felt life was not worth living?”
2. “Has there been a time in the last year that you wished you were dead, for instance, that you would go to sleep and not wake up?”
3. “Has there been a time in the last year that you thought of taking your own life, even if you would not really do it?”
4. “Has there been a time in the last year when you reached the point where you seriously considered taking your own life, or perhaps made plans for how you would go about doing it?”
5. “In the last year have you made an attempt on your life?”

Scoring: The questions are rated either “1” or “0” based on a response of “yes” or “no” respectively. Moderate to high risk: Total score >2 OR Yes to item 5 plus any other item OR any endorsement of item 4.

Geriatric Suicide Ideation Scale

The Geriatric Suicide Ideation Scale was developed because the standard SSI does not distinguish among acceptance of mortality, death ideation, and suicidal intent—important distinctions among older adults. The tool has 31 questions with 4 subscales: suicide ideation, death ideation, loss of personal and social worth, and perceived meaning in life. While several studies have pointed out its potential validity as a measure of suicide ideation among older adults, it has yet to be fully evaluated (Heisel & Flett, 2006; Heisel, 2006).

Suicidal Older Adult Protocol (SOAP)

The Suicidal Older Adult Protocol (SOAP) is a guided clinical interview with 18 items. It is the third in a series of tools for teens, adults, and older adults. Items include demographics, history of attempts, physical and psychological clinical factors, life situation, and protective factors. The clinician determines suicide risk based on professional judgment, not a score. The tool then provides a list of actions to take, depending on the responses. It is still being evaluated (Fremouw et al., 2009).

Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

SAFE-T is a pocket card for mental health clinicians and health care professionals that provides protocols for conducting a comprehensive suicide assessment, estimating suicide risk, identifying protective factors, and developing treatment plans and interventions responsive to the risk level of patients. The pocket card includes triage and documentation guidelines for clinicians. It was developed through collaboration between Screening for Mental Health, Inc. (SMH), and the Suicide Prevention Resource Center (SPRC). Douglas Jacobs, CEO and Founder of SMH, originally conceived the model of the SAFE-T pocket card. The protocols and guidelines featured on the card were developed based upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. http://www.sprc.org/library/safe_t_pcktcrd_edc.pdf

Tool 2.c: Risk Factors for Suicide

Tool 2.c

Use with Goal 2.2

Mental illness

- Major depression
- Other mood disorders
- Psychotic disorders

Substance misuse and abuse

- Alcohol
- Prescription and OTC medication

Physical illness, disability, and pain

- Poor physical health
- Functional impairments
- Pain
- Side effects of some medications
- Insomnia

Personal and family history of suicide

- Previous suicide attempt
- A family member who has died by suicide

Current life circumstances

- Social isolation
- Major life transitions, such as moving to a new residence
- Family conflict and loss
- Financial problems
- Lack of a sense of safety
- Losing autonomy, respect, supportive relationships, and participation in civic and social life
- Other people having lower expectations for them

Personal characteristics

- Inability to adjust to change
- Low rating of their own health
- Low self-esteem
- Hopelessness
- Impulsive or aggressive behavior
- Cultural or religious beliefs favorable to suicide, especially among older people

Access to means of suicide

Most common means of suicide in nursing homes include:

- Jumping from buildings
- Hanging
- Cutting
- Taking an overdose of medication

Older adults can also harm themselves by refusing to eat, drink, take medication, or follow other treatment, and by taking unnecessary risks.

Sources: Beeston, 2006; DHHS, 2001; Reed, 2007; Wojnar et al., 2009

Tool 2.d: Protective Factors for Suicide

Tool 2.d

Use with Goal 2.2

Health care and emotional health care

- Treatment for depression and other mental health issues
- Substance abuse treatment
- Treatment for physical illnesses and disabilities
- Promotion of health and wellness

Personal characteristics

- Resilience and perseverance
- Openness to experience
- Sense of meaning and purpose/Hope
- Self-esteem
- Skills in coping, problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Positive health practices and help-seeking behavior

Living situation

- Positive, pleasant, and homelike physical environment
- Accessible environment for residents with physical disabilities
- Restricted access to highly lethal means of suicide

Relationships

- Strong connections with family, friends, and the larger community
- Engagement in purposeful activities, including recreational, social, spiritual, intellectual, and creative—designed around the likes and needs of the residents
- Strong connections with staff and volunteers

Sources: Beeston, 2006; DHHS, 2001; Reed, 2007

Administrators and staff in senior living communities can create protective factors for residents. By being warm, caring, and interested in what the resident is saying, doing, or feeling, staff members can strengthen relationships with residents and improve their overall quality of life.

Tool 2.e

Use with Goal 2.3

Tool 2.e: Principles of the American Geriatrics Society and American Association for Geriatric Psychiatry's Expert Panel on Quality Mental Health Care in Nursing Homes

The following principles are part of a consensus statement on managing depression and behavioral symptoms associated with dementia that was developed in 2001–2003 by the American Geriatrics Society and American Association for Geriatric Psychiatry's Expert Panel on Quality Mental Health Care in Nursing Homes. This panel was made up of representatives of 15 professional organizations with expertise in geriatrics, mental health, and health care.

Principles

1. Persons in nursing homes are primarily people who need to be allowed to lead their lives in the most autonomous and pleasant way possible. The regulations and the institution's organization, both, should reflect this goal rather than interfere with it.
2. High-quality mental health care in nursing homes is possible only where overall care is of high quality.
3. If mental health care of nursing home residents is to improve, the tendency to overemphasize and regulate only the assessment process must change. For those with mental health disorders, treatment must follow assessment.
4. The providers who are qualified and able to provide important and necessary assessments and treatments for mental health conditions in nursing homes must be reimbursed for delivering them.
5. The institution must be committed at all levels, including its administrative leadership and medical direction, to maintaining a high quality of life for its residents. The nursing home culture (the way people live and work together and the type of environment they create) must foster good mental health care. Trusting relationships that build a sense of community, support residents so that they can contribute to the life around them, and acknowledge and respect resident choice and decision making in areas such as time to rise, times to perform other daily activities, and whether to be alone or with others need to characterize the ways staff and residents interact.
6. Adequate staffing is essential to providing good mental health care to nursing home residents. It facilitates strengthening of staff-resident relationships through permanent staff assignments. It also enables nursing assistants to be important participants in interdisciplinary care planning and conferencing

and allows for closer staff observation of resident preferences and more staff interaction with residents' families and friends.

7. A homelike physical environment (e.g., the spontaneity that is generated by the presence of children, pets, and plants) is a necessary ingredient of a high quality of life and of success in managing depression and behavioral symptoms.

"The panel also recognized that a thorough assessment of the potential underlying causes and factors contributing to depression and behavioral symptoms should encompass multiple domains if the care of residents with these conditions is to be comprehensive. These domains include the identification and treatment of pain and sensory deficits, the recognition and minimization of drug side effects, the identification and treatment of psychosis related to dementia and other psychiatric conditions common in nursing homes, appropriate evaluation and diagnosis of dementia, and appropriate diagnosis and treatment of delirium."

Source: American Geriatrics Society and American Association for Geriatric Psychiatry. (2003). Consensus statement on improving the quality of mental health care in U.S. nursing homes: Management of depression and behavioral symptoms associated with dementia. *Journal of the American Geriatrics Society, 51,*1287–1298.

Tool 2.f

Use with Goal 2.3

Tool 2.f: Key Symptoms of Depression

Depression is a serious but treatable illness that needs immediate attention. Key symptoms of depression in older adults include:

- Depressed mood most of the time, sad or "empty" feelings
- Loss of interest or pleasure in activities
- Disturbed sleep (sleeping too much or too little)
- Weight loss or gain (changes in appetite)
- Fatigue or lack of energy
- Feelings of worthlessness or extreme guilt
- Difficulties with concentration or decision making
- Noticeable restlessness (agitation) or slow movement
- Frequent thoughts of death or suicide, or a suicide attempt

Adapted from: American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (4th ed., Rev.). Washington, DC: Author.

For information on screening tools for depression, see *Tool 2.g: Screening Older Adults for Depression.*

Depression in Alzheimer's Disease and Other Dementias

The cognitive impairment of dementias makes it difficult for people to articulate sadness and other feelings associated with depression. In general, diagnostic standards for major depression also apply to depression in dementia except that the latter reduces emphasis on verbal expression and includes irritability and social isolation (Alzheimer's Association, n.d.). For information on a screening tool to use for depression in Alzheimer's, see the Cornell Scale for Depression in Dementia in *Tool 2.g: Screening Older Adults for Depression.*

For more information on depression in Alzheimer's disease and other dementias, see the following Web sites:

- Alzheimer's Association, Depression and Alzheimer's
  Available at: http://www.alz.org/living_with_alzheimers_depression.asp
- American Academy of Family Physicians, Depression and Alzheimer's Disease
  Available at: http://familydoctor.org/online/famdocen/home/seniors/mental-health/044.printerview.html

Tool 2.g: Screening Older Adults for Depression

Tool 2.g

Use with Goal 2.3

Nursing homes are required to conduct the Minimum Data Set (MDS) with all new residents (DHHS, 2009). The MDS summarizes information on residents' cognitive, physical, and psychosocial functioning; on their communication, mood, and behavior; and on their symptoms, diagnosed conditions, and treatments. However, it tends to miss cases of depression and does not assess for suicidal ideation and behavior (Simmons et al., 2004; Reiss & Tischler, Part I, 2008). Nursing homes and other types of senior living communities vary on whether they conduct other mental health screening for new residents on an ongoing basis. Yet screening can be very useful in recognizing and diagnosing depression, alcohol abuse, and risk for suicide, and then should be followed up with appropriate treatment.

There are a few screening tools that have been found to be particularly useful for older adults. The 15-item form of the Geriatric Depression Scale (GDS 15) is recommended for all older adults, including those in long-term care facilities, except those with dementia. The 2-item and 9-item forms of the Patient Health Questionnaire (PHQ-2 and PHQ-9) are also useful for older adults. All three of these tools are relatively short, which is important for older adults, since many have a limited attention span and/or educational level, and there may not be time to administer longer tools (Hyer et al., 2005; Kroenke et al., 2003; Reiss & Tishler, Part I, 2008; Spitzer et al., 1999; Yesavage et al., 1983). These three tools are in the public domain, free of charge, and included at the end of this section.

The Beck Depression Inventory is another widely used depression screening tool that has been recommended for older adults. However, it has several limitations for use in long-term care. It is longer than the GDS and PHQ, is written at a higher reading level, and has a relatively complex scoring system, all of which make it less effective with people with poor English language skills, little formal schooling, or mild cognitive dysfunction. It also has a number of questions that refer to somatic symptoms, such as sleep problems and fatigue, which may cause inflated scores with long-term care residents who may have these symptoms due to causes other than depression (Hyer et al., 2005). In addition, there is a fee to obtain the tool and scoring system. It is available at http://pearsonassess.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8018-370.

For older adults with dementia as well as possibly depression, the Cornell Scale for Depression in Dementia (a 19-item scale) is the most useful screening tool (Alexopoulos et al., 1988; Hyer et al., 2005; Reiss & Tishler, Part I, 2008), since it was developed specifically to assess signs and symptoms of depression in people with dementia. In addition to direct observation and interview of the individual, this scale gathers information from a caregiver. The Cornell Scale is in the public

domain and available free of charge at http://www.qualitynet.org/dcs/ContentServer?cid=1116947564848&pagename=Medqic/MQTools/ToolTemplate&c=MQTools.

Older adults who screen positive on any of these tools should be given a full diagnostic evaluation for depression. This evaluation should include a physical exam, since medical conditions can cause or contribute to depression. It should also include a complete medical and psychosocial history with a focus on past and present medical and psychiatric illnesses, medications taken, cognitive functioning, behavioral symptoms, family relationships, and other situational factors. The person doing the evaluation should conduct interviews with the resident, facility staff, and family members when possible. Certain lab tests may help identify physiological factors involved in a person's depression (Reiss & Tishler, Part I, 2008).

Screening Tools

Geriatric Depression Scale—15 items (GDS 15)

Instructions: Choose the best answer (*Yes* or *No*) for how you have felt over the past week.

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing things?
10. Do you feel that you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel worthless the way you are now?
13. Do you feel full of energy?

(continued on next page)

(continued from previous page)

14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?

Scoring: Score one point if you answered NO to Questions 1, 5, 7, 11, 13. Score one point if you answered YES to Questions 2, 3, 4, 6, 8, 9, 10, 12, 14, 15. Total your points.

Total point score: _____

A score > 5 is suggestive of depression and a score > 10 is almost always indicative of depression.

Translations of the GDS into about 30 other languages are available in different versions by different researchers at http://www.stanford.edu/~yesavage/GDS.html.

Source for GDS: Yesavage, J., Brink, T., Rose, T. et al. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research, 17,* 37–49.

Patient Health Questionnaire (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Feeling down, depressed, or hopeless

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Total point score: _____

Interpretation: Score > 5: probability of major depression is > 50 percent.
Score > 3: probability of any depressive disorder is 75 percent.

Information from: Kroenke, K., Spitzer, R.L., & Williams, J.B. (2003). The patient health questionnaire-2: Validity of a two-item depression screener. *Medical Care*, 41, 1284–1292.

Patient Health Questionnaire (PHQ-9)

Rate question 1 with the following categories: Not at all (score 0), Several days (score 1), More than half the days (score 2), or Nearly every day (score 3).

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?
    a. Little interest or pleasure in doing things
    b. Feeling down, depressed, or hopeless
    c. Trouble falling asleep, staying asleep, or sleeping too much

(continued on next page)

(continued from previous page)

d. Feeling tired or having little energy

e. Poor appetite or overeating

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

g. Trouble concentrating on things such as reading the newspaper or watching television

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

i. Thinking that you would be better off dead or that you want to hurt yourself in some way

Rate question 2 with the following categories: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult.

2. If you checked off any of these problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Total point score (Questions 1a-1i): _____

A score > 10 is indicative of depression when problems cause at least some difficulty.

The PHQ-9 has been translated into multiple languages. More information about this tool is available at http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9.

Source for PHQ-9: Spitzer, R., Kroenke, K., & Williams, J.B. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ Primary Care Study. *Journal of the American Medical Association, 282,* 1737–1744.

Tool 2.h

Use with Goal 2.3

Tool 2.h: Treatment for Depression

Useful Medications

Antidepressant medications act on chemical substances found in the brain. When these substances are either deficient or out of balance, depression often results. A recent systematic review of studies concluded that two main types of antidepressants are considered the most effective medications to treat depression. They are tricyclic antidepressants (classical and tricyclic related) and selective serotonin reuptake inhibitors (SSRIs) and are considered equally effective (Mottram et al., 2006). Although there is concern that SSRIs increase risk for suicide in adolescents, this is not true for older adults. Because of their positive effect on depression they may reduce the risk for suicide (Carlsten & Waern, 2009).

People do not respond to medications in the same way, so patients taking them should be monitored regularly. In addition, staff should be especially aware of the fact that some people seem to show a sudden recovery from a deep depression before they make a suicide attempt (Beeston, 2006).

Psychotherapy

Psychotherapy is often called talk therapy, that is, people seeking help simply talk with a mental health professional about their problems and various other issues in their lives. At least six types of psychotherapy have been found to be effective in treating older adults. However, all of these therapies must be delivered either by mental health professionals or by others who have been specially trained to deliver them. Clinicians who are trained in these therapies can often provide consultations in which they train professional nursing staff to use techniques from these therapies. Note that there are few studies evaluating these therapies in older adults from minority groups (Areán & Cook, 2002). These therapies include:

- ***Behavioral therapy (BT):*** A structured, time-limited therapy that addresses how behaviors affect mood. BT has been evaluated in outpatient and inpatient medical rehabilitation settings (Areán & Cook, 2002; Frazer et al., 2005; Frederick et al., 2007; Mackin & Areán, 2005; Scogin et al., 2005).
- ***Cognitive behavioral therapy (CBT):*** A structured, time-limited therapy that is designed to change thought patterns and behaviors that cause or maintain depression. CBT has been evaluated in community settings. It is frequently used in residential settings, but there are no published reports of evaluations in these settings (Areán & Cook, 2002; Frazer et al., 2005; Frederick et al., 2007; Mackin & Areán, 2005; Scogin et al., 2005). Therapist and accompanying patient manuals for older adults are available through the Stanford

School of Medicine's Older Adult and Family Center Web site: http://oafc.stanford.edu.

- ***Cognitive bibliotherapy:*** A self-directed therapy designed to change the thought patterns that cause or maintain depression. This therapy is delivered through self-guided computer programs or written materials, but there should be at least minimal contact with a mental health professional. Cognitive bibliotherapy has not been evaluated specifically in residential settings (Floyd et al., 2006; Frazer et al., 2005; McKendree-Smith et al., 2003; Scogin et al., 2005).
- ***Interpersonal therapy for older adults:*** A structured, time-limited therapy designed to improve depressive symptoms associated with problems in individuals' relationships with other people. Findings indicate that this type of therapy is most effective as a maintenance treatment when combined with antidepressant medication. It has not been evaluated specifically in residential settings (Areán & Cook, 2002; Frazer et al., 2005; Frederick et al., 2007; Mackin & Areán, 2005).
- ***Reminiscence and life review therapy:*** A therapy that involves discussion of a person's past activities, events, and experiences to help older adults resolve conflicts and accept both the successes and failures in their lives. This type of therapy can be done by mental health professionals, as well as by a trained nurse or clergy, and it can be integrated into other therapies such as CBT and interpersonal therapy. It can be delivered to individuals or in groups, and it has been used and evaluated in senior living communities (Areán & Cook, 2002; Bohlmeijer et al., 2003; Frazer et al., 2005; Frederick et al., 2007; Hsieh & Wang, 2003; Mackin & Areán, 2005; Scogin et al., 2005). Dignity therapy is a similar model that has been used with patients near the end of life. One study showed it to be a promising therapeutic intervention for suffering and distress at the end of life (Chochinov et al., 2005).
- ***Problem-solving therapy:*** A short-term intensive intervention designed to help older adults identify problems and develop skills for dealing with stress and depression and solving problems. This type of therapy has been used and evaluated in nursing homes. It can be delivered by mental health professionals and nurses who have been trained in the technique (Areán & Cook, 2002; Areán et al., 2008; Frazer et al., 2005; Frederick et al., 2007; Mackin & Areán, 2005; Scogin et al., 2005).

Electroconvulsive Therapy (ECT)

ECT is the delivery of a brief electric current to the brain to produce a cerebral seizure (Frazer, 2005). In recent years, the administration of ECT has greatly improved, and it can provide relief to many people with severe depression who have not benefited from other treatments (NIMH, 2009). A review article concluded that it is effective with older adults, but potential side effects make it most suitable for people with severe depression (Frazer, 2005).

Physical Activity and Alternative Therapies

Several review articles concluded that endurance, muscle strengthening, and aerobic exercise can improve mood and decrease depression scores among older adults (Frazer, 2005; Frederick 2007).

Of various other alternative therapies reviewed, the ones identified as having some evidence of effectiveness in treating depression among older adults were light therapy (artificial or sunlight), St. John's Wort (for mild to moderate depression), and folate (Frazer 2005).

Additional Information

The National Institute for Mental Health Web site has information on medications and psychotherapy for treating depression in older adults. http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts-fact-sheet/index.shtml#treatments

Tool 2.i: Programs for Managing and Treating Depression in Older Adults

If you are interested in implementing a comprehensive depression treatment program in your senior living community, consider taking the following steps:

- Review the depression treatment programs described below. The level of evaluation conducted on these programs varies as noted. These are examples to give you ideas of what might be possible to implement in your senior living community. When a contact is available, seek assistance in better understanding the program and how it was implemented.
- Based on your facility assessment, determine which program elements are relevant.
- Consider reimbursement when selecting treatments and programs.
- For those you want to implement, see *Tool 4.a: Planning Worksheet Example and Template* for a template of a planning sheet and an example filled in.

Depression Treatment Programs Implemented in Senior Living Communities

Multifaceted shared-care intervention for late-life depression: This intervention was originally developed for the whole population of a continuing care retirement community in Australia to deal directly with detection of depression in residents. It was implemented and evaluated in the assisted living and independent living settings of the continuing care retirement community. It was found to be more effective than routine care among all residents, of which only 27.1 percent were classified as depressed.

The intervention has three components: (1) collaboration between primary care physicians, facility health care providers, and local psychogeriatric service; (2) training for health care providers on detecting and managing depression; and (3) depression-related health education/promotion programs for residents. The resident component includes health promotion activities, such as exercise classes, talks on depression, a newsletter, and encouragement to participate in other positive activities (Llewellyn-Jones et al., 2001).

Screening and treatment program: An intervention to screen for and treat depression in nursing homes. This program was designed to be easy to implement and not too expensive. It uses a gero-psychiatric nurse to screen and develop individualized treatment plans for residents with depression. It provides extensive training to a group of volunteers ages 60–91, who then provide a 24-session treatment

program to the residents under the guidance of the nurse. Evaluation showed that symptoms of depression were reduced in the treatment group as opposed to the control group (McCurren et al., 1999).

Group therapy program: Growing Gifts is a 10-session group treatment program, implemented to promote the psychological well-being of depressed assisted living residents. Groups were co-facilitated by a geriatric social worker and a master gardener, who conducted the activity portions. Each session linked gardening activities to a discussion of coping, adapting to new circumstances, building new skills, etc. Interaction among group members was encouraged. Evaluation showed a significant decrease in depressive symptoms and an increase in life satisfaction and social support (Cummings, 2003).

Depression management program: Abramson Center for Jewish Life has a depression management program for nursing home residents that involves screening, activities, and exercise, as well as social work and psychology/psychiatry interventions if necessary. An informal evaluation showed that two-thirds of the participants experienced some improvement with this program (*Provider,* AHCA newsletter Sept. 2008). Article online at: http://www.ahcancal.org/News/publication/Provider/CaregivingSep2008.pdf

Community-Based Depression Treatment Programs for Older Adults

A number of programs addressing depression have been developed for use with older adults living in the community. The programs can be useful to senior living communities, particularly for residents in independent living and assisted living facilities. You can arrange for residents to take part in them if they are offered in a nearby community, or you can implement an adapted version of the programs for your senior living community.

The following four community-based programs have been scientifically evaluated and have shown positive results in reducing depression among older adults:

- ***PROSPECT (Prevention of Suicide in Primary Care Elderly)*** and ***IMPACT (Improving Mood-Promoting Access to Collaborative Treatment):*** These both represent a model of collaborative care in primary care settings. Collaborative care is a team approach that was initially developed to help manage chronic conditions such as diabetes. For depression care, it includes the primary care doctor, a depression care manager, and a consulting psychiatrist. The team utilizes evidence-based depression treatment (medications and psychotherapy), and the patient is an active team participant through education about depression, problem solving and behavioral activation, and relapse prevention strategies (Pearson, 2009). Two studies indicated a reduction in suicide ideation among older adults using the collaborative

care model for depression. PROSPECT and IMPACT both found that collaborative care was effective in reduction of both suicide ideation and depression among older adults seen in primary care settings (Bruce et al., 2004; Unützer et al., 2004; Unützer et al., 2002). IMPACT has an active dissemination program that includes descriptions of the program and screening tools.

IMPACT program materials are available at: http://impact-uw.org

- ***Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors):*** This program detects and reduces the severity of depression in older adults with chronic health problems and functional limitations. It integrates four evidence-based components into the regular services provided to older adults in their homes. It uses screening, education of clients and family, referral and linkage to mental health services, and behavioral activation. It differs from IMPACT and PROSPECT in that it does not use a separate case manager but rather incorporates the four elements into regular case management duties. An evaluation of this program is available (Quijano et al., 2007).

  Healthy IDEAS program materials are available at: http://www.careforelders.org/healthyideas

- ***PEARLS: The Program to Encourage Active and Rewarding Lives for Seniors:*** This program uses the following: (1) problem-solving therapy, (2) tools and strategies to increase social and physical activities, and (3) strategies to focus on pleasant events to reduce depression in physically impaired and socially isolated older adults. PEARLS is designed for older adults with minor depression or dysthymia. Key staff are the PEARLS manager, counselor, and clinical supervisor. An evaluation of this program is available (Ciechanowski et al., 2004).

  PEARLS toolkit materials are available at: http://depts.washington.edu/pearlspr/docs/pearls_toolkit_final.pdf

  [Minor depression = Have 2–4 depressive symptoms, which must include depressed mood or loss of interest or pleasure, that occur over at least two weeks, but not more than two years.

  Dysthymia = Have 2–4 depressive symptoms that occur most of the time almost every day for at least two years. This is a long-term chronic depression.]

Telephone-Based Programs

Some community-based programs use the telephone as their main form of contact with older adults. Senior living communities might consider using this type of model in their community or look to see if a similar type of program exists in their area. The following programs are thought to be successful, although they have not been scientifically evaluated:

- ***Link-Plus:*** A social work service with case management provided over the phone under auspices of the suicide prevention hotline agency, Life Crisis, Inc. Link-Plus targets older adults at risk for suicide and provides multidimensional assessment, service arrangement (case management), and supportive therapy (Morrow-Howell et al., 1998).
- ***TeleHelp-Telecheck:*** Provides older adults living at home with support. Implemented in Italy, TeleHelp is referred to as an "alarm system," with which a senior in crisis can activate a call for help. In TeleCheck, the client is contacted twice weekly by telephone for assessment of needs and emotional support (DeLeo et al., 2002). This program has been proven especially useful in rural areas and is run in some areas by churches.
- ***The Geriatric Outreach Program:*** Located at the Center for Elderly Suicide Prevention, this program provides counseling through scheduled telephone calls and home visits to older adults who may be at risk of suicide. Scheduled calls range from daily to weekly and include well-being checks as well as emotional support. Home visits provide face-to-face counseling one hour per week (Fiske & Arbore, 2000-2001).

  Information is available at http://www.ioaging.org/services/special/program_cesp

Tool 2.j: Recognizing and Responding to Substance Abuse Problems

Tool 2.j

Use with Goal 2.4

Signs and Symptoms of Misuse and Abuse

Alcohol

Physical

- Withdrawal symptoms when alcohol is removed
- Blackouts, memory and/or concentration problems
- Increased tolerance to alcohol
- Blurred vision and/or slurred speech
- Dehydration and/or malnutrition
- Fatigue
- Sleep problems and sleeping during the day
- Sexual problems

Mental and Emotional

- Denial of drinking
- Depression and anxiety
- Persistent irritability and annoyance when asked about alcohol
- Thoughts of suicide or suicide attempts
- Hiding alcohol
- Confusion and disorientation
- Problems with family and friends

Lifestyle

- Morning drinking
- Neglect of home or pets
- Changes in personal grooming and hygiene
- Drinking despite warnings and/or arrests for driving while drunk

Prescription and/or Over-the-Counter (OTC) Medications

- Sudden unexplained mood changes
- Irritability
- Lack of energy and concentration
- Loss of short-term memory
- General loss of interest
- Excessive worry about having enough pills or whether it is time to take them to the extent that other activities revolve around the dosage schedule
- Continuing to request refills when the condition has or should have improved
- Complaining about doctors who refuse to write prescriptions for preferred drugs, who decrease dosages, or who do not take symptoms seriously
- Withdrawing from family, friends, and neighbors and from normal social interaction
- Bruising, burns, fractures, or other trauma, particularly if the individual does not remember how and when they were acquired

Sources: SAMHSA, 2003a & 2003b

Risk Factors for Alcohol and Medication Misuse and Abuse by Older Adults

Alcohol

Risk factors for alcohol problems in older adults include the following:

- ***Sleep problems:*** Alcohol may help people fall asleep, but it does not improve sleep. People may fall asleep faster, but they often wake up in the middle of the night and can't get back to sleep. Interrupted sleep is not restful. Older adults are also at risk for sleep apnea, a condition where one can stop breathing while sleeping, then be awakened by a gasp for air. Alcohol can cause this condition to worsen.
- ***Gender:*** Men tend to drink more than women, but women experience more negative effects. Women who drink tend to increase drinking later in life.
- ***Family and/or personal history of substance abuse:*** People who have a family history of a substance abuse problem are more likely to experience a problem themselves. In addition, people who had a substance abuse problem earlier in their lives are more likely to experience a relapse as older adults.

- ***Current or past psychiatric disorder:*** People with psychiatric disorders are more likely to experience problems with drugs or alcohol. More women than men suffer from depression and then use substances to try to alleviate the depression.
- ***Lower tolerance for alcohol:*** As people age, the effects of alcohol are greater. For that reason, the recommended consumption guidelines for people over 65 are lower than for people who are younger.
- ***Lack of knowledge regarding sensible drinking limits for older adults:*** For men and women over 65, moderate drinking is no more than one alcoholic drink per day. Older adults should never drink alcohol if they take prescription pain medications, sleeping pills, over-the-counter sleep aids, medication for anxiety or depression, or have memory problems, and/or have a history of falls or unsteady walking (SAMHSA, 2003a).

Medications

Risk factors for medication mismanagement in older adults are as follows:

- ***Confusion/unclear thinking:*** Failing memory or cognitive impairment can result in a person not understanding instructions for taking medications or remembering whether medication was taken.
- ***Psychological impairment:*** Depression, frustration, and self-neglect can impair an older person's ability to take medication correctly. Alcohol can also affect the correct use of medicine.
- ***Previous history of psychiatric disorder or substance abuse:*** Psychiatric diagnoses may put older adults at risk for abuse of prescription drugs. Older adults with mood, personality, and anxiety disorders are at higher risk for alcohol or medication dependence. Older women are at high risk for receiving numerous prescriptions, particularly for symptoms of depression and anxiety. Older women are nearly twice as likely as older men to develop an anxiety disorder.
- ***Language and cultural barriers:*** If cultural beliefs and practices conflict with the doctor's treatment, the older person may not follow the treatment plan. Language barriers and limited literacy may cause fear or confusion when the person is unfamiliar with the medical terms used.
- ***Self-care practices:*** Older adults may not consider OTC medications, vitamins, or herbals to be drugs. Therefore, they may not tell their health care provider they are using these.

Sources: SAMHSA, 2003a & 2003b

Barriers to Recognize Alcohol and Medication Problems

It is important to know the key barriers to recognizing alcohol and medication problems in older adults.

Difficult Diagnostic Issues

Because the many issues associated with aging are a priority in visits with physicians, alcohol problems may not be raised. In addition, alcohol problems mimic other conditions commonly seen in older adults:

- Dementia unrelated to alcohol
- Side effects or bad reactions to medication
- Medical conditions and/or the worsening of an existing chronic illness
- Depression and anxiety
- Normal aging-related changes, such as a gradual slowing down of physical processes

In fact, alcohol problems, diseases, complications of aging, and medication interactions can all have similar symptoms, including:

- Dulling of the senses
- Disorientation/confusion
- Recent memory loss

Attitudes and Beliefs

Common beliefs or biases about older people and alcohol use are found in questions like:

- ***Oh, what's the use?*** Many people think alcohol problems are untreatable, hopeless, or just plain frustrating, especially in older people.
- ***She's not the type!*** A common stereotype is that only men and younger people have problems with alcohol and other drugs.
- ***What else can we expect from an older adult?*** Negative stereotypes can lead others to explain the person's problematic behavior as "he's just getting old."
- ***Don't rock the boat!*** Family members get used to alcoholic behavior and just accept it as part of life.
- ***Not in my family!*** Denial is a very common symptom of alcohol and drug use, and it may be conscious or unconscious. Denial is exacerbated when people simply don't know how alcohol affects health. The individual using

substances may not recognize the problems caused by its uses, and a caregiver may think it benefits the drinker if he or she appears untroubled by the situation.

Cultural, Language, and Gender Bias

Stereotypes about a particular racial, ethnic, and/or religious group can bias how we interpret what we see, as can stereotypes about women. Many people believe that substance abuse is mainly a problem for men. For older adults, the facts are:

- Women tend to drink alone and not in public.
- Women are more likely to use long-term prescription drugs for depression and anxiety, many of which can be dangerous if taken with alcohol.

Sources: SAMHSA, 2003a & 2003b

Guidelines for Talking to Residents about Alcohol and Medication Misuse

Your overarching goal in talking with an older adult about problems related to alcohol and medication misuse is to help him or her to understand the problem and develop motivation to engage in treatment. The following should facilitate communication:

- Establish a supportive relationship. Speak slowly and use simple language.
- Treat the person with dignity and respect. Be positive and optimistic but direct.
- Be gentle and caring. Bring up the person's good qualities and memories you share.
- Recognize the older adult's values and attitudes.
- Be mindful of the person's age and ability to understand. You may have to bring up the subject a little bit at a time instead of talking things out in one session.
- Be specific. Present the facts in a straightforward manner. Use phrases such as "I've noticed" or "I'm worried" since a person cannot argue with your feelings.
- Focus on the negative effects alcohol and medications are having on the person's life.
- Present the effects of alcohol or drug use in relation to whatever the older adult cares about most. Some may care about their health or what others are saying about them. Some may have given up on themselves but still care deeply for their grandchildren.

- Avoid words like “alcoholic” or “drug addict.” They are not helpful.
- Ask for agreement on important points.

Possible Reactions and How to Respond

Although you can be prepared and do your best to express your concern about the alcohol or medication use of another person, you cannot control how he or she responds to your concern. Don’t be surprised if you get some of the following reactions:

- **“It’s just a phase. I’m only drinking more now because I am depressed over _____ (a loss).”** Remind the person that alcohol is a depressant and will only make the depression worse.
- **“Leave me alone. It’s none of your business!”** Let the person know that you are bringing this up because you care. If the person gets angry, close the conversation and bring it up another time.
- **“I just drink because I’m lonely. There’s nothing to do once you get old.”** Remind the person of the enjoyable things he or she can still do.
- **“I’m anxious these days and need the tranquilizers to calm my nerves.”** Offer the person alternative ways to deal with stress, and state that the drugs could be affecting his or her health.
- **“The doctor says it’s ok.”** Ask if the doctor knows how many prescription and OTC medicines the person is taking and how much the person is drinking.

Source: SAMHSA. (2003a). This section was adapted from Hazelden’s *How to talk to an older person who has a problem with alcohol or medications.*

Tool 2.k: Screening Older Adults for Alcohol Abuse

Tool 2.k

Use with Goal 2.4

The Short Michigan Alcoholism Screening Test—Geriatric Version (SMAST-G)

It is often difficult to distinguish signs of misuse from signs of depression. If responses are unclear, ask for clarification. Ask the older adult to choose the response closest to his or her experience.

Using the amount of drinking and related symptoms for the heaviest drinking period of the past year will provide the most useful information. However, it is important to note any special circumstances and the time period assessed for that particular person.

SMAST-G: Alcohol Screening for Older Adults

In the past year:

1. When talking with others, do you ever underestimate how much you actually drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to relax or calm your nerves?
6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does having a drink help?

Scoring: Two or more "yes" responses indicates a probable alcohol problem, and further assessment is recommended.

Source: University of Michigan Alcohol Research Center, Short Michigan Alcohol Screening Test (SMAST-G). © The Regents of the University of Michigan, 1991. Available at http://pathwayscourses.samhsa.gov/aaac/aaac_7_pg2.htm

Alcohol-Related Problems Survey

Another widely used screening tool is the Alcohol-Related Problems Survey (ARPS). Research has shown that the ARPS is more sensitive than the SMAST-G and other tools in identifying older adults who may be at risk for or experiencing problems due to their alcohol use in combination with their other health conditions and current medication use (Moore et al., 2002; Fink et al., 2002). However, the ARPS is long (60 items), and although the survey is available free of charge, there is a fee to obtain the scoring system. If you would like to get a copy of the ARPS, contact Arlene Fink at afink@mednet.ucla.edu.

Tool 2.l: Treatment for Alcohol Abuse

Tool 2.l

Use with Goal 2.4

No single treatment approach to alcoholism works for everyone, so selecting an approach that fits the needs of the older adult is important. Information collected from the individual and family members, a physical exam, mental and social assessments, and laboratory results will help you and your resident make an appropriate decision about treatment. Treatment objectives will also affect the approach chosen.

General approaches for effective treatment include:

- Individual/group counseling on alcohol effects; relapse prevention; and management of stress, depression, isolation, socialization, and relationships
- Medical/psychiatric assessments of medication, pain management, antidepressant and anti-anxiety medications, detoxification, and provision of medical care as needed
- Marital and family counseling
- Attendance at a support group such as Alcoholics Anonymous (AA), if one can be found that has a number of older participants

Detoxification

If detoxification is necessary, it can take place at the senior living community or in a hospital. The older adult may need detoxification in a hospital setting if he or she has unstable medical condition(s), threatened suicide, withdrawal symptoms or seizures, and/or no social support, and continues to have access to the drug or alcohol.

Inpatient settings

Inpatient treatment options are for those patients who need 24-hour monitoring of their medical and psychiatric conditions.

Residential rehabilitation settings

Residential rehabilitation provides a slower paced, more repetitive treatment approach. Treatment can be specialized to address the needs of older adults, particularly those with cognitive impairment.

Outpatient settings

Outpatient treatment includes visits to the person's physician, group and individual counseling, and case management services to monitor and support the resident and help prevent relapse. Some research shows that self-help groups, like Alcoholics Anonymous (AA), can be extremely useful, but older adults do better in self-help groups with other older adults whose experiences are similar.

Unfortunately, these groups can be difficult to find. While many AA meetings include older adults, there are few that are exclusive to seniors. Some senior living communities invite AA to hold meetings in their facilities.

Brief interventions in primary care

Brief interventions by primary care physicians in outpatient settings have proved to be effective with older adult drinkers. These interventions have also been shown to be effective in senior living communities and aging service organizations when offered by persons with some authority who have health care or social service training. The interventions generally consist of giving advice, providing education, and making a contract with the person who is drinking stating that he or she will cut down on or stop drinking.

Source: Blow et al., n.d.

Tool 2.m: Emotional Health Resources in the Community

Tool 2.m

Use with Goals 2.5 and 2.6

To develop a list of contacts to whom you can turn when you have a resident in need of services, consider the following steps.

1. Contact some or all of the following:

- Hospitals, including emergency rooms and psychiatric units
- Psychiatric hospitals
- Mental health centers, including evaluation and crisis intervention teams
- Individual mental health providers, including psychiatrists, psychologists, and social workers
- Pastoral counseling resources
- Substance abuse treatment programs
- Telephone hotlines that deal with suicide, depression, and substance abuse
- Support groups for different types of mental health, health, and substance abuse problems and for dealing with losses such as of a spouse

You can find local contacts using the list at the end of this tool.

2. Ask each contact person some or all of the following questions:

- Are you willing to serve our residents?
- If we call you with a referral, what can we expect?
- What types of services can you provide to us and our residents and at what cost?
- How long might it take for you to be able to see one of our residents? For urgent problems? For nonurgent problems?
- Would a provider be able to come to our senior living community to see a resident if necessary?
- What kind of followup can you provide us and our residents?
- For a hospital, you should also ask if there is a psychiatric unit, and whether it serves adults ages 65 and older who also have medical problems. If you can establish relationships with psychiatric hospitals and psychiatric units of general hospitals, you may be able to bypass using an emergency room in some cases.

3. Create an annotated resource list with the information you have collected and make it available to appropriate social work, nursing, and medical staff.

The following national organizations can provide you with local contacts:

- American Association of Pastoral Counselors Referral Directory
  http://www.aapc.org/civicrm/profile?gid=2
- American Association of Suicidology
  http://www.suicidology.org
- American Foundation for Suicide Prevention
  http://www.afsp.org
- American Hospital Directory
  http://www.ahd.com/
- American Psychiatric Society, State Association Directory
  http://onlineapa.psych.org/listing/
- American Psychological Association
  http://www.apa.org
- NAMI Mental Health Professionals: Who are they and how to find them
  http://www.nami.org/Content/ContentGroups/Helpline1/Mental_Health_Professionals_Who_They_Are_and_How_to_Find_One.htm
- National Association of Social Workers
  http://www.socialworkers.org
- Open Directory Project, support groups directory
  http://www.dmoz.org/Society/Support_Groups/
- SAMHSA Mental Health Services Locator
  http://mentalhealth.samhsa.gov/databases/
- SAMHSA Substance Abuse Treatment Facility Locator
  http://findtreatment.samhsa.gov/
- Toll-free numbers from the National Library of Medicine
  http://healthhotlines.nlm.nih.gov/
- U.S. News & World Report Hospitals Directory
  http://www.usnews.com/listings/hospital-directory

Section 3

Tools for the Crisis Response Approach

Tool 3.a: Protocols for Responding to a Suicide Attempt

Tool 3.a

Use with Goal 3.1

Complete and post this in relevant locations throughout the facility.

Staff person with overall responsibility for this protocol: _____ _____ [insert name]

The following are the staff with responsibility for each step in the protocol:

1. The person who discovers the resident who has attempted suicide should notify the following immediately:
   a. On weekends or evenings: _____ or _____ **[insert names and numbers]**
   b. During the daytime: _____ or _____ **[insert names and numbers]**
2. _____ should call 911 immediately. **[insert name]**
3. _____should begin emergency medical treatment as indicated until the ambulance arrives. The resident should not be left alone. **[insert name]**
4. _____should notify the appropriate people. **[insert name]**

   The "appropriate people" will vary from one senior living community to another, but will include:

   ◊ The resident's emergency contact.*

   ◊ Appropriate mental health provider, within the facility and/or community: _____ or _____ **[insert names and numbers]**

5. _____ will communicate regularly with hospital staff. **[insert name]**

   The hospital will probably have to get the resident to sign its standard Release of Information form for hospital staff to communicate with the senior living community.

6. How the incident will be documented: _____
   _____

* If a resident does not want you to contact his or her emergency contact person, try to determine why. For example, the resident may say that the contact person is a big part of the problem. The decision to notify an emergency contact person against a resident's wishes should be made on a case-by-case basis. Determine who will make the final decision of whether or not to contact the resident's emergency contact person if the resident doesn't want you to. Determine what you will say and do if the emergency contact person is in denial about the seriousness of the resident's mental health issues.

Tool 3.b: Protocols for Responding to a Suicide Death

Tool 3.b

Use with Goal 3.1

Complete and post this in relevant locations in the senior living community.

Staff person with overall responsibility for this protocol: _____ _____ [insert name]

The following are the staff with responsibility for each step in the protocol:

1. _____should call 911 immediately. **[insert name]**
   (The emergency medical services personnel will notify law enforcement personnel based upon local ordinances.)
2. _____ should notify the resident's family or legal advocate. **[insert name]**
3. _____ should go to the residence to assist staff and be present for the family and any law enforcement persons who may also be present. **[insert name]**
4. _____ should notify State regulatory authorities as required by State regulations. **[insert name]**
5. _____ should provide immediate support to survivors. **[insert name]**

(Assisted Living Concepts, 2008; The Jed Foundation, 2006)

Tool 3.c

Use with Goal 3.1

Tool 3.c: Communicating with Residents, Families, Staff, and the Media

After contacting the resident's family—as indicated in *Tool 3.a: Protocols for Responding to a Suicide Attempt* and *Tool 3.b: Protocols for Responding to a Suicide Death*—and before you begin your postvention protocol described in *Tool 3.e: Protocols for Postvention after Suicide Deaths and Attempts,* you will need to talk with other residents, staff, and possibly family members of other residents. They will probably know something has happened and will be concerned. You should be prepared to answer the following questions:

- Who will be the spokesperson for the senior living community?
- Will you convene a meeting or talk with people individually?
- Will you specify the cause of the injury or death? How will you decide?
- What resources should you provide at this time?

Communicating with the Media

- Distribute to the media *At a Glance: Safe Reporting on Suicide* to enable reporters to report responsibly without sensationalizing the event. http://www.sprc.org/library/at_a_glance.pdf
- Develop protocols for handling onsite media to protect the confidentiality of victims and survivors.
- Determine to what extent family members should be involved in deciding on responses to media inquiries.
- Encourage media to include the toll-free National Suicide Prevention Lifeline telephone number (1-800-273-TALK) at the end of the coverage as part of responsible reporting.

Tool 3.d: Protocols for a Resident Returning after a Suicide Attempt

Tool 3.d

Use with Goal 3.1

Determine general procedures initially, and then create an individualized plan when needed.

Lead person for developing and implementing the plan: _____ _____ [insert name]

Assessment for suicidality:

- Tools (See *Tool 2.b. Suicide Screening Tools for Older Adults*):
- Who does the assessment: _____ **[insert name]**
- How often: _____

Communication: Specify the process by which all relevant administrators and staff members will communicate with each other about how the resident is doing:

Method of restricting access to lethal means (including when a resident is returning to an independent living setting):

Follow-up: Identify the care and treatment that will be provided to ensure the resident receives the best possible treatment and care:

Documentation: Identify where and how all interactions are documented:

Tool 3.e

Use with Goal 3.2

Tool 3.e: Protocols for Postvention after Suicide Deaths and Attempts

Person(s) responsible for implementing the postvention protocol:

_____

[insert name(s)]

1. **Identify all appropriate individuals as survivors.**

   Consider the following categories:

   a. Immediate
      - Spouses
      - Other family members
      - Close friends and neighbors

   b. Resident community at large
      - All residents
      - Volunteers

   c. Staff:
      - Administrators
      - Professional/clinical staff who may have treated the resident
      - Paraprofessionals who were in frequent contact with the resident
      - All staff

   d. Others
      - Police and emergency medical technicians
      - Others

2. **Provide support to survivors immediately after the suicide.** (Law enforcement officials usually appreciate this team's ability to support the survivors so the investigators are free to do their work.)

   ◊ _____ _____ will be the team members prepared to support survivors at the scene. **[insert names]**

   ◊ Provide survivors with as much pertinent information as possible.

   ◊ Notify survivors about resources available to help them.

3. **Assess all survivors for level of trauma and risk.**
   - ◊ _____ will select or develop assessment tools, protocols, and/or procedures to assess all survivors for levels of risk and trauma. **[insert name]**
   - ◊ _____ will perform trauma and risk assessments. **[insert name]**
   - ◊ Determine when the assessments will be administered.
   - ◊ Determine with whom results of the assessments will be shared. Confidentiality issues must be considered.
   - ◊ If the survivor appears to need treatment, make a referral, and follow up with the survivor until he or she is in treatment.
   - ◊ Determine whether other assessments, such as assessing the senior living community's buildings and grounds for safety, need to be done.
4. **Ensure that support is offered or provided to all survivors.**

   Because everyone grieves differently, one response does not fit all. Determine which of the following you will provide. Then, determine who will provide each and how it will be publicized. Types of support that senior living communities might provide include the following:
   - ◊ ***Support meetings:*** Community-wide support meetings are an effective way to help the senior living community come together and heal after a tragedy. See *Tool 3.f: Community Support Meetings for Senior Living Communities.*
   - ◊ ***Outreach teams:*** Interventions by internal or community outreach teams.
   - ◊ ***Memorial services:*** You probably already have a policy in place with regard to holding a memorial service at your senior living community. If you decide to hold such a service, you must decide whether it will be religious or nonreligious, whether to involve the family and/or residents in planning, and whether the suicide is to be mentioned explicitly or not. Some people advocate for "telling it like it is" as a way of diminishing negative connotations, but sensitivity is critical in balancing family confidentiality with the opportunity for emotional health education. Review the Suicide Prevention Resource Center's recommendations for public memorial observances, available at: http://www.sprc.org/library/aftersuicide.pdf.
   - ◊ ***Individual counseling within the senior living community or referrals to mental health providers in the larger community:*** Ensure that counselors are trained to treat people experiencing both trauma and grief. It is almost impossible for people to grieve fully until they have first processed their trauma.

◊ ***Pastoral counseling:*** If a pastoral counselor is on site, determine whether and/or how much counseling he or she can provide to residents and/or family members and friends.

◊ ***Support group for survivors:*** Consider whether it is better to offer a group at the senior living community or for residents to join an ongoing survivors' support group in the larger community. If you decide to create a group at the senior living community, you'll need to decide the following:

- Will the group be open or closed?
- Will the support be time limited or ongoing?
- What educational materials, workshops, or reading resources will you offer?

◊ ***Handouts, resources, videos:*** See *Tool 4.b: Resources List, Section VI. Fact Sheets for Consumers* in this Toolkit.

General considerations:

◊ Ensure that negative stereotypes about people with mental illnesses are avoided.

◊ It is helpful to refer to the Suicide Prevention Resource Center's media guidelines for help with the wording of these documents. The guidelines caution against the use of terms such as "committed suicide," "successful suicide," or "failed attempt," and instead suggest "died by suicide," "attempted suicide," or "took her life."

5. **Implement postvention strategies that discourage imitative suicides.**

The opportunity to talk openly about suicide, particularly among people at risk, may be welcomed as a relief. Discussing suicide does not encourage or induce thoughts about suicide. In developing a postvention program, it is important to consider the following:

◊ Decide on the advisability and nature of a candid discussion about depression, late-life suicide, and suicide pacts within the community. If knowledge of a suicide pact is revealed, deal with the issue rather than pretend it does not exist.

◊ Develop a protocol to encourage anonymous reporting of suicidal individuals by other community members. If residents and staff feel assured that their communications will remain confidential, they are more likely to report someone about whom they have concerns.

Tool 3.f: Community Support Meetings for Senior Living Communities

Tool 3.f

Use with Goal 3.2

This brief facilitator guide is intended for use following a suicide in senior living communities. This is a program initially developed by college health professionals at Cornell University to help people within the larger university community come together in the aftermath of tragic events. It is readily adaptable to a senior living community setting. During a community support meeting (CSM), trained staff members follow a format that is largely invisible to the attendees but is carefully choreographed by the CSM facilitators. Developers of the program note that participants feel taken care of, and administrators know that a protocol is in place when adverse circumstances arise (Meilman & Hall, 2006).

The fact sheet in this Toolkit, *After a Suicide: What to Expect and How to Help,* is a useful handout for CSMs.

Community Support Meetings

1. ***Opening.*** The introduction of staff members who are present is followed by a few comments regarding confidentiality and the duration of the meeting (1 hour). The facilitator requests that any members of the media identify themselves and leave unless they are willing to participate as affected individuals rather than as members of the press.
2. ***Brief description of death or event.***
   _____**[Insert your designee]** gives an official explanation of what is known about how the death occurred so that all who are present are working from the same basic set of facts. In addition, this offsets any potential adverse impact of the rumor mill.
3. ***Purpose of CSM.*** The facilitator acknowledges that this is a difficult time, that the residents and other people are courageous for attending, and that it is important that the meeting be a helpful and healing gathering for the community. Administrators are generally welcome to attend. However, they must carefully consider this in advance because there is the potential for the presence of high-ranking administrators to stifle open, honest discussion.
4. ***Opening question.*** The facilitator uses the following question to get residents talking: "We feel sad about what has happened, but we did not know _____ **[name of the deceased]** as well as you did, and we'd like to understand what he (or she) was like in order to be helpful. Can you tell us about him (or her) so that we can all share a common understanding? You can share or not share your reflections as you feel comfortable, although we hope you will be comfortable enough to

speak. We want to ask that the session and the things we discuss be considered confidential within the confines of this room. Does everyone feel okay with that?"

5. ***Sharing stories.*** This begins the heart of the process. In telling the story of the deceased, in reminiscing, in laughing, and in crying together, the grieving process is facilitated and the community reconnects with itself. Simply put, the storytelling is the work. In a sense, talking can be viewed as the psychological equivalent of chewing, and it breaks an overwhelming experience down into manageable, more easily digested pieces.
6. ***Grieving process.*** The facilitator makes a few very brief comments about grieving as a process that takes time, and he or she includes such words and phrases as shock, disbelief, feeling disorganized, feeling despair, sadness, anger (at the situation, at the person who died, at God), guilt, anxiety about oneself, and eventually acceptance. The facilitator emphasizes that there is no right or wrong way to go through the situation, and that, for a while, the grieving person may experience an emotional roller coaster.
7. ***The "what ifs . . . "*** Participants hold a discussion of the inevitable "what ifs" and "if onlys" that people often privately consider in the aftermath of a suicide. It is helpful when we ask residents to identify their own "what ifs" and to speculate out loud about the kinds of statements that others in the room may be considering, such as "if only I had done _____, he or she would still be alive." Through this discussion, we attempt to put perceived guilt on the table, identify it as being an impediment to grieving, and demonstrate to participants that they are not alone with their self-recriminations, that many people are wondering what more they could have done. It is also important to explain that suicide is complex and that there are many reasons for it, including relationships or failure at relationships, family issues, internal psychological conflicts, personal value systems, biology, logical and illogical thinking processes, tunnel vision (black and white thinking), conscious and unconscious processes, bottled-up anger directed at oneself, and religious beliefs. We explain that changing any of the "if onlys" would not have been likely to create a different outcome.
8. ***Wrap-up.*** The facilitator makes parting comments along these lines: "This gathering is important. It helps enhance a sense of community now when it's needed. You're in the fortunate position of having a community and being able to care for each other. Please look out for one another. If someone is isolating or having a hard time, invite him or her to talk about it."

9. ***Community resources.*** The facilitator identifies helpful resources within the senior living community and in the broader community, including **[insert resources]**.
10. ***Staff availability.*** The facilitator announces that staff will stay for a few minutes afterward in case anyone wants to talk individually.
11. ***Reviewing the CSM.*** After each CSM, the team assesses their work by conducting a review at the next monthly meeting of the CSM team. This process helps them continually refine their approach and allows members of the CSM team who were not participants in the particular postvention to learn from it.

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Section 4

Additional Tools

Tool 4.a: Planning Worksheet Example and Template

Planning Worksheet Example

Activity/Steps	Purpose	Staff needed	Resources needed (money, materials)	Timeline	Notes
Men's lunch group	Increase social networking Enhance coping skills	Activities director		Planning start date to imple-mentation	
1. Meet with men to select topics		Activities director		Completed by:	This is a priority for the Board
2. Contact speakers		Activities director	Speaker fees	Completed by:	
3. Arrange food and location		Dietary staff	Food for lunch	Completed by:	

Planning Worksheet Template

Activity/Steps	Purpose	Staff needed	Resources needed (money, materials)	Timeline	Notes

Tool 4.b: Resources List

I. Fact Sheets and Overviews for Professionals

Title: Suicide Prevention for Older Adults

Format: Booklet

Creator: Older Americans Substance Abuse & Mental Health Technical Assistance Center (SAMHSA)

Available at: http://www.samhsa.gov/OlderAdultsTAC/docs/Suicide_Booklet.pdf

Audience: Health care providers

Description: This booklet lists risk factors for suicide and a few statistics on suicide in older adults. It summarizes studies that show effectiveness in preventing suicide, including treatment for depression. It also lists goals and objectives from the National Suicide Prevention Strategy that address suicide prevention in older adults.

Title: Suicide Assessment and Prevention for Older Adults

Format: Brochure

Creator: Canadian Coalition for Seniors' Mental Health

Available at: http://www.ccsmh.ca/pdf/CCSMH_suicideBrochure.pdf

Audience: Clinicians

Description: This brochure describes how clinicians can recognize suicide risk, engage at-risk elders in the assessment process, perform an assessment, and address immediate and ongoing risk management. It also lists risk and resiliency factors, warning signs, and organizations that can provide additional information.

Title: Assessing Suicide Risk: Initial Tips for Counselors

Format: Wallet card

Creator: National Suicide Prevention Lifeline

Available at: http://www.suicidepreventionlifeline.org/Materials/Default.aspx

Audience: Counselors and other health care professionals

Description: This wallet-sized card describes initial steps to take when you think a person may be suicidal. It also includes the Lifeline phone number.

Title: Elderly Suicide Fact Sheet

Format: Fact sheet

Creator: American Association of Suicidology

Available at: http://www.suicidology.org/associations/1045/files/2005Elderly.pdf

Audience: Consumers

Description: This fact sheet presents statistics on elderly suicide deaths by age, gender, race, and means. It includes the role of depression, substance abuse, and other common risk factors.

Title: Senior Suicide: Understanding the Risk, Preventing the Tragedy
Format: PowerPoint presentation
Creator: SPAN USA
Available at: www.spanusa.org/?fuseaction=home.download&folder_file_id=59FE2C07-CF1C-2465-17C131427ECF3013
Audience: Mental health advocates and professionals
Description: This overview presentation reviews data by age, gender, State, and methods. It lists major risk factors and settings to access the at-risk population (including long-term care). It covers population-oriented and high-risk approaches for prevention.

II. Curricula and Training Tools

The listings below include onsite trainings as well as trainings you can obtain online and implement in your senior living community.

Title: Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (AMSR)
Format: Workshop that you have to attend
Creators: Suicide Prevention Resource Center (SPRC) and American Association of Suicidology (AAS)
Information available at: http://www.sprc.org/traininginstitute/amsr/clincomp.asp
Audience: Mental health and employee assistance program professionals
Description: AMSR is a one-day workshop based on 24 core competencies arrived at through a consensus process among leading clinician-researchers. The competencies are aimed at effectively assessing and managing suicide risk. There is a cost associated with this training. Contact the sponsor for details.

Title: Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians (RRSR)
Format: Workshop that you have to attend
Creator: American Association of Suicidology (AAS)
Information available at: http://www.suicidology.org/web/guest/education-and-training/rrsr
Audience: Mental health clinicians
Description: The RRSR is a two-day intensive training workshop based on the 24 AMSR core competencies described above. It allows mental health clinicians to practice learned skills through case application exercises. There is a cost associated with this training. Contact the sponsor for details.

Title: Preventing Suicide and Depression: A Training Program for Long-Term Care Staff

Format: Instructional kit with manual, course book, pre- and post-tests, evaluation form, and videotape

Creator: Bonnie L. Walker

Available for purchase at: http://www.terranova.org/Title.aspx?ProductCode=IP/SDVHS

Audience: All nursing home and assisted living staff, community-based caregivers

Description: This one-hour training addresses the issue of suicide among older adults, suicidal behavior, warning signs, risk factors, prevention strategies, and treatment programs. It is presented in a style appropriate for all levels of staff. There is a cost associated with this training. See the Web site above for details.

Title: Long-Term Care Educator

Format: Series of learning modules

Creator: Health Education Network (connected with the American Association of Long-Term Care Nursing)

Available for purchase at: http://www.aaltcn.org/education/ltceducatorpublications.html

Audience: Long-term care nursing assistants

Description: This series of modules covers a wide variety of topics relevant to long-term care nursing. These easy-to-read modules are used primarily for self-instruction, but they can also be used in a classroom setting with an instructor. There are about 10 modules relevant to mental health promotion and suicide prevention in senior living communities. There is a cost associated with this training. See the Web site above for details.

Title: Aging and Suicide

Format: Curriculum, online course

Creator: Clinical Tools, Inc., with a grant from NIMH

Available at: http://www2.endingsuicide.com/?id=1:7351

Audience: Primary care physicians, pharmacists, counselors, social workers, psychologists, and other primary care health professionals

Description: This course covers risk and protective factors for suicide in older adults, assessment of risk and selection of interventions for people who need urgent help, and a summary of clinical management strategies to reduce suicide risk.

Title: Late Life Suicide Prevention Toolkit: Life Saving Tools for Health Care Providers

Format: Toolkit

Creator: Canadian Coalition for Seniors' Mental Health (CCSMH)

Available at: http://www.ccsmh.ca/en/projects/suicide.cfm

Audience: Health care providers (physicians, nurses, front-line workers, mental health professionals)

Description: These training materials include an interactive, case-based DVD; the *National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide;* a clinician pocket card; a facilitator's guide; and a PowerPoint presentation.

Title: Suicide Prevention for Older People: Early intervention, assessment and referral options for staff working with older people who may be at risk of suicide

Format: Training manual

Creator: New South Wales Department of Health (AU)

Available at: http://www.health.nsw.gov.au/pubs/2003/pdf/suicide_prevent.pdf

Audience: Health workers, non-health workers working with older people

Description: This is a guide for mental health educators on how to conduct a one-day workshop on suicide prevention and older people for both health and non-health workers with clinical and/or assessment and referral responsibilities. The workshop focuses on understanding suicide risk in older people, strategies for early intervention and prevention, as well as methods of responding to varying levels of risk.

Title: Get Connected: Linking Older Adults With Medication, Alcohol, and Mental Health Resources

Format: Toolkit

Creator: SAMHSA and National Council on Aging

Available at: http://ncadistore.samhsa.gov/catalog/ProductDetails.aspx?ProductID=16523

Audience: Aging services providers

Description: This toolkit is designed to assist program managers with planning prevention programs to address substance use and mental health problems in older adults. It covers assessing the readiness of an organization to implement a program, creating an arsenal of resources as sources of information, planning staff education, and writing a program plan. The toolkit is accompanied by a booklet that profiles program success stories.

Title: Geriatric Mental Health Care Training Series

Format: Curriculum/toolkit

Creator: John A. Hartford Center for Geriatric Excellence

Available at: http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=324184

Audience: Nursing home staff

Description: The primary purpose of this training series is to train nursing home staff in caring for and managing residents in six areas, including recognizing and treating depression and mental health issues in long-term care. Supplemental materials provide specific guidance on delivering the training, as well as materials and handouts for participants. An evaluation of this training series is available (Smith et al., 1994).

Title: Depression: Overcoming Stigma

Format: Webinar

Creator: National Council on Aging

Available at: http://www.ncoa.org/content.cfm?sectionID=379&detail=2631

Audience: Community-based senior services providers

Description: This piece includes archived slides and a recording of a webinar discussing overcoming both public and self stigma so that depression can be effectively addressed.

Title: QPR

Format: Program description

Creator: QPR Institute

Available at: http://www.qprinstitute.com

Audience: Professional and lay mental health gatekeepers

Description: QPR is an emergency mental health gatekeeper training intervention that teaches lay people and professionals to recognize and respond positively to someone showing suicide warning signs and behaviors. The training is delivered in a standardized one- to two-hour format by certified QPR gatekeeper instructors. Although QPR is not specifically designed for older adults, it has been used successfully with older adults by a wide variety of staff in some nursing homes in Montana. In the nursing homes, a brief PowerPoint presentation was shown before the one-hour QPR training to address key issues relevant to suicide prevention in older adults. Several evaluations of QPR in populations other than older adults are available at http://www.qprinstitute.com under the link “Evidence for QPR.” There is a cost associated with this training. Contact the sponsor for details.

Title: ASIST

Format: Program description

Creator: LivingWorks Education, Inc.

Available at: http://www.livingworks.net

Audience: Professional and lay caregivers

Description: ASIST is a two-day, highly interactive, practice-oriented workshop that teaches suicide first aid to caregivers so they can encourage help seeking in at-risk individuals. It is designed for all caregivers, including professionals, paraprofessionals, and lay people. In Montana, ASIST has been used successfully with home health care nurses who serve older adults, but it has not yet been tried in senior living communities. An evaluation of this training program is available (Silvola et al., 2003). There is a cost associated with this training. Contact the sponsor for details.

III. Information about the Physical and Social Environment

Title: Eden Alternative

Format: Program description

Creator: Eden Alternative

Available at: http://www.edenalt.org

Audience: Nursing home staff and administrators

Description: Eden Alternative is a program model that seeks to alter "institutional" aspects of traditional nursing homes by improving the overall environment. The principles include a human habitat with plants, pets, and children; easy access to companionship; and opportunities for residents to give care to each other. Nursing homes can become an Eden Alternative home through a certification process that ensures commitment to the model. Those certified receive staff training and ongoing support from Eden Alternative. Two evaluations of this program are available (Lombardo et al., 1996; Bergman-Evans B., 2004).

Title: Pioneer Network

Format: Description of Pioneer Network's work and links to resources

Creator: Pioneer Network

Available at: http://www.pioneernetwork.net

Audience: Anyone interested in long-term care

Description: The Pioneer Network is a center for all stakeholders in the field of aging and long-term care who focus on providing home and community care. The Pioneer Network provides resources on and advocates for culture change in eldercare models, from long-term nursing home care to short-term transitional care to community-based care, to create homes that are consumer-driven and resident-directed. It supports research and public policy changes; collects and shares practices and procedures; creates learning, communication, and networking opportunities; and coordinates with State coalitions.

Title: National Alliance of Small Houses (NASH)

Format: Information and resources

Creator: National Alliance of Small Houses

Available at: http://www.smallhousealliance.org

Audience: Long-term care administrators and staff

Description: NASH is an online community dedicated to redesigning the philosophy, architecture, staffing patterns, and service delivery of long-term care.

Title: Design Principles: Supportive Physical Design Principles for Long-Term Care Settings

Format: Guidelines

Creator: Canadian Coalition for Seniors' Mental Health

Available at: http://www.ccsmh.ca/en/designprinciples.cfm

Audience: Long-term care administrators

Description: These guidelines describe features of physical design in long-term care settings that can enhance the well-being and quality of life in residents.

Title: The American Geriatrics Society and American Association for Geriatric Psychiatry Recommendations for Policies in Support of Quality Mental Health Care in U.S. Nursing Homes

Format: Guidelines

Creator: American Geriatrics Society and American Association for Geriatric Psychiatry (AGS/AAGP)

Available at: http://www.americangeriatrics.org/education/policies2003.pdf

Audience: Nursing home administrators

Description: Policy recommendations from a 2003 expert panel are included on the following issues: access to screening, assessment, and treatment referral; adequately financing needed services; ensuring a skilled and responsive workforce; providing incentives for quality mental health care; and changing the culture of nursing home life through greater involvement of residents in decision making.

IV. Mental Health Treatment Guidelines

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

Format: Guidelines

Creator: Canadian Coalition for Seniors' Mental Health

Available at: http://www.ccsmh.ca/en/guidelinesdownload.cfm

Audience: Mental health clinicians, administrators, and policymakers

Description: These national guidelines for Canada provide background information and recommendations related to the assessment and treatment of people at risk for suicide and prevention of suicide in older adults.

Title: 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)
Format: Guidelines
Creator: Canadian Coalition for Seniors' Mental Health
Available at: http://www.ccsmh.ca/en/natlGuidelines/ltc.cfm
Audience: Long-term care clinicians, administrators, and policymakers
Description: These national guidelines for Canada provide background information and recommendations related to the assessment and treatment of mental health issues in long-term care for older adults. There is also a brief section on organizational and system issues.

V. Mental Health Programs

Title: ElderVention
Format: Program description
Creator: Area Agency on Aging, Region 1
Available at: http://www.aaaphx.org/ELDERVENTION (information on the program)
Audience: Community-based professionals working with older adults
Description: This program provides prevention education for older adults who are at risk for depression and suicide. Workshops are held at multiple venues, such as senior centers and long-term care facilities. Individual home-based education is provided for isolated, at-risk older adults. Mental health treatment services are also provided. The program promotes effective coping and social networks through life transitions. It also provides suicide prevention education to community professionals who work with older adults. This program is currently being scientifically evaluated.

Title: Friendship Line
Format: Program description
Creator: Institute on Aging, Center for Elderly Suicide Prevention
Available at: http://www.ioaging.org/services/special/program_cesp (information on the program)
Audience: Professionals in mental health and aging, consumers
Description: This program offers a range of services, including a 24-hour crisis and support hotline, outreach calls to seniors for emotional support, home visits for counseling and psychotherapy, bereavement counseling, support groups, online mental health screening, and education on suicide intervention.

Title: PROSPECT—Prevention of Suicide in Primary Care Elderly: Collaborative Trial

Format: The program is described in an unpublished treatment manual and video. It is not designed to be packaged for implementation.

Creator: None specified

Available at: Information is available through the program evaluator Charles F. Reynolds III, MD ReynoldsCF@msx.upmc.edu

Audience: Mental health professionals, primary care providers

Description: This intervention combines treatment guidelines with care management for older adults diagnosed as depressed who are living in the community. A depression care manager works with a primary care physician and supervising psychiatrist. Treatment includes depression screening and may include educating depressed patients and their families about depression and antidepressant treatment, and identifying and addressing related physical and psychiatric conditions. An evaluation of this program is available (Bruce, M. L. et al., 2004).

Title: IMPACT Improving Mood-Promoting Access to Collaborative Treatment for late life depression.

Format: Manual, background materials, online training

Creator: IMPACT Implementation Center, University of Washington, Psychiatry & Behavioral Sciences

Available at: http://impact-uw.org/

Audience: Primary care providers, mental health professionals

Description: The IMPACT model includes several key components: collaborative care implemented by the primary care provider, a depression care manager, and a consulting psychiatrist; patient education; antidepressant medication; and counseling such as Problem Solving Therapy. Two evaluations of this program are available (Unützer et al., 2004; Unützer et al., 2002). A webinar on IMPACT by the National Council on Aging is available at http://www.ncoa.org/content.cfm?sectionID=379&detail=2643

Title: PEARLS: The Program to Encourage Active and Rewarding Lives for Seniors

Format: Implementation toolkit

Creator: University of Washington Health Promotion Research Center, in collaboration with Aging and Disability Services, Northshore Senior Center/Senior Services (SS), and Interactive Outcomes

Available at: (description of toolkit) http://depts.washington.edu/pearlspr (toolkit) http://depts.washington.edu/pearlspr/docs/pearls_toolkit_final.pdf

Audience: Community-based senior services providers

Description: This community-based treatment program is designed for use during home visits and includes the following: (1) problem-solving therapy, (2) tools and strategies to increase social and physical activities, and (3) strategies to focus on pleasant events to reduce depression in older adults. The target audience is older adults with minor depression or dysthymia. An evaluation of this program is available (Ciechanowski et al., 2004). A webinar on PEARLS by the National Council on Aging is available at http://www.ncoa.org/content.cfm?sectionID=379&detail=2641 [Minor depression = Have 2–4 depressive symptoms, which must include depressed mood or loss of interest or pleasure, that occur over at least two weeks, but not more than two years.

Dysthymia = Have 2–4 depressive symptoms that occur most of the time almost every day for at least two years. This is a long-term chronic depression.]

Title: Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)

Format: Program guide

Creator: Baylor College of Medicine's Huffington Center on Aging

Available at: http://www.careforelders.org/healthyideas

Audience: Professionals in community agencies serving older adults

Description: This is a community-based program to detect and reduce the severity of depression in older adults with chronic health conditions and functional limitations. It integrates four evidence-based components into the regular services provided to older adults in their homes: screening, education of clients and family, referral and linkage to mental health services, and behavioral activation. It differs from IMPACT and PEARLS in that it does not use a separate case manager but rather incorporates the four elements into regular case management duties. An evaluation of this program is available (Quijano et al., 2007). Two webinars on Healthy IDEAS by the National Council on Aging are available at http://www.ncoa.org /content.cfm?sectionID=379&detail=2650 and http://www.ncoa.org/content .cfm?sectionID=379&detail=2590.

Title: Abramson Depression Management Program
Format: Newsletter description of a program used in one long-term care facility
Creator: Researchers and clinicians at the Madlyn and Leonard Abramson Center for Jewish Life, North Wales, PA
Available at: http://www.ahcancal.org/News/publication/Provider/CaregivingSep2008.pdf
Audience: Psychologists, social workers, therapeutic recreation specialists, and nurses
Description: This program provides services to long-term care residents identified as at-risk for depression, using three levels of interventions: (1) activities and exercise; (2) social work case managers who address issues of adjustment, loss, and relationships; and (3) mental health care.

VI. Fact Sheets for Consumers

Title: When it seems like there is no hope, there is help.
Format: Brochure
Creator: National Suicide Prevention Lifeline
Available at: http://www.suicidepreventionlifeline.org/Materials/Default.aspx
Audience: Consumers
Description: This brochure lists the warning signs for suicide and has the Lifeline phone number. It also has two wallet-sized cards with this same information that you can tear off and put in your wallet. Separate wallet cards are also available in Spanish.

Title: Senior Suicide: Understanding the Risk, Preventing the Tragedy
Format: Brochure
Creator: SPAN USA
Available at: http://www.spanusa.org/index.cfm?fuseaction=home.viewPage&page_ID=67297CD2-E40B-7B4E-B3630A4E0D7F479A (under the topic Suicide and Older Adults)
Audience: Consumers
Description: This brochure provides brief data, facts on suicide in older persons, risk and protective factors, and programs that have been shown effective in preventing senior suicide. It lists four sources of help, including 1-800-273-TALK.

Title: Suicide Awareness for Older Kansans

Format: Brochure

Creator: Kansas Department on Aging

Available at: http://www.sprc.org/stateinformation/PDF/resources/ks_SuicideOlderAdultBrochure.pdf

Audience: Consumers

Description: This brochure provides data on suicide in older adults, a checklist for self-assessment, myths and facts, a checklist of things you can do to maintain good mental health, and a list of crisis hotlines and other organizations for more information.

Title: Older Adults: Depression and Suicide Facts

Format: Fact sheet

Creator: National Institute of Mental Health

Available at: http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts.shtml

Audience: Consumers

Description: This fact sheet provides data on suicide prevalence, the relationship between suicide and depression, and treatment options. It also includes a short self-test for depression and other health problems that may signal depression or physical illness.

Title: Suicide Survivors

Format: Fact sheet

Creator: Suicide Prevention Resource Center

Available at: http://www.sprc.org/featured_resources/customized/survivors.asp

Audience: Suicide survivors

Description: This sheet has information for these who have experienced the loss of a loved one to suicide. It includes information on self-care, helping children, and survivor support groups.

Title: Coping After a Suicide

Format: Brochure

Creator: Families for Depression Awareness

Available at: http://www.familyaware.org/coping_after_suicide.php

Audience: Suicide survivors

Description: This brochure provides general information on suicide, including warning signs and how survivors can get help and support after a loved one takes his or her life.

Title: Quick Tips for Survivors

Format: Tips sheet

Creator: CrisisLink

Available at: http://www.crisislink.org/programs/hope/other_resources.html

Audience: Suicide survivors

Description: This sheet lists some suggestions to help suicide survivors cope with their loss.

Title: Suggestions to Help Yourself Survive

Format: Information sheet

Creator: CrisisLink

Available at: http://www.crisislink.org/programs/hope/other_resources.html

Audience: Suicide survivors

Description: This four-page information sheet provides positive messages to survivors in the areas of accepting the suicide, expressing grief, dealing with grief, dealing with guilt, other feelings and reactions, and caring for oneself.

Title: SOS Handbook

Format: Handbook

Creator: Jeffrey Jackson for American Association of Suicidology

Available at: http://www.sprc.org/library/SOS_handbook.pdf

Audience: Suicide survivors

Description: This 30-page handbook provides clearly written, basic information on a large number of issues related to dealing with suicide as a survivor.

Title: AgePage: Depression

Format: Bulletin article

Creator: National Institute on Aging

Available at: http://www.nia.nih.gov/NR/rdonlyres/69FCF3C9-C417-4EDB-A362-A962A30009FA/9791/DepressionpartAP.pdf

Audience: Consumers

Description: This issue of the bulletin, *AgePage,* provides information on the causes and symptoms of depression, how to get help, treatment options, and prevention.

Title: Elderly Depression
Format: Fact sheet
Creator: SAVE
Available at: http://www.save.org/index.cfm?fuseaction=home.viewpage&page_id=a82dfca2-afe8-3478-1a4e1f9445d46407
Audience: Consumers
Description: This fact sheet provides information on recognizing depression, how to help a person who may be at risk of suicide, and sources to get help.

Title: Alcohol Use and Abuse
Format: Bulletin article
Creator: National Institute on Aging
Available at: http://www.nia.nih.gov/NR/rdonlyres/89CF17D6-ADF4-498A-AD58-F4C85D606E66/7410/Alcohol_Use_And_Abuse.pdf
Audience: Consumers
Description: This issue of the bulletin, *AgePage,* provides information on recognizing alcohol abuse, the effects of alcohol on elderly drinkers, and how to obtain help. It points out an association between depression and alcohol misuse.

Tool 4.c: National Organizations and Federal Agencies with Information on Emotional Health of Older Adults

The following organizations and federal agencies have resources on suicide prevention and/or the health and emotional health of older adults. The information below is derived from the Web sites of each organization.

American Association of Suicidology (AAS)

AAS promotes research, public awareness programs, public education, and training for professionals and volunteers, and it serves as a national clearinghouse for information on suicide. A membership organization, AAS produces resources on suicide among older adults, provides access to survivor resources nationwide, hosts national annual conferences for professionals and survivors, and serves as an accrediting body for crisis intervention programs.
http://www.suicidology.org

Suicide Prevention Action Network USA (SPAN USA)

SPAN USA is an advocacy organization that mobilizes survivors to impact public policy addressing suicide and promoting suicide prevention. Consistent with their mission of raising awareness of suicide as a preventable public health problem, they feature several resources on suicide among older adults, including archived presentations, public policy briefings, campaign materials, and speakers to provide training and conference presentations.
http://www.spanusa.org/

American Foundation for Suicide Prevention (AFSP)

In its mission to advance knowledge of suicide and suicide prevention, the AFSP funds research and pilot programs, including on adaptation of prevention interventions for older adult populations; physical illness and suicide in elderly Americans; and development of interventions to reduce hopelessness, a major risk factor for suicide in older adults. AFSP has a network of local chapters, which sponsor activities such as a Symposium on Suicide Among the Elderly and Out of the Darkness Walks. Chapters can provide connections to local resources and services addressing suicide prevention.
http://www.afsp.org/

Administration on Aging (AoA)

The Federal AoA delivers services funded through the Older Americans Act to promote the development of a comprehensive and coordinated system of home- and community-based long-term care that is responsive to the needs and preferences of older people and their family caregivers. Much of the information on suicide among older Americans concerns the association between elder abuse and suicide, and it is produced by the AoA National Center on Elder Abuse (NCEA).
AoA: http://www.aoa.gov
NCEA: http://www.ncea.aoa.gov/NCEAroot/Main_Site/Index.aspx

National Council on Aging (NCOA)

NCOA is a service and advocacy organization that brings together nonprofits, businesses, and government to develop creative solutions that improve the lives of all older adults, and especially the vulnerable and disadvantaged. They produce briefs on the Stop Senior Suicide Act, the IMPACT study for management of late-life depression, and overcoming stigma. They also provide archived presentations on programs to promote emotional health and suicide prevention among seniors, such as PEARLS, Healthy IDEAS, and the toolkit Get Connected!: Linking Older Adults With Medication, Alcohol, and Mental Health Resources.
http://www.ncoa.org/index.cfm

American Association of Homes and Services for the Aging (AAHSA)

AAHSA has 5,700 member organizations that manage facilities in nursing care, assisted living, independent living, home- and community-based services and adult day services. It provides information on facility management, issues such as recruiting and retaining a high-quality workforce, and making improvements to promote well-being among residents.
http://www.aahsa.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's mission of "Building Resilience and Facilitating Recovery" encompasses a broad focus on mental health and substance abuse. SAMHSA funds and supports the National Lifeline, and it developed the National Registry of Evidence-based Programs and Practices, which includes reviews of two suicide prevention programs geared toward older adults. The Older Americans Substance Abuse and Mental Health Technical Assistance Center was a project of the AoA and SAMHSA. Its Web site is an authoritative source of information on emotional health, suicide prevention, and aging, especially information on mental illness and suicidal behavior co-occurring with substance abuse. Their publication, *Evidence-Based Practices*

for Preventing Substance Abuse and Mental Health Problems in Older Adults, has an extensive section on suicide prevention.
SAMHSA: http://www.samhsa.gov
Older Americans Substance Abuse and Mental Health Technical Assistance Center: http://www.samhsa.gov/OlderAdultsTAC/

Suicide Prevention Resource Center (SPRC)

This SAMHSA-funded center primarily serves State-level agencies and coalitions, as well as State, tribal, and campus grantees, in suicide prevention activities across the lifespan. Among the useful resources are State pages, which provide information on significant prevention activities in each State; the *Weekly Spark*, a current awareness newsletter that summarizes significant research findings and local, State, national, and international news concerning suicide; and the SPRC Library, which includes a collection focused on adults over age 65.
SPRC Library: http://library.sprc.org/browse.php?catid=21
SPRC: http://www.sprc.org/

National Suicide Prevention Lifeline

The Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. Call **1-800-273-TALK (8255)**. Callers are routed to the closest possible crisis center in their area. With a network of more than 145 crisis centers across the country, the Lifeline's mission is to provide immediate assistance to anyone seeking mental health services. The Lifeline also provides a wide variety of free informational materials, including brochures, wallet cards, posters, booklets, magnets, buttons, PSAs, and special materials for veterans.
http://www.suicidepreventionlifeline.org/default.aspx

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