Promoting Emotional Health & Wellbeing and Preventing Suicide: A Resource for Care Home Settings

July 2023

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Acknowledgments

We would like to thank the following people/groups for their contributions to this resource:

Phil Ainsworth and Alec Tinker, Public Health, Barnsley Metropolitan Borough Council

Older People's Mental Health Community of Practice, Yorkshire and the Humber Mental Health Clinical Network (Chair: Fiona Goudie)

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Introduction

Every death by suicide is a tragedy. Many people do not realise that suicide is preventable and that there are ways to identify those at highest risk and actions to reduce the chance that they will go on to take their own life. Suicide is most common among middle-aged men, but older adults are also affected by suicide with rates increasing in the oldest age groups in both males and females. Risk factors and the way mental health conditions present in later life can differ to younger adults, so it is important that staff working with this population understand what to look for and how to effectively respond to residents they think may be at risk.

This resource is intended to be used by leadership and management teams in care homes (residential homes, nursing homes and dual registered homes) for older adults. Whilst some aspects may be relevant for care homes supporting younger adults, the specific detail around presentation of suicidal behaviours, risk factors and triggers are specific for the older adult population.

The resource has been developed through collaboration between public health specialists in healthy ageing and mental health and suicide prevention, and clinical psychologists specialising in the mental health needs of older adults and is published under the auspices of the Association of Directors of Public Health, Yorkshire and the Humber.

Suicide in later life

The suicide rate in the UK has been on a downward trend over the past 25 years, with rates remaining fairly stable over the last decade. Many people do not realise that suicide remains a risk for older adults. In both men and women, the suicide rate is highest in mid-life and then reduces as people grow older, but rises again in later old age, particularly for men. Analysis of suicide rates by age group show that men aged 85+ have similar rates of death by suicide (16.5 per 100,000 persons aged 85-89 and 17.4 per 100,000 persons aged 90+) as men aged 25-29 (16.8 per 100,000 persons). Source: ONS 2022.

Older adults may also undertake self-harming behaviour and several studies have indicated that people in this age group who self-harm have increased suicidal intent than other age groups and that self-harm is more often fatal.

It is therefore important that those who work with older adults in care homes are alert to the fact that, though rare, self-harm and suicide remain a risk for their residents.

Purpose

The purpose of this resource is to promote and protect the health and wellbeing of care home residents by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicide. In addition, this document is intended to support and guide care home staff and acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components. This resource provides information on signs, symptoms and risk factors for suicide and suicidal thoughts, as well as providing a checklist and crisis response plan for care homes to complete and implement. This supporting resource complements statutory guidance documents and policies supporting the overall safeguarding and mental health and wellbeing of residents and staff.

Key actions for care homes

- Create a health-promoting environment for positive wellbeing for all residents
- Recognise the risk factors for suicide among your residents
- Identify a key local health professional to contact with concerns about residents' mental health and wellbeing
- Respond to any resident who may be at higher risk of suicide
- Identify lead for suicide prevention in your setting
- Provide suicide prevention and awareness training for staff
- Develop a response plan to follow in the case of a suicide in the care home

Prevention

Reducing the likelihood of suicide amongst your residents requires a two-strand approach: taking action that will improve the mental wellbeing of all residents as well as tailored support and interventions for those who are identified as being at higher risk of suicide.

Whole population approaches are about promoting the protective factors for mental wellbeing and creating health-promoting environment that benefits all residents, irrespective of risk status. This means making the care home a welcoming and comforting environment where all residents can continue an active and fulfilling life.

The move into residential care can be a significant stressor, especially if it was against the wishes of the individual. Supporting individuals' transition to the new environment is key. Moving into residential care can provide increased social interactions for those who may have been isolated before, but for others it may represent a loss of independence and autonomy. Spending time getting to know residents' interests and preferences, encouraging connections between individuals where appropriate but not forcing people into situations that they feel uncomfortable with, is essential. Some ideas to consider include:

- Provide access to spiritual or faith activities
- Provide access to health and wellness activities, such as exercise classes or interactive games, walking and gardening
- Provide access to intellectual activities, such as book clubs, arts and crafts, music, cooking and computing
- Facilitate contact with family members and friends
- Provide opportunities for volunteering and mentoring activities, such as supporting new residents or intergenerational activities
- Support residents to cope with changes in their functional abilities
- Ensure support is available for residents to cope with loss and bereavement

An Individual Approach involves responding to residents at risk and is a crucial part of a comprehensive approach to suicide prevention. Risk factors for suicide in older adults may be different to those for younger people, as mental ill-health can also present differently in older adults. These are outlined in detail below. It is important that staff working with older adults are aware of these differences to ensure potential warning signs are not missed.

When an individual is identified as displaying risk factors for suicide, then the actions to increase the safety of that individual is the same as for people of other ages:

- Seek medical assessment and referral to psychological services for residents that display symptoms of mental ill-health
- Ensure access to potential means of suicide or self-harm, such as medications and chemicals, is controlled and ligature points removed

Understanding Risk Factors, Signs and Symptoms

Patterns of suicide by age group show that rates peak in mid-life (45-54 years) before declining as people age until the ages of 80-84, from when they begin to rise. Suicide rates increase in the oldest

age groups for both males and females (ONS, 2021) and older adults who attempt suicide are more likely to use lethal means and to die from suicide than younger people who make a suicide attempt. Care homes should therefore be prepared for some residents experiencing suicidal thoughts and, potentially, to make attempts to take their own life. There should not be an assumption that because an older adult is resident in a safe care facility, that they are not at risk of suicide.

Relationship between self-harm and suicide

The relationship between self-harm and suicide is complicated. Although people who self-harm are significantly more likely to die by suicide or to harm themselves using more serious methods than the general population who do not self-harm, people may have many motivations for self-harm and are not always intent on dying. However, several studies have noted that older adults who self-harm have increased suicidal intent than other age groups and that self-harm is more often fatal (Hawton and Harriss 2008, Oude Voshaar et al 2011).

Indirect self-destructive behaviours, such as the refusal to eat, drink or take medications may sometimes be considered as a means of self-harm and could increase the effectiveness of suicide attempts (Conwell, Pearson and DeRenzo 1996). Possible self-harm should always be taken seriously, as it will inevitably reflect an attempt to manage a high level of psychological distress. Therefore, it is important to work with the person to understand their motivations and to not assume the motivations for self-harm are the same every time.

Risk factors for suicide in older adults

Insights into risk factors come from the process of psychological autopsy, where the circumstances present in the lives of older adults who have taken their own life are examined; academic studies have used this approach to identify the risks that are particularly relevant for older adults. Risk factors to be aware of include:

- Existing psychiatric illness was present in between 71% and 97% of suicides included in psychological autopsy studies, and depression is a noted risk factor (80% of those aged over 74 who die by suicide have depression).
- Deterioration of physical health, particularly cancers and long-term conditions, have been associated with increased suicide risk. The suicide risk increases as the number of conditions an individual has increases.
- Pain is particularly considered to be a risk factor for older men.
- Impairments of daily activities, irrespective of a confirmed physical or mental health diagnosis, is significantly associated with suicide. An individual who believes they have a serious health condition, even without a diagnosis, may be at increased risk.
- Social factors, particularly stressful life events such as bereavement, family or relationship breakdown and serious financial problems, may contribute to increased suicide risk.
- Social connectedness is particularly important; where a desire to ‘belong’ is thwarted and/or somebody feels that they are a burden, then suicidal desire can increase. This is particularly the case when both factors are present.
- Older adults who self-harm are more likely than other age groups to subsequently die by suicide, and self-harm is more likely to be fatal. The most common means of self-harm in later life is self-poisoning.
- Older adults that have cognitive impairment as well as other risk factors may find it difficult to use their previous coping mechanisms and, therefore, their risk of suicide may be further increased.

(Conwell, van Orden and Caine, 2011)

Some residents may experience more than one risk factor, for example somebody whose mobility has deteriorated to the extent that their family can no longer take them out to lunch, to a favourite café or pub, or home for Christmas Day.

Contemporary mental health practice recognises the impact of trauma, resulting from an event or series of events, or set of circumstances experienced by an individual as harmful or life-threatening (trauma informed practice). It is therefore important to note that care home residents may have experienced adverse traumatic experiences throughout their life.

If risk factors are identified, care home staff should liaise with the health professional leading the resident's care.

The absence of risk factors does not mean the absence of suicide risk and not all people in high-risk groups may be vulnerable to suicide, but you should be aware of and take action if you notice any change in behaviour or mood (see *Intervention* section below).

Mental wellbeing in later life

As noted above, existing psychiatric illness is common among older adults who die by suicide. Older adults are as likely to experience poor mental health as younger people, but less likely to have a formal diagnosis or to have access to the full range of treatments. This may be in part due to older adults not articulating their feelings and thinking that their symptoms are an expected aspect of ageing. In addition, depression often presents differently in older adults.

Symptoms of depression that may be experienced at any age	Symptoms of depression that are more common in older adults and might be the *only presenting features*
• Core symptoms: low mood, reduced enjoyment, lack of energy • Psychological symptoms: low self-esteem, hopelessness/guilt, suicidal thoughts • Biological symptoms: reduced appetite, weight loss, feeling lower in the morning, early wakening, reduced sleep, poor concentration, agitation or slowness.	• Physical rather than emotional symptoms: faintness or dizziness, pain, weakness all over, heavy limbs, lump in throat, constipation • Health anxieties (especially if unusual for the individual) • Prominent anxiety • Unusual behaviours. • Slowing down of emotional reactions or agitation • Psychotic features: delusions of guilt, poverty or physical illness, or having no clothes which fit. Auditory hallucinations with derogatory or obscene content provoking guilt and paranoia

Source: Mental Health in Older People. A Practice Primer. https://www.england.nhs.uk/wp-content/uploads/2017/09/practice-primer.pdf

Distinguishing whether symptoms are depression or another pre-existing or new condition, or even a side effect of medication, can be difficult. One simple and sensitive indicator for depression is lacking interest in something previously enjoyed, such as visits from family and friends.

If you notice changes in a resident's behaviour that could be a symptom of depression it is recommended that you seek the opinion of the resident's GP.

Staff Training

It is important that staff properly identify and effectively support residents at risk of suicide and a key element of supporting staff to do that is through increasing knowledge and competence via training. Staff, such as nursing assistants, dining, housekeeping and maintenance personnel should all be encouraged to undergo basic training in mental health and suicide prevention, as they will interact with residents on a regular basis and are in a good position to notice changes in residents' behaviour. There are a number of e-learning modules currently available, that although not specific to residential care settings, will provide a basic overview of mental health in older people and basic suicide prevention strategies.

Training Module	Provider	Training Type
Mental Health in Older People	Social Care Institute for Excellence	E-learning
Suicide Prevention: We need to talk about suicide	Health Education England and Public Health England	E-learning
Suicide Awareness Training	Zero Suicide Alliance	E-learning

The Self harm and suicide prevention framework provides a competence framework for self-harm and suicide prevention in adults and older adults, recommending skills and knowledge for professionals across a broad range of backgrounds and experiences, including professionals and volunteers who work in mental health, physical health and social care.

A complementary Older People's Mental Health Competency Framework details the essential skills, knowledge and abilities required for health and social care roles at all levels to address the needs of older adults with mental health problems.

Suicide Prevention Lead

It is suggested that each care home setting identifies a Suicide Prevention Lead. This lead role would be responsible for:

- Updating setting policies, procedures and protocols in relation to emotional wellbeing and suicide prevention
- Ensuring all staff are aware of policies, procedures and protocols
- Convening regular meetings to review internal action plans and test and evaluate approaches.
- Overseeing the delivery of training and ensure staff across the setting have the required competencies and knowledge.

Intervention

It is an important part of any suicide prevention approach to assess the risk of suicide and intervene and take action if you encounter a resident who is at immediate risk. If a resident is talking about wanting to die or talking about feeling hopeless or having no reason to live, it is recommended to take the following steps:

1. Do not leave the resident alone.
2. Remove any lethal means from the resident's room.
3. Contact your identified local health professional to raise concerns about the resident's mental health and wellbeing OR contact local crisis team.
4. If the danger for self-harm seems imminent, call for an ambulance.
5. Contact the resident's emergency contact person.
6. Ensure that the resident is screened by a mental health professional who will determine whether referral for treatment is needed and, if so, facilitate the resident's obtaining treatment.
7. If possible, make sure the resident's GP/lead health care provider is involved in the process of obtaining treatment.
8. Document all actions taken (in the resident's chart or a log book).

There may residents who are not at immediate risk for suicide but who you have concerns about and may be at risk. In these cases you should take the following steps:

1. Talk with the resident in a supportive and caring way. Listen by showing understanding and withholding judgement. You could mention changes you have noticed in her or his behaviour and that you are concerned.
2. If the resident needs further help, calmly support the resident, since evidence suggests older adults are often reluctant to seek care. Reassure the resident that seeking help is a positive step that can help him or her feel better.
3. Obtain the resident's permission to talk with a personal contact, such as a family member.
4. Obtain the resident's permission to get in touch with local mental health services.
5. Continue to stay in regular contact with the resident and pay attention to how she or he is doing. Provide encouragement to reinforce treatment and positive gains.

Differences in cultural background can affect how older adults respond to problems, the way they talk about death and dying, and their attitudes toward suicide, as well as how they feel about sharing personal information and seeking help. It is important to be aware of possible differences and tailor your responses accordingly. For example, individuals from some cultures may not be open to seeing a mental health provider, but they may be willing to talk with a faith community leader.

As people get older they often think more about death and dying, and sometimes they talk more about it. It is important to note that:

- Talking about death and dying can be healthy for older adults, but a sudden focus on wanting to die or a preoccupation with death is a cause for concern.
- Any statements made by older adults about wanting to die should be taken seriously.

Safety Plans

If a resident is experiencing suicidal thoughts it can be helpful for their key worker to develop a safety plan with them. The safety plan outlines the signs that are specific to this individual that may indicate they are nearing crisis, and steps that can be taken to address these feelings including:

- Internal coping strategies – things the person can try on their own, such as removing themselves from a situation or looking at soothing images
- How friends and family can be used to distract them from suicidal thoughts. It may include a list of people who can be contacted in a crisis or places a person might go
- A list of mental health professionals and agencies to call, including local services the person is already in contact with, a local crisis service and the Samaritans
- How to make it harder for the person to harm themselves.

The safety plan should be developed with the individual it relates to, feels achievable to them and that they have ownership of the plan (for example, if they want to change the list of people to contact). (Content from Samaritans)

A template safety plan can be downloaded at: https://www.getselfhelp.co.uk/docs/SafetyPlan.pdf

After a Death by Suicide

Although death and dying are, unfortunately, familiar experiences in residential care settings, the death of a resident by suicide can be a very different experience and have an especially profound emotional effect on both residents and staff. Survivors of suicide loss often experience complex reactions, which may include feelings of grief, guilt, confusion, shame, and embarrassment. A suicide death can result in an increased risk of suicide for vulnerable residents and staff. Therefore, an essential part of suicide prevention is responding appropriately immediately following a suicide attempt or death and in implementing activities that address the emotional impact on family, friends, staff and others affected by a suicide death or attempt (postvention).

Immediate Response

Staff should be prepared to respond to a suicide death, 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 staff, and people 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. It is helpful to develop a crisis response plan to guide your setting response following a death by suicide (See Appendix II).

The immediate response following a death by suicide should include the following steps:

- Alert the manager on duty and any other staff members, as per your crisis response plan and agree lead for contacting police. Consider the immediate support needs of the staff members who may have discovered the suspected suicide.
- Ensure that nothing is disturbed at the scene if it appears that a person has taken their own life.
- Provide prompt, accurate information to co-workers without discussing any details of the incident – you may need to inform some staff that there has been a suspected suicide, others simply that a resident has died. Do not share details of apparent method of death.
- If possible, secure the location, close doors or blinds or screen the location where the person has died.
- Be available to provide prompt, accurate information to the emergency services.
- Immediately seek personal support from line manager, colleague, mental health first aider (if in place, provide link to contact details).
- Follow existing protocols to inform family as appropriate.
- Consider housekeeping that may be required following a suicide attempt or suspected suicide in the workplace and incorporate this within crisis management or emergency planning procedures.
- Agree internal communication approach for staff and residents.
- Health and Safety Review and risk – consider what internal procedures you would put in place to capture any organisational learning from an incident. At a later point, if anything in the workplace may have been a factor in the suicide or suicide attempt, take steps address these.
- Consider the ongoing support required for individuals undertaking this work, which may be distressing.

Postvention

Every person who dies by suicide leaves behind survivors 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 care home setting. The type of support may vary for each of the three categories of survivor: family, close friends, and neighbours of the resident; the care home community; and staff.

If there is a suspected suicide death, it is recommended the senior management team meet to prepare the postvention response according to the crisis response plan within the first 24/48 hours following the death. The team shall consider how the death is likely to affect other residents and staff and determine who might be most likely to be affected. Family members should also be referred to postvention services with appropriate consent. In relation to postvention, the crisis response plan should contain the following elements:

- Identifying the lead person for leading the postvention response
- Approaches to identify those who might require postvention support
- Details of how to support people affected by a suicide immediately after the suicide death or attempt, recognising that a range of interventions will be required.
- How to assess survivors for levels of trauma and risk
- Type of support to be offered or provided to all those affected by the death individually and/or in groups
- Support employees and staff to return to a state of normality.
- Checking in with residents at risk at later times after the death, including on the anniversary of the death/other significant dates

Media Coverage

Media attention to a suicide death or attempt in a care home can complicate the efforts of staff members to address the problem and protect other vulnerable members of the care home 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 direct them to the Samaritans media guidelines for reporting suicide.

Memorials and Related Events

Decisions around memorials are likely to depend on your setting and the circumstances of the death by suicide. There may be a funeral service, but depending on the family's wishes, attendance of staff and residents may not be possible. In that case, there might be support among staff and residents for a separate memorial service. Any memorial should balance the need to honour the deceased (and to take action of some kind) and the risks of others imitating or modelling the suicidal behaviour. Ideally,

and if possible, the lead is taken by residents and/or their representatives. Input from the family of the deceased continues to be of great importance after a suicide. The family might have specific cultural or religious concerns or constraints about memorial events. It is important to keep memorial events, if they take place, as low key as possible while also maintaining sensitivity for the wishes of close friends and family. Bear in mind potential media coverage or photographs, if the death has or is likely to hat attract media attention. In general, death by suicide should be marked in the same way as other deaths. However, there may be more need to provide a positive outlet for the need to 'do something' in order to make meaning of the loss. Emphasise other means to honour the deceased, including fundraising or community service activities. You may want to invite representatives from your local postvention/suicide bereavement service to be in attendance at the memorial service to support anybody in distress. Be aware of the potential impact of funeral events held by the deceased's family.

Coronial Process

If a death is unexplained there will be a coroner's inquest to establish where, when and how the person died. Although the inquest will be opened soon after the death, it is likely to be adjourned until after other investigations have been completed. This can take many weeks (the average time estimated for an inquest is 18 weeks). Inquests are held in a public court setting, with evidence by witnesses. The process may prove distressing for those affected by the death, particularly for those who are called to give evidence or who are named during the proceedings. Inquests do not seek to establish whether anyone was responsible for a person's death. However, the Coroner's conclusion could cause relatives, friends and care home staff to once again ask themselves whether anything could have been done to prevent the suicide. Postvention support should be offered to relatives, friends and care home staff leading up to and throughout the inquest process. You can find out more about the coronial process here and you should involve your legal team in any response or preparation for response to an inquest process.

Definitions

Prevention
'Interventions designed to reduce the occurrences of new cases', after the US National Academy of Medicine (formerly the Institute of Medicine)

Self-harm
We use the National Institute for Health and Care Excellence's (NICE's) definition of self-harm:
'[…] any act of non-fatal self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.'

Suicide
Suicides are defined as 'deaths by intentional self-harm and deaths of undetermined intent by individuals aged 10 and over', following the 2017 report from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
Suicide attempt
An act of self-harm in which the person intended to die and believed that the means and method of the attempt would be fatal.

Assessment
A discussion between a person and a professional, usually with a health and social care background (though some other professionals may also conduct assessments) about the person's mental and physical health, family background, everyday life, and any other factors that are important to the person. This discussion helps the professional to understand what the person is experiencing and how complex their problems might be in order to inform plans for support, care and treatment. Family, carers and significant others may also be involved in this discussion with the person's agreement.

Postvention
An intervention which takes place after a death by suicide. It involves providing support for those who have been bereaved. This includes family, friends, professionals and peers.

Risk assessment
This refers to the comprehensive assessment of risk by a suitably qualified professional for an individual who is expressing suicidal ideation, or presenting with self-harm or a suicide attempt. It does not refer to the use of a specific risk assessment tool.

Safety plan
A co-produced, personalised plan that includes practical ways to help keep a person safe. This might include strategies that are known to help the person during times of distress, details of people or services to contact during a crisis, or reducing access to means to harm oneself.

Supervision
An activity that gives professionals the opportunity to review and reflect on their clinical work. This includes talking about areas or events that might have been experienced as difficult or distressing for the professional. The person who provides supervision (the 'supervisor') will be a more senior and/or experienced professional, but some organisations also use peer supervision effectively. Supervision is distinct from line management or case management.

Transitions
The planning and process of transfers of care, from the initial planning, through the transfer itself to the follow-up support. This includes transitions between services, transitions from children and young people's services to adult services and transitions from inpatient to community services.

Support Organisations

Rethink

The largest national voluntary sector provider of mental health services, with 340 services and more than 130 support groups.

Helpline 0845 456 0455

www.rethink.org

Mind

Mind is the leading mental health charity in England and Wales. It campaigns to create a better life for everyone with an experience of mental distress

Tel: 020 8519 2122

www.mind.org.uk

Samaritans

Anyone can contact Samaritans any time, free from any phone on 116 123. This number is free to call and will not show up on your phone bill. Or you can email jo@samaritans.org or visit www.samaritans.org to find other ways to speak to Samaritans.

National Suicide Prevention Alliance (NSPA)

Is an alliance of public, private, voluntary and community organisations in England, who are willing to take action to reduce suicide and support those affected by suicide. Produce a calendar of events and training that can be accessed by organisations

www.nspa.org.uk

Mental Health First Aid England

Provides training and consultancy services

www.mhfaengland.org/

Resources

**Please note that some of the resources listed are from international sources and whilst useful please note they refer to guidelines and data from their country of origin.*

Zero Suicide Alliance Training

Free online training from Zero Suicide Alliance

FREE online training courses to teach you the skills and confidence to have a potentially life-saving conversation with someone you're worried about.

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

Canadian Coalition for Seniors' Mental Health (2008)

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.

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities

Substance Abuse and Mental Health Services Administration (2011)

This toolkit, produced by the US Department of Health and Human Services, contains information and resources to help staff in senior living communities promote emotional health and prevent suicide among their residents and also to help residents become active participants in mental health promotion and suicide prevention efforts. It includes information on recognizing and responding to people who are suicidal and/or have depression or substance abuse problems, responding to a suicide death, conducting a one-hour staff training, and implementing a comprehensive suicide prevention program in SLCs.

Suicide Prevention for Older Adults in Residential Communities: Implications for Policy and Practice

Podgorski, C. A., Langford, L., Pearson, J. L., & Conwell, Y. (2010). PLoS Medicine, 7(5).

This journal article describes approaches to suicide prevention that can be used in residential communities for older adults as well as special considerations for those communities in developing suicide prevention plans and creating healthy communities.

In the Workplace

Samaritans Online Guidance and Training (2023)

This webpage details how the Samaritans can support workplaces with a range of programmes for a variety of different organisations.

Crisis Management in the Event of a Suicide: A Postvention Toolkit for Employers

This toolkit from Business in the Community (supported by Samaritans) is designed to support employers in their response to the suicide of an employee, at work or outside the workplace. The principles around how to best support staff outlined in the toolkit could be applied in the event of a suicide in a care home.

Appendix I Care home suicide prevention checklist

	ACTION	
1.	Name of local clinician(s) to consult when you have concerns about a resident's mental health	
2.	Emergency contact numbers (local Mental Health crisis service, Samaritans) are prominently displayed in the care home office, accessible to all staff at all times.	
3.	Name(s) of care home mental health and suicide prevention champions	
4.	Implemented a range of interventions for all residents to promote positive mental wellbeing (see Page 6).	
4.	Staff training is completed and up to date: • Signs and symptoms of depressive illness and suicidal ideation (all staff) • Signs of immediate risk for suicide and action to take (all staff) • Responding to a suicide in the care home including support for family, staff and residents (Mental Health Champions)	
5.	'*Ensure any current risk assessments undertaken by health professionals (including those prior to admission) are shared where appropriate (including with the individual's key worker). Relevant actions should be incorporated into the individual's care home safety plan.*	
.		
6.	A suicide response plan has been developed including: • Access to postvention support for all staff and residents • Additional support or counselling for staff and/or residents that may have discovered the death • Additional support to and checks upon at risk residents (this may include residents previously identified as being at higher risk of suicide and residents who were close to the individual who has died, irrespective of previous suicide risk). • Formal review mechanism of the circumstances surrounding suspected suicides and recording and action of any lessons that could be learned	

Appendix II Example Crisis Response Plan following a Death by Suspected Suicide

This Crisis Response Plan should be enacted following a death by suspected suicide.

This plan has been signed off by **[include names of management/safeguarding leads/mental health champions]** and all staff are aware of this plan.

This plan was last updated **DD/MM/YY.**

	IMMEDIATE ACTION	
	Alert Manager on duty and any other staff members as appropriate. Use on duty number **01XXX XXXXXX** Agree lead for contacting police.	
	Ensure that nothing is disturbed at the scene and secure the location, closing doors or blinds or screen the location of the completed suicide.	
	Provide prompt, accurate information to co-workers without discussing any details of the incident.	
	Provide prompt, accurate information to the emergency services.	
	Immediately seek personal support from line manager, colleague, mental health first aider (if in place, provide link to contact details).	
	Follow existing protocols to inform family as appropriate.	
	Follow existing protocols to complete appropriate paperwork.	
	If anything in the workplace may have been a factor in the suicide or suicide attempt and is accessible to other residents, take steps to remove, and address any known factors.	
	Agree internal communication approach for staff and residents and who will lead this.	
	Identify the lead person for delivering the postvention response.	
	Identify those who might require postvention support and refer to appropriate interventions.	

	LONGER TERM ACTIONS	
	Health and Safety Review – consider what internal procedures you would put in place to capture any organisational learning from an incident.	
	Consider the support required for individuals undertaking this work, which may be distressing	
	Review the local support services and suicide bereavement services that are available in your local area, ensuring all details are accessible to staff who may need to access this information.	
	Support employees and staff to return to a state of normalcy.	
	Check in with residents at risk at later times after the death, including on the anniversary of the death/other significant dates	

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