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JC JoyAge 賽馬會樂齡同行計劃
Holistic Support Project for Elderly Mental Wellness

Suicide Prevention Practical Tools

Table of Contents

Table of Contents

EARLY DETECTION

Tool 1.1 Risk factors and protective factors of suicide among older adults

In order to detect at-risk individuals as early as possible, helping professionals must have a thorough understanding of and ability to identify risk and protective factors for suicide. Early identification typically serves as the first step for helping professionals towards providing tailored effective prevention and/or intervention for at-risk individuals in an optimal manner (Monk et al., 2007; SAMHSA, 2015).

Predisposing / Risk factors		Protective factors	Precipitating factors
• Poor vision • Hearing problems • **Substantial number of diseases*** • **Chronic pain/ illness*** • Not having a partner (e.g., unmarried, widowed) • Living alone • Previous suicide attempt • Family suicidality history • Financial loss/debt • Job loss/ unemployed • History of abuse • **Substance abuse*** (e.g., drug or alcohol) • Older age • Gender (male) • Access to lethal means	• **Depression*** • Anxiety • Loneliness • Hopelessness • **Psychiatric disorder*** • Limited frequency of social contact and social integration (i.e., being socially excluded) • **Limited social support***	• Treatment for physical illness and disabilities • Intervention for depression and other mental health issues • Hope for the future • Robust social connections (e.g., relatives, friend, the general community) • Participation in meaningful activities (e.g., leisure, intellectual, religious) • Sense of competence and accomplishment • Self-understanding • Optimistic outlook • Resilience and perseverance • Skills in coping, problem solving, conflict resolution • Cultural and spiritual beliefs that work against suicide, and encourage protecting oneself • Beneficial health habits and help-seeking actions	• Recent significant loss or humiliating event (e.g., death in the family) • Fresh exposure to suicide event • Amelioration of depressive symptoms which leads to enhanced motivation • Newly discharged from medical care

* Significant factors for older adult

Tool 1.2 Sample of brief screening tools for recent mental health condition and suicidality

OBJECTIVE

To conduct an initial assessment of the individual's recent (i) mental health status and (ii) suicidal risk. Bear in mind this questionnaire should only be treated as a reference, and is not a substitute for proper clinical assessment or diagnosis.

GUIDELINES

The interviewer can utilize the questions below to gain an initial understanding of the individual's emotional status. This questionnaire consists of 4 parts. Part 1 involves simple enquiries about the individual's recent circumstances; Part 2 involves quick mental health screening; Part 3 involves more in-depth assessment of mental health status; Part 4 involves follow-up suggestions. For Part 2, where the individual discloses that they are under emotional stress most of the time, interviewers should then ask corresponding questions listed in Part 3 to further understand the individual's situation and relevant follow-up recommendations. We recommend volunteers and frontline workers to complete Part 1 and 2, and in instances where the individual has indicated emotional distress in Part 2, helping professionals then complete Part 3 and provide follow-up recommendations as laid out in Part 4.

Part 1: Self-introduction and asking about the individual's recent circumstances

"Hello, we are [centre name], calling to learn more about your recent circumstances. How are you? Do you have time for a brief chat?"

Interview date: _____ (DD/MM/YYYY)

Time: _____ (AM/PM)

Name of individual: _____ Member no: _____

Gender: Male / Female Age: _____

Part 2: Quick mental health screening

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
		Questions 1+2 (Total score)		***/ 6***

Questions 1 + 2 < 3, no obvious depressive symptoms;
Questions 1 + 2 ≥ 3, presence of depressive symptoms, please complete Part 3.1

3. Feeling nervous, anxious, or on edge	0	1	2	3
4. Not being able to stop or control worrying	0	1	2	3
		Questions 3+4 (Total score)		***/ 6***

Questions 3 + 4 < 3, no obvious anxiety symptoms;
Questions 3 + 4 ≥ 3, presence of anxiety symptoms, please complete Part 3.2

Part 3: Detailed emotional health condition assessment (completed by helping professional)

Part 3.1: Depressive symptoms (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating				
6. Feeling bad about self - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other could have noticed? Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

PHQ-9 Total score (Questions 1-9): /27

Questions 1-9 total score: [0-4 = No depressive symptoms; 5-9 = Mild; 10-14 = Moderate; 15-19 = Moderately Severe; ≥20 = Severe depression – referral needed]

If Question 9 score = 0, then no suicidal risk; If Question 9 score ≥1, then there is suicidal risk and interviewer should conduct self-harm and suicidal risk assessment (i.e., starting from Question 9.1)

Self-harm/suicidal risk assessment

	NO	YES
9.1 In the past month, have you thought that you would be better off dead?	0	1
9.2 In the past month, have you thought about harming yourself?	0	1
9.3 In the past month, have you thought about suicide?	0 *Skip to question 9.7*	1 *Complete questions 9.4 – 9.6*
9.4 Do you have a suicide plan?	0	1
9.5 Do you have the tools for suicide?	0	1
9.6 Have you attempted suicide?	0	1
9.7 Throughout your whole life, have you ever attempted suicide?	0	1

Overall suicidal risk

Questions 9.1, 9.2 or 9.3 answered yes, then low suicidal risk
Questions 9.3 + 9.4 or questions 9.2 + 9.3 + 9.7 answered yes, then moderate suicidal risk
Questions 9.4 + 9.5 + 9.6 + 9.7 answered yes, then high suicidal risk

Part 3.2: Anxiety assessment (GAD-7)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
10. Feeling nervous, anxious, or on edge	0	1	2	3
11. Not being able to stop or control worrying	0	1	2	3
12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it's hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid as if something awful might happen	0	1	2	3

Generalized Anxiety Disorder 7-item Scale Total score of questions 10 – 16: / 21

Total score of questions 10 – 16 [0-4 = no obvious anxiety; 5-9 = mild; 10-14 = moderate; ≥15 = severe]

Part 4: Follow-up recommendations for varying levels of emotional health and suicide risks

Level of depression and anxiety	Follow-up recommendations
No obvious depressive or anxiety symptoms	• Share mental health information • Encourage maintenance of mental and physical wellness • Maintain contact with and more frequently care about friends and family
Mild depressive and anxiety symptoms	• Remind the individual that they may have already indicated symptoms of emotional distress, and will need to be more careful about their own situation • Encourage and provide information on mental health wellness, ◆ Maintaining healthy life habits ◆ Enhancing positive mood ◆ Managing insomnia • Practice relaxation exercises • Offer regular and continuous concern
Moderate to moderately severe depressive and anxiety symptoms	• Remind the individual that they have exhibited obvious symptoms of emotional distress that possibly reach a clinical level • Need for close monitoring of personal conditions • Need for social worker to actively intervene ◆ In light of the individual's presenting symptoms, discuss corresponding mental health information to understand their needs and appropriate intervention ◆ Beware of the individual's relatively negative thoughts and actions, and help them identify and adjust such thoughts and actions ◆ Find out more about the individual's familial and other support systems, and encourage them to seek help ◆ Enhance protective factors ◆ Encourage frequent physical exercise and relaxation • When necessary, discuss with the individual the option of seeking psychiatric services or suggest they consult their own family doctor for initial diagnosis • Provide relevant information about community resources • Need for thorough follow-up and continuous assessment
Severe depressive and anxiety symptoms	• Remind the individual that they have exhibited relatively severe symptoms of emotional distress which require clinical attention and intervention • Social worker to evaluate whether there is an immediate risk of self-harm/suicide • When there is an immediate risk to life, promptly call or locate the individual's position and contact the police • Requires the active intervention of social workers, which may include immediate meeting with the individual (arrange for conversation in person or video call) ◆ In light of the individual's presenting symptoms, discuss corresponding mental health information (e.g., how to maintain physical and mental wellness) to understand their needs and appropriate intervention ◆ Enhance protective factors ◆ Find out more about the individual's familial and other support systems, and encourage them to seek help • When necessary, inform family members about the individual's situation and discuss follow-up services • Encourage the individual to seek psychiatric services, or a referral to a psychiatrist or a clinical psychologist for diagnosis and treatment • Provide relevant information about community resources • Need for thorough observation, follow-up and ongoing assessment (including self-harm and suicidal risk assessment)

Follow-up actions for varying levels of suicidal risks

Suicidal risk	Suicidal plans & action	Follow-up
Low risk	None	• Enhance personal protective factors ◆ Express concern ◆ Provide information about lifestyles and activities relevant to maintaining physical and mental wellness
Moderate risk	Relatively detailed suicidal plans	• Enhance personal protective factors ◆ Provide information about lifestyles and activities relevant to maintaining physical and mental wellness • Effective interventions ◆ Co-create a crisis response card ◆ Provide relevant information about community resources • Continuous assessment ◆ Ongoing suicidal risk assessment
High risk	Detailed suicidal plans, methods and tools	• Enhance personal protective factors ◆ Provide and explain information about lifestyles and activities relevant to maintaining physical and mental wellness • Inform family ◆ When necessary, inform family members about the individual's situation • Discuss with family about follow-up services, and arrangement of suitable support and activities ◆ Individual counselling ◆ Family counselling • Continuous assessment ◆ Ongoing and thorough observation of the individual ◆ If necessary, conduct further assessment of the individual ◆ Provide relevant information about community resources • Ensure safety ◆ If there is a risk to life, promptly call or locate the individual's position and contact the police

Tool 1.3 Myths and facts about suicide

Distinguishing between common myths and facts about suicide can enhance both helping professionals' and the general public's knowledge, skills, and attitudes regarding suicide prevention work (CSRP, 2022; Monk et al., 2007; SAMHSA, 2015).

MYTHS	FACTS
Individuals who mention or make disclosures about suicide will not actually try to kill themselves.	People who die by suicide typically exhibit various warning signs and indicators (up to 80% of individuals). Suicidal threats should be considered with thorough follow-up action.
Individuals who die by suicide have extreme determination to kill themselves, and would have done so regardless of any intervention.	Suicidal individuals are usually hesitant, and therefore well-timed intervention can offer them a lifeline.
Inquiring about suicide will prompt individuals to bring about their suicidal ideations or plans.	When done with compassion and non-judgmental attitudes, inquiring about suicide will likely allow individuals to feel heard, understood and consoled.
Individuals who have a history of suicide are less likely to make further attempts.	Individuals who have a history of suicide are prone to repeated attempts.
Suicide is predominantly a youth problem.	In Hong Kong, the rate of suicide among older adults (aged 60 or above) is higher than among young people.

Tool 1.4 Checklist of professional competence in preventing suicide among older adults

For each question, tick the answer that best matches your current situation.

	YES	NO
1. Have you ever received any training on common mental illness among older adults?	☐	☐
2. Have you ever received any training on assessing suicide risk among older adults?	☐	☐
3. Do you know what factors may increase the risk of suicide among older adults?	☐	☐
4. Do you know how to recognize the warning signs of suicide?	☐	☐
5. Do you know how to identify symptoms of depression?	☐	☐
6. Do you provide older adults with information and resources on depression and suicide?	☐	☐
7. Do you know the workflow or practice guideline on handling suicidal clients in your unit?	☐	☐
8. Do you know who can give you support to handle suicidal clients from your community/organization?	☐	☐
9. Do you know how to support family carers of an older adult who has suicide risk?	☐	☐
10. Do you have a plan and resources to help individuals bereaved by a suicide death?	☐	☐

The above checklist may guide you to build up your knowledge and skills which are essential to help detect depression and suicide problems among older adults in your service unit.

Adapted from: SAMHSA, 2015

Tool 1.5 Sample psychoeducation material on warning signs of suicide

KNOW THE WARNING SIGNS OF SUICIDE

This pamphlet contains information to support readers' learning on the identification and management of possible warning signs of suicide.

Has anyone ever told you something along the lines of the following? Have similar thoughts ever crossed your mind?

- "I'm a burden to others, and their lives will improve without me."
- "It's okay…I will no longer be a nuisance to you soon."
- "Life is overwhelmingly difficult. It's too much to handle now."
- "I don't feel like living anymore."
- "There's nothing else to do other than kill myself."

Do these descriptions fit you or someone you know (e.g., family member, friend, neighbor)?

The individual believes that life no longer has any meaning since their bereavement (i.e., loss of a significant person or thing). They are emotionally affected (e.g., shorter temper towards caregivers) and have leaned towards unhealthy coping mechanisms (e.g., increased drinking habits).

The individual has departed from their usual routine (e.g., absent from work or school, skipped physical therapy sessions without valid reasons). They have recently encountered sleeping problems and feelings of hopelessness.

What are the common indicators of potential suicide risks?

Individuals who exhibit the following behaviour are more likely to be facing an imminent and higher risk of suicide:

- mentioning their feelings of hopelessness or lack of motivation to continue living
- expressing personal desire and thoughts to kill themselves or otherwise die
- searching for methods to attempt suicide (e.g., posting on web forums; acquiring a deadly means like charcoal)

Individuals who exhibit certain other behaviours might also be facing a moderate or higher risk of suicide, particularly when such behaviour is relatively novel, has increased in frequency or intensity, and/or appears connected to a negative occurrence in their life:

- mentioning feelings of overwhelming suffering or helplessness
- mentioning that they are worthless or a hindrance to others
- escalating their use of unhealthy coping mechanisms (e.g., alcohol, drugs)
- taking reckless actions or generally carrying themselves in an anxious or disturbed manner
- getting excessive or inadequate sleep
- showcasing hints of withdrawal or expressing perceptions of isolation
- speaking about taking revenge or otherwise displaying their anger
- undergoing acute shifts in mood

Early detection

What can be done if warning signs for suicide have been identified?

After determining that an individual has shown indicators for suicide risks, the primary task will be encouraging them to find appropriate help. Owing to possible social stigma, many individuals often face internal hurdles when trying to seek assistance for mental health or suicide-related issues. They might also have no help-seeking experience and feel serious uncertainty about future events, or hold the idea that they can resolve the problems without outside intervention.

Useful tips/actions when an individual has exhibited one or more warning signs for suicide:

- In relation to our centre, please contact:

  _____

- Within the community, please contact:

  _____

  _____

- When you cannot effectively reach a mental health professional/service, call the Samaritans 2389 2222/ 2896 0000 (multi-lingual) or Suicide Prevention Services 2382 0000 at any time.
- The chief aim is to link the individual with a mental health professional/service to conduct a prompt evaluation of suicide risk. If you believe that the individual is at imminent risk of trying to end their life, call 999. Remain with the individual until further assistance arrives, and try to speak in a supportive manner.

Remember: Looking after your own mental health and physical health should be equally important. Find assistance if you have a mental health issue, just like you would see a doctor when catching the flu!

WE CAN HELP PREVENT SUICIDE !

Adapted from: SAMHSA, 2015

Tool 1.6 Tips for preventing depression and anxiety in older adults

Self-help options for older adults

1. Increase understanding
   - learn more about mental health issues
2. Adopt positivity
   - Keep a positive mindset regarding themselves, the society and future
3. Sustain a healthy way of living
   - Have daily exercise; avoid unhealthy eating habits, smoking, drinking or other substance abuse; keep a consistent and reasonable sleeping schedule
4. Sustain robust physical health
   - Work together with professionals on the management of medical needs (e.g., hypertension, diabetes mellitus)
5. Find joy in life
   - Set aside time to enjoy activities on a daily basis and develop leisure and hobbies
6. Sustain a proactive mind by continuous learning
   - Remain updated on contemporary issues and don't lose touch with the wider community
   - Be aware of resources in society that can help lessen isolation
7. Build up interpersonal connections
   - Chat and hang out with trusting acquaintances and family members that can provide support; reach out to individuals that have similar experiences
   - Look out for and help loved ones (e.g., assisting in childcare can be personally enjoyable and rewarding)
   - Share personal stories and wisdom with younger people (e.g., through volunteer or mentoring services)
8. Be mindful of personal circumstances
   - Remain alert to stressors; try not to set aims which are difficult to accomplish, and don't be too anxious
   - Find timely support if challenges continue
9. Be financially independant
   - Devise early finanical arrangementst to secure living standards; look for support from government where necessary

Options for family and friends to help depressed older adults

1. Accompany older adults and avoid minimizing their emotions
   - Suggest to go out together for walks, excursions or activities that the older adult likes
   - Chat with and listen to older adults, offer suitable reassurance and instil hope
2. Communicate with older adults' doctor if there are any uncertainties
3. Encourage and help older adults to find support
4. Learn more about community support groups, and participate in group activities with older adults
5. Do not downplay or neglect suicide warning signs and any comments about death and suicide. If the older adult has suicidal ideation, stay with them and promptly find help by calling the hospital or a doctor

Adapted from: Centre for Health Protection of the Department of Health, 2012

Tool 1.7 Promotion of health and mental wellness among older adults

This tool contains suggested activities to help older adults maintain and advance their health and mental wellness.

Social activities

- activities include maintaining a communal platform for individuals to socialize, various types of group excursions (e.g., cultural - Chinese opera; outdoors - day trips to islands) and celebratory gatherings for important dates (e.g., Chinese New Year; anniversaries). By participating in such social activities, older adults are provided with enjoyment, have less risk of loneliness and increased emotional support and improved connection with other individuals.

Health and wellness activities

- group exercise programmes and interactive events can enhance physical activity, balance, circulation, and flexibility. Hiking and landscaping offer physical activity and chances to not remain indoors. Programmes that teach breathing and relaxation skills, stretching exercises, Chi Kung, Taiji can lessen stress and improve general health. Interactive games that incorporate a dialogue element (e.g., bingo) are fun reciprocal methods for delivering wellness information to older adults.

- artistic events (e.g., poetry sharing; handicraft workshops; listening to music; story-writing) can boost ingenuity, imaginativeness and personal expression.

- programmes about health subjects (e.g., safety behaviour; nutrition and diet; common physical ailments) will enable older adults to more effectively manage their wellbeing.

- programmes about coping strategies will empower older adults to more effectively handle specific issues (e.g., grief and bereavement; changes with getting older; sexual difficulties; everyday stress; caregiving responsibilities; interpersonal dynamics; personal finance; daily matters).

- spiritual and religious events (e.g., masses and congregations; celebratory activities for special occasions; prayer meetings; meditation training; individual time for self-reflection) will allow older adults to discover the purpose, significance, and value of living.

- reminiscence activities encourage older adults to review their life so far through creative methods (e.g., compiling scrapbooks; keeping diaries; narrating personal stories) that will enable them to establish self-assurance and gain life-direction.

Educational and skill-building activities

- learning new skills or knowledge (e.g., digital literacy; economics; cooking; landscaping; caregiving) can build up their self-belief and confidence.
- intellectual activities (e.g., reading clubs; facilitated group discussion of hot topics; public speaking events; foreign language classes) will increase cognitive ability and personal sense of capability.
- mastery and creative activities (e.g., language or mathematical games; puzzles; creative writing; drawing; handicrafts) are often enjoyable, offer a feeling of success, and help sustain good moods.

Volunteering and mentoring

- older adults can derive a feeling of direction and meaning from exercising opportunities and their ability to help others. Here are some illustrations:
  - in non-governmental organizations, individuals may lend a hand towards preparing and conducting activities, writing, and editing a newsletter, assisting peers with daily chores and special tasks (e.g., buying groceries, visiting the doctor, going for a walk); manage a community green space, facilitate and oversee fundraising, or find other ways to volunteer their services.
  - older adults can share and utilize personal experiences to educate and mentor individuals from all age groups (i.e., children to fellow senior citizens) and different backgrounds (e.g., fellow participants who are taking up Chinese).
  - beyond their usual non-governmental organization, older adults can volunteer for other community groups and networks (e.g., Agency for Volunteer Service) which potentially serve many different causes.
  - joining events that involve younger generations (e.g., babysitting school age children; acting as a mentor for adolescents) can revitalize older people, and allow them continued opportunities to give back to society. For local inspiration, please consider the initiatives of Agency for Volunteer Service.

Behavioural health awareness

- Enlist the help of a behavioural health expert to set out accessible services and prompt help-seeking actions (e.g., sharing personal experiences or stories about the benefits of chatting with a helping professional on matters that cause distress or negative emotions). It is important to remember that helping professionals must comply with principles of confidentiality and can only override such principles when the individual or another person is facing imminent harm.

Adapted from: (SAMHSA, 2015)

Tool 1.8 Warning signs for suicide

During clinical interviews or other interactions, clients may exhibit warning signs of imminent suicide risk in numerous ways (e.g., what they say, feel, do and/or think). Awareness of the following indicators is crucial for helping professionals to undertake comprehensive suicidality risk assessments and in turn devise appropriate responses (CSRP, 2022; SAMHSA, 2015).

Verbal

- ☐ Makes direct and indirect statements of wanting to die or hurt/kill themselves (e.g., "I no longer want to live.")
- ☐ Mentioning that they feel overwhelming suffering, hopelessness or helplessness (e.g., "I have no future anymore.")
- ☐ Mentioning that they are worthless or a hindrance to others (e.g., "They'd be better off without me.")
- ☐ Defensive response to queries about their suicidality
- ☐ Bidding farewell to friends or relatives
- ☐ Indications of suicide plan (including time, means or after-death arrangement)

Affective

- ☐ Experiences unbearable psychological pain
- ☐ Extreme/acute mood changes (e.g., abrupt changes from severe depression to optimism or serenity)
- ☐ Extreme sadness/Weepiness
- ☐ Fiery temper/Irritability
- ☐ Detached/Indifferent/Numbness
- ☐ Guilt

Behavioural

- ☐ Exploring means to hurt or kill themselves (e.g., surveying potential jumping site)
- ☐ Self-neglect
- ☐ Taking reckless actions or carrying themselves in an anxious or disturbed manner
- ☐ Withdrawing/isolating from relatives, friends and community (e.g., becoming disinterested in social opportunities or household work)
- ☐ Disposing of personal possessions
- ☐ Drafting a Will
- ☐ Shifts in sleeping or eating patterns
- ☐ Sudden change in body weight
- ☐ Escalating use of unhealthy coping mechanisms (e.g., alcohol, drugs)
- ☐ Fatigue or hyperactivity
- ☐ Diminished performance of daily activities

Cognitive

- ☐ Self-blame or self-defeating
- ☐ Lack of purpose in life
- ☐ Feeling hopeless, helpless or incompetent
- ☐ Impaired memory
- ☐ Few reasons to continue living
- ☐ Low self-esteem/self-worth
- ☐ Poor concentration
- ☐ Unable to think clearly

Tool 1.9 Clinical scales to assess common mental health issues in older adults

To detect mental health issues in older adults, and hence their suicidality, as early as possible, helping professionals can utilize the following validated scales as part of comprehensive risk assessment procedures (especially during interviews).

DEPRESSION

Patient Health Questionnaire-9 (PHQ-9) (Kroenke & Spitzer, 2002)

No. of items: 9

Chinese version: Available

Charges: Free

Geriatric Depression Scale (GDS) (Yesavage et al., 1983)

No. of items: 30

Chinese version: Available

Charges: Free

ANXIETY

Generalised Anxiety Disorder Assessment (GAD-7) (Spitzer et al., 2006)

No. of items: 7

Chinese version: Available

Charges: Free

HOPELESSNESS

Beck Hopelessness Scale (BHS) (Beck, 1988)

No. of items: 20

Chinese version: Available

Charges: Free

LONELINESS

UCLA Loneliness Scale (Liu et al., 2020; Russell, Peplau, & Ferguson, 1980)

No. of items: 20

Chinese version: Available

Charges: Free

Tool 1.10 Dos and don'ts when you are meeting an older adult with suicide risk

DO

- Be attentive when listening and empathetic
- Remain objective
- Strive to be supportive, considerate and collected
- Look into the individual's factors and indicators of suicidality (e.g., symptoms and risky behaviours)
- Identify the individual's available resources (both internal and external)
- Remove method to commit suicide (if able)
- Mobilize the individual's existing resources
- Where the individual faces severe or imminent risk of suicide, accompany them and make repeated assurances until suitable professional help has been provided

DON'T

- Interrupt or neglect the individual's responses
- Only focus on the superficial facts of the situation
- Challenge or doubt the individual
- Respond with inappropriate emotion upon listening to the individual's personal issues
- Act in a disingenuous manner (e.g., by expressing inconsiderate or unhelpful ideas like "You are not serious about wanting to die by suicide" or "Things always turn out for the better")
- Make unrealistic promises
- Guarantee unconditional confidentiality regarding suicidality
- Give false hope (e.g., the individual can find suitable help from anyone)
- Where the individual faces severe or imminent risk of suicide, simply turn away or otherwise ignore their situation to evade own professional or clinical responsibilities

Adapted from: (CSRP, 2022)

Tool 1.11 General tips on how to engage with a client

Establishing good rapport with clients and making use of effective communication skills can assist helping professionals achieve meaningful engagement, and thereafter conduct effective suicidal risk assessment.

SKILLS	EXAMPLES
1. Utilize open-ended questions • Prompt the individual to elaborate personal issues in their own words	• 'In what ways can I help you?' • 'At this moment, what is causing you distress?'
2. Practice empathetic listening • Pay attention to the individual's precise words and ascertain their core thoughts, particularly any hidden messages	• If an individual discloses that 'For the last couple of days, I have been suffering from severe insomnia which caused me to lose all interest in almost everything', his/her distress not only relates to sleep issues but the loss of interest towards things
3. Utilize and take account of non-verbal cues • Frequently smile and maintain positive eye contact; nod occasionally to indicate that you are paying attention to the individual's words and you acknowledge their circumstances • Examine the individual's overall presentation (e.g., facial expressions, posture, tone of voice, and use of language) • React to the individual's non-verbal cues in ways that show genuine compassion and attentiveness • Do not hastily interrupt when the individual is talking	• 'You seem quite down and out… is there something other than your sleep issues that is bothering you?' • 'I can sense that you are under the weather; please tell me if there are reasons other than your physical discomforts that cause you distress.'
4. Facilitate verbal responses • Talk in a mild reasonably paced manner to enable the individual to feel relaxed • Use simple verbal responses to assure the individual that you are listening and spur them on to keep talking	• 'I understand what you are saying.' • 'I truly acknowledge what you feel.' • 'Kindly continue.' • 'You can tell me more, if you feel comfortable.'

Early Detection

SKILLS	EXAMPLES
5. Normalize and validate the individual's situation and perspective • Unconditionally acknowledge and accept the individual's hardships, feelings, struggles and pain in life	• "It must truly be very difficult for you to endure these challenging times." • Don't say meaningless suggestion or things like "All you have to do is pull yourself together." or "Things will work out."
6. Be cognizant of the deterrence stemming from stigma about suicide • Understand it may not be easy for the individual to talk about suicide with a helping professional, given that potential stigma hinders the individual's willingness to self-disclose	• "Many people who feel sad may have thoughts about hurting themselves or wishing to die. Have you ever experienced this?"
7. Discern the motives underlying suicidal ideation/behaviours • Try to understand more about the individual's thoughts, especially the motives behind their suicidal behaviours. In particular, older adults may have specific motives (e.g., to escape pain, stop being a burden on others) • Understanding the motives behind the individual's suicidality will provide crucial hints and direction for later intervention	• "Why do you want to end your life?"

Adapted from: (CSRP, 2022)

INTERVENTION

Tool 2.1 Safety Plan

SAFETY PLAN

When you have thoughts of harming or killing yourself, please undertake the below steps. Bear in mind that although suicidal ideation can often appear intense and enduring at the time, these harmful ideas will eventually fade away given adequate support and time. Feelings of desperation and helplessness will expire, and by then you will be able to focus on dealing with issues that have caused the negative thoughts in the first place. You have the ability to pass through the current perilous situation – just remember that it is vital to reach out to others for assistance!

As you might have trouble focusing with clarity of mind when consumed with suicidal thoughts, reproduce this safety plan and keep a copy in readily accessible locations (e.g., within a wallet, phone case or bag).

ACTION 1 Engage in these activities to settle or calm myself:

_____

ACTION 2 Go through my reasons to keep on living:

_____

ACTION 3 Contact a friend, relative or loved one

Name: _____ Phone no.: _____

ACTION 4 Contact a backup individual if the above cannot be reached

Name: _____ Phone no.: _____

ACTION 5 Contact a helping professional (e.g., social worker, doctor, psychologist)

Name: _____ Phone no.: _____

ACTION 6 Call a crisis hotline

Phone no.: _____

ACTION 7 Head to a safe location

ACTION 8 Visit the emergency room of the closest hospital

ACTION 9 Where I believe that I wouldn't be able to safely reach the hospital on my own, call 999 for emergency transfer to the hospital (prompt and secure transportation will be arranged for me)

Adapted from: Monk et al., 2007

Tool 2.2 Suicide risk assessment matrix

Owing to the complexity of suicidal cases, helping professionals can reference the suicide risk assessment matrix below for an easier grasp on how to categorize the risk level of a client. In general, the exercise involves a comprehensive evaluation of their risk factors, protective factors and suicidal ideation or behaviour. Ultimately, the matrix serves as guidance only and does not set out any mandatory steps/conditions to be fulfilled - helping professionals will need to rely on professional knowledge, experience, and clinical judgment to reach their determination of suicidal risk for the client at hand (Monk et al., 2007).

Risk factors	Level of suicide risk		
	Low	Intermediate	High/Very High
Suicidal ideation	☐ Occasional and strong but fleeting thoughts of dying. ☐ No or weak desire to die.	☐ Frequent, strong, and enduring thoughts of dying, that are often difficult to dispel. ☐ Ambivalent desire to die.	☐ Extreme and inexorable thoughts of dying. ☐ Certain or strong desire to die.
Plans for suicide (e.g., urgency)	☐ No imminent plans for suicide. ☐ No threats to die.	☐ Imminent but unspecified plans to die (e.g., near future but non-specific time). ☐ Indirect threats to die.	☐ Imminent and concrete plans to die (e.g., time and place). ☐ Unambiguous threats to die.
Means of suicide (e.g., availability, severity)	☐ Method of suicide not practical, accessible, or extensively considered.	☐ Method of suicide feasible with moderate chance of rescue (e.g., ingesting chemicals, drugs overdose).	☐ Method of suicide readily available and mostly lethal with little chance of rescue (e.g., jumping off a building, hanging).
Emotional/mental state	☐ Unhappy and easily triggered. ☐ Slight mental distress.	☐ Fluctuating moods, lack of emotional expression. ☐ Moderate mental distress.	☐ Emotional numbness, or turmoil (e.g., anxious, perturbed, exasperated). ☐ Significant or intolerable mental distress (e.g., severe feelings of rejection and social disconnection).
Familial/social support	☐ Adequate or reasonable familial/social support.	☐ Minimal or weak familial/social support. ☐ Medium conflict with family members or important persons.	☐ Severe lack of familial/social support (e.g., isolation). ☐ Intense conflict with important persons.
History of suicide (and self-harm)	☐ No history.	☐ Single past suicide attempt.	☐ Multiple past suicidal attempts.

Tool 2.2 Suicide risk assessment matrix

Risk factors	Level of suicide risk		
	Low	Intermediate	High/Very High
Motivation to continue living	☐ Somewhat hopeful that situation will change for the better. ☐ Concrete plans for the future.	☐ Negative and bleak outlook. ☐ Unclear and gloomy plans for the future.	☐ Feelings of hopelessness and helplessness. ☐ No plans for the future and views living as pointless.
	Remarks _____ _____ _____		
Other risk factors	☐ Clinical diagnosis of mental disorder(s) ☐ Family history of suicidality ☐ Friends/acquaintances with suicidality ☐ Recent significant loss ☐ Unsettled grief ☐ Substance use problems ☐ Ongoing relationship issues ☐ Recent legal accusations (e.g., involvement in crime) ☐ Averse attitudes towards finding help ☐ Important others view lightly the client's suicidality ☐ Violent or murderous thoughts ☐ Pattern of impulsive actions ☐ Deterioration of cognitive functioning (e.g., psychosis)		
Helping professional's clinical judgment about overall level of suicide risk	☐ Low ☐ Intermediate ☐ High/very high Comments: _____ _____ ** Please note that the categorization of risk level is merely a clinical impression based on holistic assessment of the above factors*		

Date of assessment _____

Tool 2.3 Risk management diagram

Low to mild risk

- Psychotherapy that targets underlying issues
- Enhancing coping skills
- Identifing resources and personal strenghts
- Ongoing assessments and monitoring

Moderate risk

- Stabilisation
- Safety plan
- Considering hospitalization
- Reducing access to lethal means
- Enhancing problem solving skills
- Ongoing assessments and monitoring
- Family involvement
- Proper referral

High or imminent risk

- Stabilisation
- Being accompanied
- Removal of means
- Ensure safety (call 999 in emergency)
- Proper referral
- Family involvement
- Hospitalization
- 24-hour availability or emergency or crisis services
- Individual support (addressing immediate problems)
- Medication
- Multidisciplinary support/treatment

Tool 2.4 Client's need for hospitalization checklist

A suicidal client's need for hospitalization will be more pressing if they exhibit the following conditions:

(A) Overall/general

- ☐ High/imminent suicide risk
- ☐ High/unclear risk factor to protective factor ratio
- ☐ Impulsivity (i.e., leads to quick changes in level of risk)
- ☐ Urgent necessity to intervene with a severe existing psychiatric issue (e.g., major depression, psychosis)

(B) Specific (Linehan, Heard, & Armstrong,1993)

- ☐ Suffers from unbearable mental disorder with lack of social support and threatens to attempt suicide
- ☐ Poses a danger to oneself or others
- ☐ On psychotropic treatment which demands thorough monitoring and exhibits a history of severe misuse
- ☐ Has high levels depression or anxiety, and does not respond to outpatient intervention
- ☐ In an overpowering crisis and fails to deal with the situation without the possibility of grave harm to self, and a lack of secure surroundings (i.e., possibility of suicide overrides disadvantages of hospitalization)

When should involuntary admission be considered? Involuntary admission under the Mental Health Ordinance (Cap. 136)

- ▶ Hospitalizations are typically arranged with the client's consent
- ▶ Involuntary admission should be considered if the client is (i) showcasing thoughts or behaviours that gravely endanger their life or the life of others, and (ii) consent cannot be readily obtained, taking into account these factors:
  - ☐ The client's safety cannot be ensured in the current environment
  - ☐ The client is suspected or already known to have a mental disorder that significantly diminishes their ability to react suitably to their surrounding or to interact with others

Clients' family involvement

As long as family members are effectively engaged (e.g., psychoeducation on risk management and treatment consequences), their participation in the decision-making process should be encouraged. When dealing with crisis, strive to maintain close cooperation with the police or community nursing services. *Please refer to Tool 2.5 and Tool 2.6 of this Toolkit for detailed guidance.*

Tool 2.5 Basics about involvement of the client's family

With regards to a client's suicidal thoughts and/or behaviour, family members commonly react in the following manners, which might have varying origins and implications:

(1) Shock, disbelief and distress (e.g., feelings of despair, helplessness, and failure)

- The family's "presumed world" has been destroyed
  - similar to any trauma, helping professionals will need to afford family members appropriate time, information and empathy in order to deal with their responses
- Feelings of genuine helplessness, even when the client's suicidality had been recurrent
- Self-perceptions of being irresponsible or guilty for the client's general plight or suicidality, especially if the family member is a primary caregiver
- Self-perceptions of being blamed by the client or others (e.g., relatives, acquaintances or even helping professionals)

(2) Enraged (e.g., at the client for their "selfishness" in contemplating suicide)

- Potentially accentuated by anticipatory grief (i.e., stemming from apprehension that the client will ultimately kill themselves), and familial history related to grief and bereavement
- Worries about diminished income or prestige and possible stigma (e.g., "How will our relatives view us?")
- Views that the client has persistently been the "troubling issue" within their family, which has caused repeated trouble and expended their time and resources

(3) Indifference, fatigue and helplessness

- Particularly likely if the client had a relatively enduring suicidal history
- Signs of compassion fatigue, which may be accentuated by actual/perceived inadequate support from relevant institutions and others

Non-judgmental, empathic support from clinicians for families

If available, family support is a substantial resource to be utilized. This includes:

- Offer psychoeducation on suicidality, mood disorders and substance abuse problems, and when necessary utilizing therapy to enhance overall functioning within the family (e.g., how to live with a suicidal person)
- Helping professionals together with family members can re-establish the interaction methods of the family, and delve into potential solutions for conflicts (e.g., setting clear boundaries)
- Helping family members maintain or restore their competence in dealing with familial, social or professional matters
- Building and maintaining a positive connection with family members is crucial in suicide prevention work
- Not only can family members provide invaluable supervision and updates on the client's actions and status, they may further lend a hand in ensuring the client's adherence to their established intervention or safety measures (e.g., help implement specific measures that aim to minimize suicidal risk)

Challenges in mobilizing family support

Many older adults with greater suicidality face considerable social alienation as there are few people to back them up in real life. Difficulties in mobilizing family support will more likely arise when:

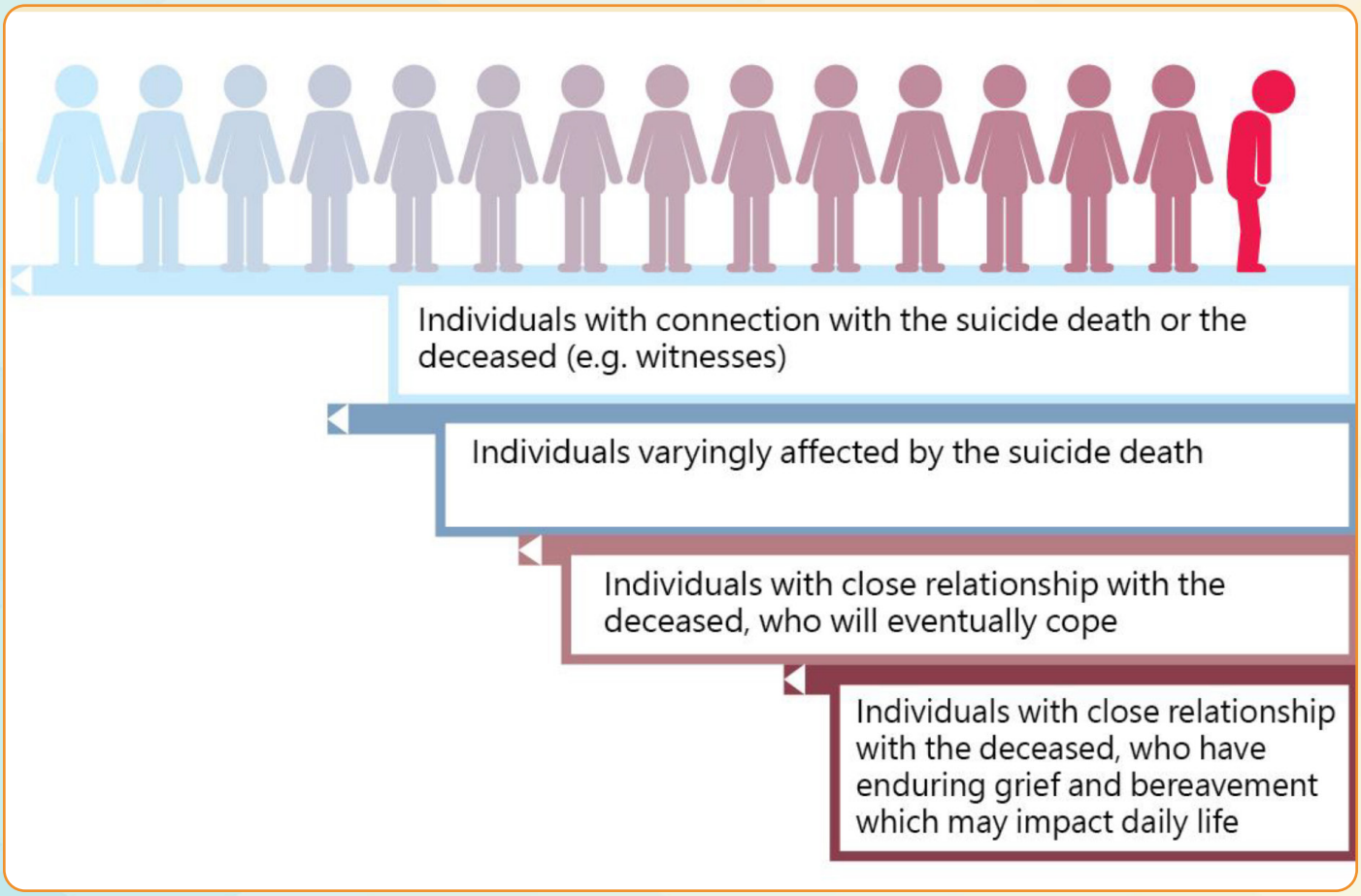
- The client suffers from a mood disorder or other psychological issues that negatively twist their view of support
- The client feels further isolated due to battling other challenges such as physical ailments, financial strain, or substance abuse
- The client is not readily offered love or care from family members and close acquaintances, who may even be driven away by frustrations regarding the client and their problems

Tool 2.6 Checklist for professionals to support client's family in suicide prevention efforts

- [ ] Teach the client's family about suicidality and common risk factors
- [ ] Involve the client's family's engagement in ongoing risk evaluation of the client
- [ ] Provide general tips to identify the client's actions that imply suicide risk, and clarify things they should bear in mind
- [ ] Educate family members on how to notice objective facts that help in risk evaluation (e.g., exploring recent instances of suicidality exhibited by the client)
- [ ] Respect the opinions and wishes of the client's family
- [ ] Maintain suitable communication with family members, and understand and accept their suggestions and concerns indicating that the client's family's suggestions and concerns have been considered
- [ ] Delineate the appropriate limitations of disclosure on matters related to the client's suicidality, especially when they face severe or pressing risk
- [ ] Engage and mobilize potential sources of support for the client (e.g., regularly involving the client's family within the overall response and intervention process)
- [ ] Clearly specify the role of the client's family within the overall response and intervention process
- [ ] Inform the client's family of the expected frequency and manner of their participation (e.g., marital or family-based intervention)
- [ ] Go over the limitations/boundaries of response and intervention (e.g., marital or family-based treatment may be more suitable or effective when the client has enduring suicidality which negatively impacts household life; marital or family-based treatment will be more efficacious)
- [ ] Promptly respond to contacts and requests by the client's family, especially when they appear concerned; enlist another member of the helping team to respond when personally unavailable
- [ ] Provide avenues of information (e.g., pamphlets, online pages, books) for the client's family and encourage them to engage with alternative help to lessen their isolation
- [ ] Where the client has passed away due to suicide, keep in contact with family members and offer suitable support. Also refer to Chapter 3 on "Postvention" of the Suicide Prevention Practical Guide for details.

POSTVENTION

Tool 3.1 Determine who may be affected by the suicide - The continuum model on effects of suicide exposure



Reference: Cerel, McIntosh, Neimeyer, Maple, & Marchall (2014)'

Tool 3.2 Determining the level of intervention required based on the continuum model on the effects of suicide exposure

The following may facilitate your decision regarding what level of intervention is needed in your community/centre following a suicide.

Level 1: Universal

- It is recommended to ensure that leaflets and pamphlets containing psychoeducational materials are available in the centre at all times.
- Identify those who have been exposed to or affected by the suicide in the community and distribute the leaflets to them.

Level 2: Community and group based

- Groups (e.g., open self-help, peer support or voluntary groups) on the topic of grief and bereavement can be provided on a regular basis in the community to support bereaved older adults.
- If a member known in the community/centre has committed suicide, when appropriate, a remembrance event can be organized.

Level 3: Individual support or closed group

- If individuals are displaying depressive symptoms in response to the suicide death, consider offering one-to-one support and psychoeducation regardless of their relationship with the deceased.
- Consider conducting a risk assessment to explore the impact of another person's suicide on their mood and risk level.

Level 4: In-depth psychotherapy

- If certain individuals are experiencing more severe symptoms (See Section 3.2.3), and the symptoms are affecting their daily life functioning, more in-depth psychotherapy provided by mental health service / qualified practitioners and frequent emotional support is required.
- Conduct a risk assessment and consider also referring to specialized mental health professionals.

Tool 3.3 Guide for social workers – how to support the bereaved individual (suicide survivor)

STEP 1 OFFER PRACTICAL SUPPORT

Making initial contact:

- ☐ Contact to be made within 48 hours if referred by police (with consent)
- ☐ Initial contact can be made by a trained coordinator

During the initial contact, the coordinator can consider the following:

- ☐ Offer condolences and explain the services available
- ☐ Check who else may be affected
- ☐ Address practical questions or concerns, identify any safeguarding or safety issues (act accordingly if identified)
- ☐ Arrange face-to-face meeting within 7-14 days
- ☐ Offer information about support options

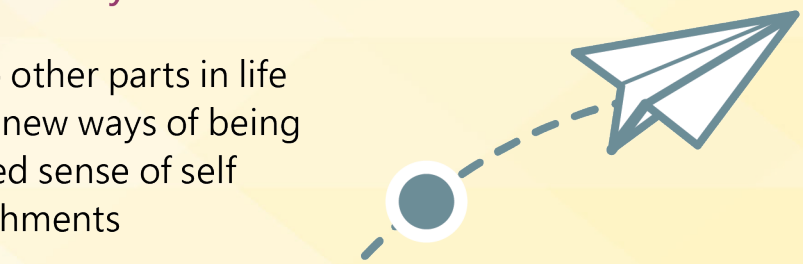
Clinical remark:

- Please note that suicide survivors may not be ready to receive support that you offer immediately after the suicide. They are often preoccupied with arranging for the funeral and dealing with the practicalities etc. Continued and regular contact with survivors and leaving them with a leaflet that includes psychoeducation information and where to seek help if needed will be helpful.

STEP 2 PROVIDE ONE-TO-ONE SUPPORT

Reinvest in the new reality

- Learn new skills
- Redirect energy to other parts in life
- Readjust, develop new ways of being and have a renewed sense of self
- Let go of old attachments



Adjust to the new environment without the lost person

- Review memories
- Encourage personalized way of 'connection' to the deceased
- Change elements of the environment that are reminders of the loss music, art etc.

Experience the pain and react to the loss

- Walk alongside the survivor and be an empathic listener
- Support survivor to identify, and find ways to express, their feelings. Feelings can be expressed verbally or via non-verbal means such as drawing, music, art etc.

To accept the reality and recognize the loss

- Acknowledge the death: verbal acknowledgement and behavioral rituals
- Walk alongside the survivor in seeking answers to the question "Why"

Postvention

To facilitate the expression of different emotional reactions, here are some suggestions:

Possible emotional reactions	Possible underlying reasons	Potential area to support the person experiencing such emotions
Profound sadness	• Normal reaction to losses and separation	• Validate the feelings of sadness, allow emotional expression • Do not try to cheer up the person
Anger at the person, towards others, or God (or any higher being)	• Anger is often the surface feeling and what drives the anger may be feelings of guilt, blame, preventability and abandonment • For clients who die as a result of suicide, the 'killer' and the deceased are the same person. This may cause a very conflicting and confusing set of emotions for the survivors, which are not easily resolved	• Allow the individual to feel the anger • Do not judge the anger • Name the angry feeling and ask questions to find out to whom it is directed
Anxiety and worry about yourself and others	• Fear of being alone • Worries about financial security • Fear of uncertainties and changes lying ahead	• Acknowledge and validate the feelings of anxiety • Address any practical worries
Relief	• Possible feeling if the deceased has been struggling with illness/behaviour for a long time	• Acknowledge such feelings and watch out also for feelings of guilt
Numbness	• Some individuals react in this way (often unconsciously) to be emotionally detached from the pain	• Acknowledge such feelings and explore what lies behind the numbness
Shock	• The impact associated with suicide can be overwhelming. It is described as similar to other traumatic events such as natural disaster or accidental death	• Acknowledge the shock and facilitate the expression of the feeling • Ask how the person found out about the suicide death
Guilt and blame	• Survivors often believe they "should" have been able to save their loved one's life. In hindsight, survivors often ruminate about what they could have done • Some survivors may believe that a single event preceding the suicide triggered or caused the suicide (e.g., we had a fight, I left her alone) • Assigning responsibility to a single event, circumstance, or individual to explain the suicide death is common. This may be driven by the survivor's need to make sense of the seemingly incomprehensible	• Acknowledge the feelings of guilt • It is important to note that reasons contributing to suicide cannot be attributed to one single event. Reasons behind suicide are often complex involving multiple interrelated factors • Do not say "do not feel guilty", but try to say "it is hard to understand why they chose to commit suicide, but do know that you are not responsible for their death"
Shame	• Shame may stem from guilt and self-blame • Shame is associated with suicidal stigma	• Accept feelings of shame • Understand the shame associated with suicide and stigma
Abandonment and rejection	• Suicide is seen as a strong feeling of abandonment/rejection; From the perspective of the suicide survivors, the deceased chose to die instead of continuing to maintain a relationship with them. Suicide survivors may also feel that the deceased refused their help	• Acknowledge and accept feelings of rejection • Recognize possible isolation and loneliness
Confusion and disbelief	• Confusion about why their loved ones committed suicide is a common experience of many suicide survivors • The inability to get answers can be a heavy burden	• Understand that the process of searching for answers can help suicide survivors overcome these feelings, even though answers are rarely found

Tool 3.4 Assessment and monitoring for complicated grief responses

1 At-risk client groups that might have a higher chance of developing complicated or prolonged grief

- ☐ People closest to the deceased
- ☐ People with an unhealthy attachment relationship with the deceased
- ☐ People with mental illness
- ☐ People exposed to the suicide death
  - ◆ Some suicide survivors may be the first person to discover the suicide death (e.g., discovering the deceased lying in the bedroom); this may provoke intense emotional reactions that are similar to exposure to other traumatic events
- ☐ Perceived suddenness of the suicide death

2 Signs and symptoms that may suggest complex bereavement disorder. Note that the symptoms must have persisted for at least 12 months following the death and experienced to a clinically significant degree to be considered as complex bereavement. If your client is displaying these signs and symptoms, more comprehensive and in-depth intervention may be necessary

- ☐ Persistent yearning or longing for the deceased
- ☐ Intense sorrow and emotional pain in response to the death
- ☐ Preoccupation with the deceased
- ☐ Preoccupation with the circumstances of the death
- ☐ Marked difficulty accepting the death
- ☐ Experiencing disbelief or emotional numbness over the loss
- ☐ Difficulty with positive reminiscing about the deceased
- ☐ Bitterness or anger related to the loss
- ☐ Maladaptive appraisals about oneself in relation to the deceased or death (e.g., self-blame)
- ☐ Excessive avoidance of reminders of the loss
- ☐ A desire to die in order to be with the deceased
- ☐ Difficulty trusting other individuals since the death
- ☐ Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased
- ☐ Confusion about one's role in life, or a diminished sense of one's identity
- ☐ Difficulty or reluctance to pursue interests since the loss or to plan for the future

Tool 3.5 Guide to develop a community based postvention plan

When is a community-wide response needed?

Postvention is an essential part of public health. The impact of suicide is not limited to close family members or friends; the impact of each suicide can be wide-reaching. Estimates vary on how many people are affected by each suicide – ranging from 6 to 60 (Berman, 2011). Therefore, the organization or even the community as a whole can become a "survivor". This is especially so for organizations or community centres that have close-knit relationships and interact with one another on a regular basis.

The objectives of a community wide response are as follow:

Details of each objective can be found in Section 3.3.2 of the Suicide Prevention Practical Guide

Postvention

The following is a step-by-step guide to develop a postvention plan before a suicide occurs

STEP 1

Understand your local context and community, and the perceived needs

☐ Understand and gather as much information as possible about the suicide deaths that have occurred in the community in the last few years (at least two years):

- How many people die from suicide in your area each year?
- In Hong Kong, you can check with The Centre for Suicide Research and Prevention at The University of Hong Kong for the data.

- Where in the community did these suicide deaths occur?
- Are there any particular locations associated with suicide?

What are the association between those who died by suicide and the community service providers?

Explore if there are any suicide or self-harm patterns or trends in your community

- To understand what has happened after each suicide
- How did the news about suicide deaths spread in the community?
- Were there any special arrangements or actions taken in the community?
- What actions were effective? What issues and concerns arose?
- Decided how to report the suicide incident, for example, is there a need for police support and/or notification of immediate family members of the suicide death?

STEP 2

Involve the stakeholder community

☐ Identifying stakeholders and mobilizing their active involvement is central to any postvention development and delivery. The key players may include: police, coroner's officers, district officers, housing providers, mental health services, religious groups etc.

☐ Form consensus on:

- ambition for the service
- target audiences; ideas for the service
- any challenges that may have unintended impacts on other services
- any synergies with existing services
- consider setting up a steering group (for delivering the project), advisory group (for consultation for ideas), and stakeholder group (beneficiaries of the services) if necessary

STEP 3

Envision what good community support is like

☐ Within the multidisciplinary group, set the objectives of the postvention support service and consider setting these goals:

To reduce the incidence of suicide amongst loss survivors

To reduce stigma and isolation felt by people bereaved by suicide

For professionals and community, recognize that bereavement by suicide brings unique challenges that need unique support

To reduce the risk of contagion and the risk of suicide clusters

STEP 4

Set the service gap

- [ ] Identify any crisis response plan already in place that can be modified or adapted for older adults. Solicit information and feedback about what works well and what doesn't. Is there a need for enhanced service, or for improving coordination and support for an existing service?
- [ ] Identify the gaps in the community and explore if there are sufficient resources to address the gap
- [ ] Before setting up the service, how will a person bereaved by suicide receive support? Imagine after setting up the service, how will you envision the person and community bereaved by suicide receiving support? Can we take reference from other communities?
- [ ] Consider the following potential targets of your service:
  - Adults
  - Children and adolescents
  - Next of kin
  - Close family members
  - Close friends
  - Family friends
  - Ex-colleagues
  - Frontline professionals that worked with the person who died (e.g., social workers or project officers etc)
  - Strangers who witnessed the death or who found the person who died
  - People outside the community who were close to the person who died
- [ ] What will the service offer? Consider the following:

- ◆ Psychoeducational information only
- ◆ Service provided as a response to bereaved individuals requesting support
- ◆ Provide service proactively as outreach to suicide survivors
- ◆ Individual support from a trained volunteer
- ◆ Assessment services from a qualified person (with training in postvention and bereavement services)
- ◆ Individual support from a trained volunteer

- ◆ Individual support from a qualified counsellor/psychologist/social worker
- ◆ Self-help group
- ◆ Facilitated group (open or closed)
- ◆ Drop-in support sessions
- ◆ Referral pathway from general practitioners to mental health services for people at risk
- ◆ Remembrance event

STEP 5

Develop the service and plan delivery

- [ ] Set out the details of the service plan (for reference to bereavement support, see 3.2)
- [ ] Ensure there is support for staff and have regular meetings to follow up staff's wellbeing (e.g., debrief, peer support, peer supervision)
- [ ] Training is essential for postvention services; training should be provided to all staff who will be in contact with suicide survivors. Staff should be made aware of the risk of suicide among suicide survivors

Adapted from: "Support after a suicide: developing and delivering local bereavement support services", published by National Suicide Prevention Alliance, 2020

SELF-CARE FOR HELPING PROFESSIONALS

Tool 4.1 Checklist of indicators for helping professionals' work-related stress

In the realm of health care, research has suggested that suicidal expressions and actions are some of the most stressful behaviours when managing clients (Monk et al., 2007). Helping professionals need to have a clear understanding of the occupational hazards of suicide prevention work, especially burnout and compassion fatigue. Throughout the entire process of service provision, helping professionals should continually assess their own wellbeing and adopt effective self-care and coping measures. Indicators of excessive work stress may express themselves in the following manner:

BEHAVIOURAL

- [ ] Loss of enthusiasm
- [ ] Coming to work late
- [ ] Low sense of accomplishment
- [ ] Being easily frustrated and angry
- [ ] Becoming increasingly rigid
- [ ] Finding it difficult to make decisions
- [ ] Being inactive
- [ ] Increasing withdrawal from work
- [ ] Irritation with coworkers

PSYCHOLOGICAL

- [ ] Pessimism
- [ ] Depression
- [ ] Despair
- [ ] Emptiness
- [ ] Emotional numbing or flooding
- [ ] Negative self-concept
- [ ] Guilt
- [ ] Self-blame for not accomplishing more
- [ ] Increased feelings of vulnerability
- [ ] Difficulty trusting others
- [ ] Intrusive thoughts or images of personal or work-related trauma events

PHYSIOLOGICAL

- [ ] Physical depletion
- [ ] Fatigue
- [ ] Irritability
- [ ] Headaches
- [ ] Gastrointestinal disturbances
- [ ] Back pain
- [ ] Weight changes
- [ ] Changes in sleep pattern

PROFESSIONAL

- [ ] Cynicism, hostility or boredom towards clients
- [ ] Blaming clients
- [ ] Dread of working with certain people/ situations
- [ ] Daydreaming during sessions
- [ ] Quickness to diagnose or medicate
- [ ] Avoidance of meetings
- [ ] Avoidance of difficult topics with clients

SPIRITUAL

- [ ] Loss of faith, meaning or purpose
- [ ] Feelings of alienation or estrangement
- [ ] Changes in values
- [ ] Changes in religious beliefs or religious affiliation

Tool 4.2 Self-assessment of compassion fatigue - Professional Quality of Life (ProQOL)

Compassion Satisfaction and Fatigue (ProQOL) Version 5 (2009)

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1 = Never	2 = Rarely	3 = Sometimes	4 = Often	5 = Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *(help)*.
_____ 3. I get satisfaction from being able to *(help)* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *(help)*.
_____ 7. I find it difficult to separate my personal life from my life as a *(helper)*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *(help)*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *(help)*.
_____ 10. I feel trapped by my job as a *(helper)*.
_____ 11. Because of my *(helping)*, I have felt "on edge" about various things.
_____ 12. I like my work as a *(helper)*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *(help)*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *(helped)*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *(helping)* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *(helper)*.
_____ 20. I have happy thoughts and feelings about those I *(help)* and how I could help them.
_____ 21. I feel overwhelmed because my case (work) load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *(help)*.
_____ 24. I am proud of what I can do to *(help)*.
_____ 25. As a result of my *(helping)*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *(helper)*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

What is my score and what does it mean? In this section, you will score your test and then you can compare your score to the interpretation below.

Scoring

1. Be certain you respond to all items.
2. Reverse your score for items 1, 4, 15, 17 and 29. For example, if you scored the item 1, write a 5 beside it. This method will enable the assessment results to be more accurate.

You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

To find your score on **Compassion Satisfaction**, add your scores on questions 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.

The sum of my Compassion Satisfaction questions was	My Level of Compassion Satisfaction
22 or less	Low
Between 23 and 41	Average
42 or more	High

To find your score on **Burnout**, add your scores on questions 1, 4, 8, 10, 15, 17, 19, 21, 26 and 29. Find your score on the table below.

The sum of my Burnout questions was	My Level of Burnout
22 or less	Low
Between 23 and 41	Average
42 or more	High

To find your score on **Secondary Traumatic Stress**, add your scores on questions 2, 5, 7, 9, 11, 13, 14, 23, 25, 28. Find your score on the table below.

The sum of my Secondary Traumatic Stress questions was	My Level of Secondary Traumatic Stress
22 or less	Low
Between 23 and 41	Average
42 or more	High

Tool 4.3 Self-care and coping measures

In each domain, list the things that you can do to promote self-care; place a cross in the particular quarter to currently how far from where you want to ideally be in treating yourself (i.e., further or closer to the "Where I want to be" box " in the middle).

GENERAL LIST OF RESOURCES

Tool 5 General list of resources

Mental health promotion and psychoeducation references

Below are a number of resources that can be introduced to older adults and family carers to raise their awareness of mental health and other related issues (e.g., suicide and caregivers' needs).

Please scan the QR code to watch the video clips/access links to resources

RECOMMENDED TOPICS	USEFUL LINKS AND REFERENCES
Psychoeducation leaflet & other resources for loss/ suicide survivors	**The HKJC Centre for Suicide Research and Prevention** **(Chinese version)** https://csrp.hku.hk/content/uploads/2022/06/A-Handbook-for-Survivors-of-Suicide_CHI.pdf **(English version)** https://csrp.hku.hk/content/uploads/2022/06/A-Handbook-for-Survivors-of-Suicide.pdf **Conversations matter fact sheet and podcasts** Tips for handling safe and effective conversations after a suicide death. Includes basic tips on what to say to and do for a person who has lost someone close to them through suicide, as well as when you are worried someone you know may be thinking about suicide. Hunter Institute of Mental Health, Australia. (2016) http://www.conversationsmatter.com.au/ **Coping with the suicide of a loved one** Stacey Freedenthal (2013) http://www.speakingofsuicide.com/2013/05/29/coping-with-the-suicide-of-a-loved-one/ **SOS: A handbook for survivors of suicide** A pocket-sized quick reference booklet for suicide loss survivors. American Association of Suicidology. Also available in Spanish. (2003) http://www.suicidology.org/store/BKctl/ViewDetails/SKU/AASS-6 and http://www.suicidology.org/Portals/14/docs/Survivors/Loss%20Survivors/SOS_Espanol.pdf **After-death arrangements** Jockey Club End-of-Life Community Care Project "吾該好死" pamphlet http://www.socsc.hku.hk/JCECC/%E5%90%BE%E8%A9%B2%E5%A5%BD%E6%AD%BB_IOA.pdf

Tool 5 General list of resources

RECOMMENDED TOPICS	USEFUL LINKS AND REFERENCES
Ageing and mental health	**Health Bureau - Preventive Care for Older Adults** https://www.healthbureau.gov.hk/pho/main/preventive_care_for_older_adults.html?lang=2 **Ebook on Mental Health for Older Adults** https://www.elderly.gov.hk/ebook_mental_health/mobile/index.html
Common mental health problems in older people	**Elderly Health Service, Department of Health** **Chinese version** https://www.elderly.gov.hk/tc_chi/healthy_ageing/mental_health/index.html **English version** https://www.elderly.gov.hk/english/healthy_ageing/mental_health/index.html **Health Bureau - Primary Healthcare Office** **Preventive Care for Older Adults - Primary Healthcare Office** https://www.healthbureau.gov.hk/pho/main/preventive_care_for_older_adults.html?lang=2 **Institute of Mental Health, Castle Peak Hospital** **Mental health tips** **Chinese version** https://www3.ha.org.hk/cph/imh/mhi/index_chi.asp?lang=1 **English version** https://www3.ha.org.hk/cph/imh/mhi/index.asp
Mental Health First Aid for older persons	**Mental Health Association of Hong Kong** http://www.mhfa.org.hk/Page_Introduction.php
Mindfulness materials	**Newlife 330 3-minutes breathing space exercise (Cantonese)** https://www.youtube.com/watch?v=56MkjZa8iuk **Newlife 330 Mindfulness bodyscanning exercise (Cantonese)** https://www.youtube.com/watch?v=vnn5Xjp0fp0&t=124s
Wellness Recovery Action Plan®	**New Life Psychiatric Rehabilitation Association** **Chinese version** https://www.nlpra.org.hk/tc/pnp/wrap **English version** https://www.nlpra.org.hk/en/pnp/wrap **The Samaritan Befrienders Hong Kong** https://sbhk.org.hk/?page_id=32063&lang=en
Life education outreach programmes	**Carers' Corner, Elderly Health Service, Department of Health** https://www.elderly.gov.hk/english/carers.html

Tool 5 General list of resources

RECOMMENDED TOPICS	USEFUL LINKS AND REFERENCES
Support for family carers	**Carers' Corner, Elderly Health Service, Department of Health** https://www.elderly.gov.hk/english/carers.html **Carer Corner, Smart Elders, Hospital Authority** https://www21.ha.org.hk/smartpatient/SmartElders/en-us/Carer-Corner/ **Social Welfare Department** **Leaflet on Services Supporting the Carers** https://www.swd.gov.hk/doc/elderly/carers_leaflet_detail(2).pdf **Suicide Prevention Services** **STAND BY YOU – Family Support for Elderly Mental Health** https://www.sps.org.hk/?a=group&id=stand_by_you **656 Carer** https://656carer.com/
Categorization and diagnosis of mental health illnesses	**Health Bureau Patient Health Questionnaire – 9 items, a tool to screen for depression (online version)** **Chinese version** https://www.dhc.gov.hk/tc/depression_questionnaire.html **English version** https://www.dhc.gov.hk/sc/depression_questionnaire.html

Tool 5 General list of resources

Access to suicide prevention and mental health related support and resources in the local community

SUICIDE CRISIS HOTLINES

Social Welfare Departmental Hotline	2343-2255
The Samaritans (multi-lingual)	2896-0000
The Samaritan Befrienders Hong Kong	2389-2222
Suicide Prevention Services	2382-0000
Caritas Family Crisis Support Centre	18288
Tung Wah Group of Hospitals CEASE Crisis Centre	18281
Youth Outreach	9088-1023
Hong Kong Federation of Women's Centres	2386-6255
Hong Kong Single Parents Association	2778-4849
The Hong Kong Council of Social Service (人間互助社聯熱線)	1878-668
Richmond Fellowship of Hong Kong – Justone 24-hour Community Mental Health Support Project	3512-2626

COUNSELLING SERVICES

Breakthrough Counselling Centre	2377-8511 / 2632-0777
The Hong Kong Federation of Youth Groups (關心一線)	2777-8899
Hong Kong Christian Service	2731-6251
Baptist Oi Kwan Social Service	3413-1604
Methodist Centre	2520-4933
Hospital Authority 24 hour Psychiatric Hotline	2466-7350

ORGANIZATIONS PROVIDING SERVICES FOR THE BEREAVED

The Comfort Care Concern Group	2361-6606
Society for the Promotion of Hospice Care – Jessie & Thomas Tam Centre	2725-7693
The Samaritans (multi-lingual)	2896-0000
The Samaritan Befrienders Hong Kong	2389-2222 / 2319-1177
Suicide Prevention Services - Project BLESS	2382-2737
Care for Life Association	2863-8151

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