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Holistic Support Project for Elderly Mental Wellness

Suicide Prevention for Older Adults: Practical Guide and Toolkit

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Qualifying Statements

At the outset, please note that this practical guide (also 'this document') does not set out any universal or fixed standards for concerned parties to adopt in their suicide prevention work. Instead, this document chiefly aims to enhance the theoretical knowledge and practical knowhow of its readers. Our target audience is chiefly helping professionals who are likely to encounter at-risk or suicidal clients in their lines of work, and in this document they can find common terms, skills and practice examples applicable for common institutions (e.g., social work organization) to faciliate their undertaking of suicide prevention work.

Please be cognizant that helping professionals are not deemed to have the necessary expertise to implement specific treatment methods as described in this document. They are recommended to assess their own capacity and available resources when engaging in suicide prevention work, and if needed, to seek further advice, education and/or training on such matters. Those who have any immediate or significant questions about the contents and application of this document should consult a qualified mental health, legal or otherwise relevant professional.

When making any decision regarding suicidal clients, helping professionals are reminded to exercise their own clinical judgment and bear appropriate responsibility. As risk assessment of suicidality remains inherently difficult, helping professionals should adopt a 'better safe than sorry' approach by considering the most optimal approaches for both risk management and intervention after taking account of the whole picture. In any event, the authors and their respective agencies disclaim all liability for any losses caused by reliance on and/or the utilization of any information contained within this document.

Introduction

A. About 'JC JOYAGE'

According to a study, about 10% of the elderly population in Hong Kong have depressive symptoms. Factors such as stress, health problems and a lack of social engagement usually contribute to the vulnerability of older people and cause higher risks of elderly depression or other major illness. In response to this concern, The Hong Kong Jockey Club Charities Trust approved over HK$366 million to initiate the 'JC JoyAge: Jockey Club Holistic Support Project for Elderly Mental Wellness' (JC JoyAge). Through cross-sectoral collaboration, JC JoyAge provides a community-based supporting network for our senior citizens to enhance their resilience in facing the challenges of ageing. The service model bridges the District Elderly Community Centre ("DECC") and Integrated Community Centre for Mental Wellness ("ICCMW") to establish a collaborative and integrated service model, which renders standardised prevention and timely intervention services for the elderly at-risk of or with depressive symptoms, according to their risk level and severity of symptoms, etc. For more details of the project, please visit http://www.jcjoyage.hk/.

B. Objectives of the toolkit

'JC JoyAge' provides various types of training to helping professionals working with older adults (including: social workers, counsellors, psychologists, occupational therapists, physiotherapists and psychiatric nurses working in mental health services) to enable them to master the skills and knowledge needed to enhance their capacity for case intervention and management. This practical guide is part of the programme.

The main purpose of this toolkit is to offer practical guidelines for helping professionals and the community at various stages of suicide prevention efforts (i.e., early detection and assessment, intervention, and postvention) amongst older adults. Recommended actions are described and appended with easy-to-reference tables, questionnaires, and measures in the corresponding toolkit.

For the better management of clients with suicide risks, the authors have also detailed fundamental knowledge regarding suicide (e.g., major contributing factors, common myths and facts) and pragmatic skills required of helping professionals (e.g., proper engagement with individuals).

How to use this suicide prevention practical guide

This practical guide is separated into a main booklet and accompanied by a corresponding toolkit. The latter is designed to be a practical tool providing quick reference for frontline professionals/ social workers. The toolkit includes checklists, questionnaires, worksheets, and reference tables that workers can use in their clinical practice. The main booklet lays out the theoretical background and knowledge behind the toolkit, which contains more comprehensive and detailed coverage of the steps in the assessment, intervention and postvention stages. The main booklet also includes case examples and contextualised information specific to Hong Kong and older adults, referred to as 'clinical remarks'.

Lists of support and educational resources are laid out for quick reference (e.g., hotlines) and advanced learning (e.g., non-government organization websites).

Whilst it is acknowledged that the public health approach should be adopted in any suicide prevention efforts, interventions at the wider community level (i.e., universal prevention strategies) will not be the focus in this toolkit. For more details, readers are encouraged to read the book chapter "Suicide Prevention in Hong Kong: Opportunities and Challenges" (Yip et al., 2013).

C. SUICIDE PHENOMENON AMONGST OLDER ADULTS

Close to 800,000 people die globally due to suicide every year, that is one person every 40 seconds (Word Health Organization [WHO], 2019). Suicide, by definition, is an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome (WHO, 2014).

The World Health Organization has reported that older adults have a greater chance of dying as a result of suicide attempts than any other age group (WHO, 2019). Suicide, therefore, amounts to an emerging public health concern that involves significant mortality and family turmoil (Brooks, Burruss, & Mukherjee, 2019). Indeed, there are high rates of suicide among older adults in many countries. Within the United States, more than 7,000 persons aged 60 and above commit suicide annually (Logan, Hall, & Karch, 2011), these rates increased by 25% between 1999 and 2014 (Curtin, Warner, & Hedegaard, 2016). A study conducted in 2010 reported that one intentional death by suicide in the older adult population occurred every 1.5 hours (Carlson & Ong, 2014).

In Hong Kong, the suicide rate was around 12.3 out of 100,000 people in the year of 2021, with older adults almost double the population average, the most common methods of suicide by adults aged 65 or above were jumping from a height (54.5%), followed by hanging (33.9%), carbon monoxide poisoning (2.3%), ingestion of a drug or other substance (2.6%), and other methods (6.8%) (Centre for Suicide Research and Prevention, 2022). In 2017-2019, data were collected from 4,259 older adults in Hong Kong from a local project, 'JC JoyAge: Jockey Club Holistic Support Project for Elderly Mental Wellness', which found that older adults with visual impairment, anxiety, and loneliness were more prone to having thoughts of suicide.

Previously, community efforts in suicide prevention amongst older adults were set up in 1998 by the organisation, Suicide Prevention Services. The pilot programme targeted older adults with suicidal tendencies in the community and provided early assessment and detection screening. Following the pilot programme, community efforts such as volunteer outreach, befriending by older adult volunteers, community education and training have been implemented.

CHAPTER 1. EARLY DETECTION

Chapter 1. Early Detection

The ability to identify/detect older adults at high suicidal risk as early as possible is essential for helping professionals to design and implement suitable prevention and/or intervention efforts. For optimal reduction of suicidal risks, early detection of high-risk older adults at both centre and individual levels should be the goal.

1.1 Early detection of older adults with suicidal risk at centre level

Building centre readiness and sensitivity toward issues on suicide will always be crucial for effective detection of vulnerable individuals during daily screening, and further provision of tailored prevention programmes (e.g., manage shared risk factors like social isolation). Centres should regularly assess such readiness and sensitivity as an organization and for staff members, and thereafter develop plans for making general improvements and reducing knowledge or service gaps regarding their suicide prevention work.

1.1.1 Risk and protective factors for suicide among older adults

Tool You Can Use:

- Tool 1.1: Risk factors and protective factors for suicide among older adults

In most instances, suicidality results from an array of underlying factors rather than a single reason. To identify/detect at-risk older adults as early as possible during day-to-day work, helping professionals thus must have a thorough understanding of, and ability to recognize, the common risk and protective factors for suicide. Risk factors are characteristics of an individual or their environment that elevate the likelihood that they will die by suicide. On the other hand, protective factors are elements that reduce the chances of suicide and other related behavioural health problems. (Monk et al., 2007; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015)

Clinical Remarks

To promote awareness on mental health among older adults, it is helpful to establish a social-friendly environment to talk about mental health and related issues (e.g., adaptation to ageing and suicide prevention). Senior centres can support such community capacity building by:

- Facilitating cross-sector collaboration, including multi-disciplinary professionals, neighbours, families, peers, and older adults to develop a strategy to promote wellness in ageing
- Organizing programmes to raise mental health literacy and reduce social stigma towards mental health problems
- Highlighting the risk of depression and how it can be treated. Recovery stories shared by peers can encourage help-seeking behaviours among those in need
- Providing time and space for screening and consultations at a trusted location that is easily accessible to older adults
- Mobilizing volunteers to help identify at-risk individuals via regular concern calls or home visits
- Inviting sharing of emotional experience in every encounter by staff with older adults. Pay attention to non-verbal cues (e.g., slow speech and non-responsiveness can also tell us a lot)

1.1.2 Brief screening tools

Tool You Can Use:

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

The use of screening tools in regular service can facilitate helping professionals' timely recognition of indicators of clinical depression and suicide risks in their clients. These screening tools should be relatively brief and concise because older adults may have weaker cognitive abilities (e.g., shorter attention span) and/or lower educational levels. Individuals who are assessed to have risk should undergo full diagnostic depression assessments and/or suicidality evaluation (see Tools 1.9 and 2.2), to enable accurate diagnosis, effective intervention, and appropriate follow-up.

CLINICAL REMARKS

Example of screening for in-need older adults during a special occasion

Agency: The JC JoyAge Project Team (HKU research team & partner NGOs)

Date: February – August 2020 (the first half-year after the onset of the COVID-19 pandemic)

Target: 8,382 individuals aged 60 or older

Screening method: Telephone interview

Screening tools : PHQ-2 & GAD-2

Results:

1. One in ten older adults reported depressive or anxiety symptoms. Half reported both depressive and anxiety symptoms
2. A larger share of adults aged 60-79 reported depressive or anxiety symptoms compared to adults aged 80 and older
3. A larger share of females than males reported depressive or anxiety symptoms
4. One in five dementia carers reported depressive and anxiety symptoms, twice the rate among non-dementia carers

Implications in brief:

1. Further in-depth assessment was conducted to identify the risk of mood problems and suicide during the pandemic
2. Triage follow-up interventions were suggested according to the severity of mood problems and suicide risk
3. The need for tailor-made intervention was highlighted for special targets (i.e., female older adults and carers)
4. In view of social distancing measures during the pandemic, creative means of delivering the intervention were suggested (e.g., online talks and support groups)

1.1.3 Train up professionals and volunteers

Tools You Can Use:

- Tool 1.3: Myths and facts about suicide
- Tool 1.4: Checklist of professional competence in preventing suicide among older adults
- Tool 1.5: Sample psychoeducation materials on warning signs of suicide

Due to the multifaceted reasons described above, it is not unlikely that older adults will experience suicidal thoughts and feelings at some point, regardless of whether they are receiving social services/care. Therefore, policies should be implemented to enhance the older adult suicidal risk awareness of both helping professionals and the general public, including family members of clients and volunteers of non-government organizations. With better psychoeducation on basic knowledge of suicidal risk and its management, we can heighten recognition of at-risk individuals, improve help-seeking behaviour and accessibility of interventions, and reduce stigma. To do so, helping professionals and centre members/volunteers should first be equipped with accurate basic understanding about suicide, and be ready to fulfil their role in suicide prevention work.

1.1.4 What you can do

Taking account of the specific circumstances (e.g., clientele risk, community resources), centres should devise a range of suicide prevention policies and actions.

Tools You Can Use:

References and tools to increase professionals' and members'/volunteers' mental health awareness

- Tool 1.1: Risk factors and protective factors for suicide among older adults
- Tool 1.3: Myths and facts about suicide
- Tool 1.5: Sample psychoeducation material on warning signs of suicide

Conduct health screening on a regular basis

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

Promote overall health and mental wellness among older adults

- Tool 1.6: Tips for preventing depression and anxiety in older adults
- Tool 1.7: Promotion of health and mental wellness among older adults

1.2 Early detection of older adults with suicidal risk at client level

Helping professionals may not always be equipped with the skills to identify or manage suicidal clients, especially if they do not work in a setting dedicated to suicide prevention. This belies the reality that all helping professionals, unfortunately, have a high chance of encountering clients with suicidal risk during their normal line of work. At a minimum, helping professionals must possess a thorough understanding of standard risks factors and warning signs (i.e., more individual and imminent) for suicide, so that they can continuously monitor changes in clients' circumstances and hence gauge the need for further assessment of depression or suicidal risk.

1.2.1 Identifying client groups with higher suicidal risk

In general, helping professionals should pay greater attention to older adults with the following suicidal risk factors, and consider whether to conduct a direct suicidality assessment:-

1. Those who express suicidal ideations (for example, clients who have provided an answer of "Several days", "More than half the days" or "Nearly every day" for question 9 of the PHQ-9)
2. Those who have made previous suicide attempts
3. Those experiencing psychological illnesses or emotional turmoil
4. Those whose behaviour suggests the presence of underlying psychological issues
5. Those recently discharged from a psychiatric hospital
6. Those recently discharged from an A&E service
7. Recent significant loss or humiliating event (e.g., death in the family)
8. Recent exposure to suicide
9. Improvement in depressive mood resulting in improved strength

1.2.2 Identifying warning signs during clinical sessions

Tools You Can Use:

- Tool 1.8: Warning signs for suicide
- Tool 1.9: Clinical scales to assess common mental health issues in older adults
- Tool 2.2: Suicide risk assessment matrix

During clinical interviews or other interactions, clients may exhibit warning signs of imminent suicide risk in numerous ways (e.g., in what they say, do and/or feel). Awareness of the usual indicators are crucial for helping professionals to undertake comprehensive suicide risk assessments and devise an appropriate response.

VERBAL

- Making direct and indirect statements of wanting to die or hurt/kill themself
  - 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 inquiries about their suicidality
- Bidding farewell to friends or relatives
- Indications of a suicide plan (including time, means or after-death arrangements)

AFFECTIVE

- Experiencing unbearable psychological pain
- Extreme/acute mood changes (e.g., abrupt changes from severe depression to optimism or serenity)
- Extreme sadness/weepiness
- Fiery temper/irritability
- Detachment/indifference/numbness
- Guilt

BEHAVIOURAL

- Exploring means to hurt or kill themself (e.g., surveying a potential jumping site)
- Self-neglect
- Taking reckless actions or carrying themself in an anxious or disturbed manner
- Withdrawing/isolating from friends, family and society (e.g., lacking interest in household or social tasks)
- 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 in daily activities

COGNITIVE

- Self-blame or self-defeating
- Lack of purpose in life
- Few reasons to continue living
- Low self-esteem/self-worth
- Feelings of hopelessness, helplessness or incompetence
- Impaired memory
- Poor concentration
- Inability to think clearly

Clients who exhibit significant warning signs (in either frequency or severity) will need direct risk assessment on their suicidality. In any event, besides clinical observation during sessions, a clinician may use standardized tools to quickly assess whether the client is likely to have certain mental health issues that commonly affect older adults.

CLINICAL REMARKS

Case example:

Madam Lee, aged 64, single and with no child, used to visit the elderly centre once or twice a month to take part in recreational activities. She has a very good friend who she knew in an orphanage since childhood who recently informed her that she had received a cancer diagnosis that would take the friend's life soon. Her friend told Madam Lee she had been fighting the cancer for a year and struggled to disclose the news to her until recently. Madam Lee suddenly feels extremely sad. She loses interest in visiting the centre, and also has difficulty eating and sleeping with her body weight dropping remarkably in the past two weeks. Madam Lee cannot control her thoughts about the dying process of her friend, and having thoughts that her friend may leave her one day, she wants to end her own life.

As Madam Lee is one of your programme participants, you phone her to ascertain the reason why she has not attended recently. She tells you about her friend and her reaction to her friend's news. Madam Lee adds that she does not even dare to visit her friend. Madam Lee feels ambivalent about what to do, though she dislikes her current situation.

Questions for you:

1. What emotional problems do you think Madam Lee is experiencing? What are the significant signs?
2. Do you think Madam Lee is at risk of suicide? Why or why not?
3. What clinical assessment do you think is necessary for Madam Lee? Is there any other information that is crucial for you in deciding whether Madam Lee is at risk of suicide?
4. How would you prepare to engage Madam Lee in further individual-based support?

1.2.3 How you can provide support

Tools You Can Use:

- Tool 1.8: Warning signs of suicide
- Tool 1.9: Clinical scales to assess common mental health issues in older adults
- Tool 1.10: Dos and don'ts when you are meeting an older adult with suicide risk
- Tool 1.11: General tips on how to engage with a client
- Tool 2.1: Safety plan

CLINICAL REMARKS

Some barriers which may stop older adults from disclosing suicidal thoughts:

- taboo of suicide held by the individual/in our culture
- lack of rapport or feelings of safety
- presence of a family member or friend who is not ready to show understanding
- worker's non-empathetic attitude or efforts to avoid such topics and minimize client's warning signs

Good engagement with the client is crucial for risk assessment, including:

- acknowledging the client's difficulties and struggles
- normalizing negative emotions
- having an empathetic attitude towards the client's efforts
- being non-judgmental and open minded to the client's motives behind the suicidal ideation and behaviours

CHAPTER 2. INTERVENTION

Chapter 2. Intervention

2.1 Conceptualization of suicidality and general principles of intervention

Understanding the theories of suicide could help clinicians to assess and manage an individual's suicidal behaviour.

Model of conceptualizing suicidal behaviours (Shneidman, 1996)

Suicidality is a symptom of underlying distress and is the result of a combination of factors that cause psychological pain, including underlying mental and physical illness. To understand the complexity of suicidal behaviour, Shneidman offers a simple framework organized around three main questions to assess risk and work with suicidal individual, which form the crux of suicide assessment and treatment efforts:

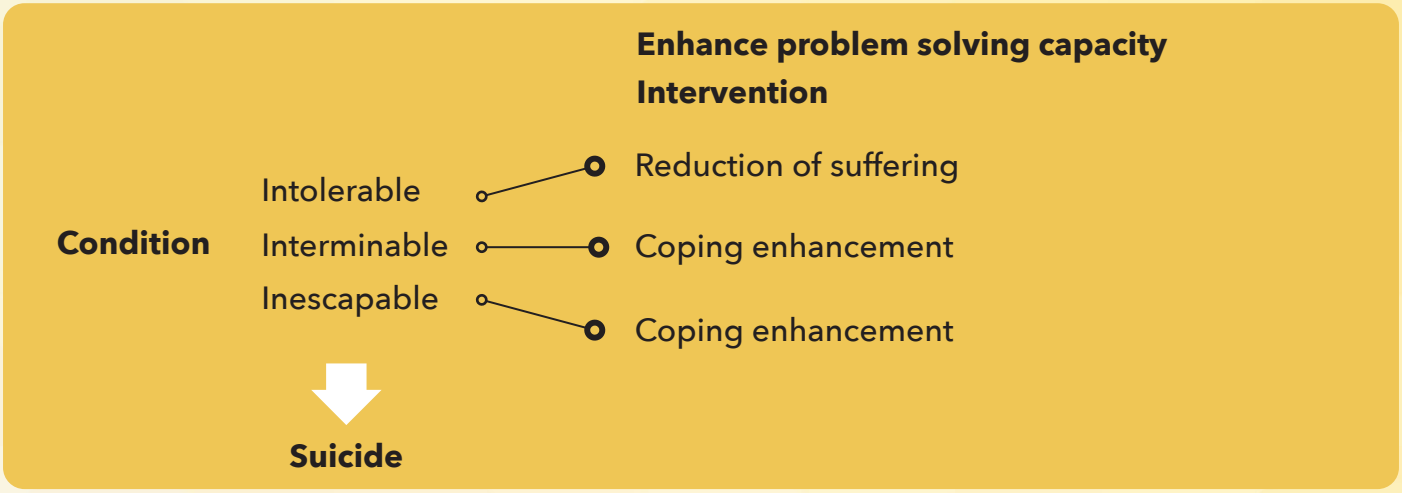
1. What factors are contributing to and maintaining the client's psychological distress?
2. How is the client coping with this distress (distress tolerance)?
3. What can be done (e.g., tangible, physical or psychological) to reduce the client's psychological distress in the short term and develop improved tolerance for this distress in the long term?

The three cognitive conditions (***"The Three I's"***) that contribute to an individual considering resorting to suicide as a coping behaviour (Chiles and Strosahl, 1995) are:

- Physical or emotional pain that is experienced as "Intolerable"
- A life situation perceived as "Interminable"
- A life situation that is perceived as "Inescapable", such that no coping action already tried or conceived will make a significant difference.

Problem-Solving Model of Suicidal Behaviour

(Centre for Applied Research in Mental Health & Addiction, 2007)



In this problem-solving conceptualization of suicidality, intervention focuses on reducing the client's distress, and at the same time helping to increase the client's capacity to cope with difficulties from emotional, cognitive and behavioural perspectives.

Chapter 2. Intervention

A comprehensive approach to managing suicidality includes the following three stages (Bilsker & Forster, 2003):

1. Stabilization and safety of the client. In cases of high imminent risk, stabilization may take the form of inpatient hospitalization
2. Assessment of temporal and distal risk/protective factors
3. Ongoing management of contributing factors and active problem-solving, including treatment of underlying mental illness and problem-solving focused on increasing coping ability.

Tools You Can Use:

- Tool 1.1: Risk factors and protective factors for suicide among older adults
- Tool 2.1: Safety plan
- Tool 2.2: Suicide risk assessment matrix

2.2 Determine the level of suicidal risk in a session

Tools You Can Use:

- Tool 1.8: Warning signs for suicide
- Tool 2.2: Suicide risk assessment matrix

2.2.1 Questions to ask

Generally, an individual exhibits a higher risk of suicide when they are subject to more risk factors or less protective factors. Nonetheless, the expression of suicidality might not always correspond to levels of suicide ideation (i.e., at-risk individuals might hide their strong intent or plans to die by suicide). When determining the level of suicidal risk, helping professionals must keep an open and cooperative attitude while making a comprehensive investigation of the client's situation. Below are several general tips and sample questions (on suicidal ideation/intention/planning) to enhance the accuracy of such risk assessment.

General tips

Be sure to...

- build a clear understanding of the client's suicidal ideation (e.g., severity, time span, and content)
- tease out the details of the client's suicide plans (e.g., time, place, and method)
- gauge the client's availability of and access to means (e.g., purchase of charcoal)
- check for any preparatory actions (e.g., disposal of valued possessions or drafting a will)

GENERAL TIPS

Try to...

- directly inquire about the client's suicidality (this can be incorporated as part of routine tasks in a session)
- utilize questions that elicit concrete description of facts/thoughts/behaviour rather than simple opinions (e.g., "What precisely happened when you had a mental breakdown?")
- recognize the client's potential reluctance to talk about matters related to their suicidal risk, and accordingly fine-tune the approach in interviewing
  - sincere presumption of the client's existing thoughts/behaviour (e.g., "What suicidal methods have you contemplated?" and not "Have you thought about how to kill yourself?")
  - afford the client the opportunity to deny specific questions (e.g., "Have you ever thought of jumping off a bridge?" and not "I know you want to jump off a bridge.")

SAMPLE QUESTIONS

(Centre for Applied Research in Mental Health & Addiction, 2007)

(A) Thoughts of dying by suicide

- Existence (e.g., "Have you ever or recently had thoughts of harming or killing yourself?"; "Do you sometimes wish to die?")
- Frequency (e.g., "How frequently do you have thoughts regarding suicide?")
- Duration (e.g., "How persistent is this suicidal ideation?")
- Intensity (e.g., "How strong or unbearable is this suicidal ideation?")
- Reasons to live or die (e.g., "What are your reasons for wanting to die?". Alternatively, "What are the motivations for you to keep on living?")

(B) Intent to die by suicide

- Existence (e.g., "Have you ever or recently had the intention of acting out such ideation?")
- Intensity (e.g., "How severe are your suicidal intentions?")

(C) Plans to die by suicide

- Existence (e.g., "Have you come up with a plan to commit suicide?")
- Details (e.g., "What have you specified in your plan? For instance - when, where and how?")
- Feasibility (e.g., "Do you have the means to carry out such a plan?")
- Degree of control (e.g., "What is the extent of your control over your situation or specifically your suicide plan?")

2.2.2. Understand the personal meaning of suicide for the individual

Beyond evaluating a client's risk and protective factors, helping professionals should try to ascertain their personal meaning for any suicidal ideation or behaviour. By inquiring about the client's relevant context during risk assessment, helping professionals can better pinpoint their specific motivations and thereafter devise a tailored risk management response. Common motifs of suicidality encompass loss, notions of control/power, atonement, escape and retribution.

(A) Loss

- response to anticipated or sudden personal loss (e.g., relationship, health)

(B) Notions of control/power

- belief that suicide affords one power over themself

(C) Atonement

- belief that one is the root of others' issues/difficulties
- belief that death can provide a solution to one's misdeeds

(D) Escape

- desire to stop intolerable suffering
- belief that one can reunite with loved ones after death

(E) Retribution

- belief that significant others will be negatively impacted by death

2.2.3. Identify level of suicide risk

Tool You Can Use:

- Tool 2.2: Suicide risk assessment matrix

Owing to the complexity of suicidality assessment, helping professionals can reference the matrix below for an easier grasp on how to categorize the risk level of a client (Centre for Applied Research in Mental Health & Addiction, 2007). In general, the exercise involves a comprehensive evaluation of the client's risk factors, protective factors and suicidal ideation or behaviour. Ultimately, the matrix provides guidance only and does not set out any mandatory steps/conditions to be fulfilled - helping professionals will need to rely on solid knowledge, experience and clinical judgment to determine the client's risk for suicide (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., extent, 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 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.
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 continued living as pointless.
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)		

2.3 Intervention and management in responding to the level of suicidal risk

2.3.1 Recommend level of care to match the level of risk identified

Tools You Can Use:

- Tool 2.1: Safety plan
- Tool 2.2: Suicide risk assessment matrix
- Tool 2.3: Risk management diagram
- Tool 2.4: Client's need for hospitalization checklist

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

2.3.2 Voluntary and involuntary hospitalization

Tool You Can Use:

- Tool 2.4: Client's need for hospitalization checklist

When should hospitalization be considered?

In general, when a client with suicidality is assessed with any of these conditions, hospitalization will have to be considered (Centre for Applied Research in Mental Health & Addiction, 2007):

(A) Overall/general condition

- 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 for treatment of a severe underlying psychiatric issue (e.g., psychosis or major depression)

(B) Specific condition

- the client suffers from unbearable psychosis, dearth of social backing, and threatens to attempt suicide
- the client is resolute in posing a danger to themself or others
- the client is receiving psychotropic treatment which demands thorough monitoring and has a record of previous severe overdose
- the client has high levels/debilitating depression or anxiety, and does not respond to outpatient intervention
- the client experiences an overpowering crisis and fails to deal with the situation without the possibility of grave harm to themself, and a lack of secure surroundings (i.e., possibility of suicide overrides disadvantages of hospitalization)

When should involuntary admission be considered?

According to involuntary admission under the Mental Health Ordinance (Cap. 136):

- with the consent of the client
- if a client is demonstrating thoughts or behaviour that gravely endanger their own life or others, they may be subject to involuntary admission even though the consent cannot be readily obtained
- the client's safety cannot be ensured in the current environment
- the client is suspected of having or already known to have a mental disorder that significantly diminishes their ability to react suitably to their surroundings or to interact with others

Involvement of family and other parties (Centre for Applied Research in Mental Health & Addiction, 2007)

- as long as family members are engaged, their participation in the decision-making process should be encouraged. Psychoeducation on risk management and treatment consequences can be helpful to facilitate their participation
- collaboration with the police or Community Nursing Service, if appropriate, is important in handling a crisis situation

2.3.3 Utilize brief problem-solving approaches to manage suicidal ideation

Suicidal ideation is a symptom of different underlying problems. These problems cover a suicidal individual's mood state, perceptions, and attitudes on how to deal with a current adverse life situation. To uncover the underlying problems, clinicians must make additional effort to establish a sense of security and trust with an at-risk individual. Direct confrontation with suicidal thoughts should be avoided, for example, by telling the person that their religion does not allow them to end their life. Such responses may discourage the client from further disclosing the psychological processes behind their suicidal thoughts or certain complicated moods like isolation and guilt. Hence, it is essential to talk more about the client's subjective experience and address the problems with which they have been struggling. Taking into account a list of ten prevalent commonalities of suicidal ideation, helping professionals can adopt corresponding problem-solving approaches to manage a specific individual at risk (Monk et al., 2007; Shneidman, 1996)

	Prevalent Commonalities of Suicidal Ideation	Problem-solving Approach
1	**The objective of suicide is to solve a problem**	• Look into why the client regards suicide as a way out • Ascertain alternatives that could amount to a way out for the client
2	**The aim of suicide is a discontinuation from consciousness**	• Enhance the client's awareness regarding the implications of suicide • Assist the client in weighing other options to suicide that could achieve their desired results
3	**The impetus for suicide is unbearable psychological distress**	• Acknowledge and validate the client's suffering • Assist the client in recognizing options that may reduce their suffering, including less desirable or functional options (e.g., drinking alcohol) • Strengthen the client's understanding that little changes can lead to a significant difference

	Prevalent Commonalities of Suicidal Ideation	Problem-solving Approach
4	**The origins of stress for suicide are unmet psychological wants**	• Look into the significance of frustrated wants for the client • Transfer the focal point from a current problematic status to a future target scenario (e.g., utilize 'miracle questions')
5	**The feelings accompanying suicide are helplessness and hopelessness**	• Find alternatives to such emotions • Investigate the level of capacity which a client has to act with less suicidality • Utilize presumptive language that expresses implied beliefs of engagement, competence and hope
6	**The thought accompanying suicide is indecision**	• Acknowledge and encourage the client's will to live without invalidating their suffering • Ascertain the client's motives to continue living (e.g., significant others)
7	**The mindset underlying suicide is constriction**	• Find opportunities to disrupt cognitive restrictions by shifting the focus from failure and catastrophe to contemplation of successes, abilities and resources
8	**The social behaviour related to suicide is disclosure of intention**	• Explain that disclosure of intention does not always occur, and such disclosure will sometimes be expressed in a way that won't be understood by the listener • Inquire about the client's suicidal intention whilst bearing in mind that they are a comprehensive individual with healthy traits, psychiatric indicators and suicidal plans
9	**The response to suicide is avoidance**	• Acknowledge the client's motivation to escape from a distressful scenario and look for options and aims that are preferable to suicide • Set targets for intervention together with the client
10	**Where the pattern underlying suicide is uniformity of long-lasting coping practices**	• Look for evidence of the client's abilities to cope (even within crisis scenarios) • Presume that that client can grow from and build on personal successes (even amongst suffering, dread and indifference)

2.3.4 Document, evaluate and regularly monitor suicidality

Bearing in mind the inherent volatility of a client's suicidal risk, helping professionals should regularly check, assess, and record their past and current overall situation. More specifically, beyond taking stock of aggravating indicators (e.g., recent significant personal loss) and mitigating factors (e.g., restricted access to lethal means), helping professionals will need to keep track of enduring risks (e.g., previously expressed suicidal ideations and plans) and register the measures adopted for the client until they no longer exhibit a clinically significant suicide risk.

Clients typically face a greater suicide risk during the initial months after medical discharge. In fact, individuals who have previously tried to commit suicide have suicidal risks up to 100 times greater than the average person (Chung et al., 2017). Given the tightknit connections between the medical, mental and community health systems, helping professionals will need to devise measures that can readily identify and engage potential suicide attempters for early intervention when they come into contact with any of these systems (e.g., when they use hospital services).

Helping professionals will need to fully utilize suicide prevention resources within the community to effectively sustain clients' mental wellness and manage their suicidal risk (e.g., Samaritans, ICCMW, Community Nursing Service, and crisis hotlines). Many institutions maintain round-the-clock suicide intervention efforts, and provide prompt support to individuals who are undergoing pressing mental health issues.

Besides dealing with the immediate suicide crisis of a client, helping professionals may also need to devise and offer longer-term tailored responses to manage the origins of their suicidality. This will usually involve a comprehensive assessment of possible risks and protective factors, and how they might influence one another. As an illustration, a person admitted to a treatment facility for physical or mental problems might nonetheless be masking significant relationship issues at home, indicating that measures aimed at promoting general coping ability in a stressful home setting will be more suitable for lowering their overall suicide risk.

CLINICAL REMARKS

Refer to the case example, Madam Lee:

Your supervisor and you agreed to meet Madam Lee promptly for further assessment. During a home visit, Madam Lee appeared with low mood and mild health problems. She explained, having known that her friend might die soon, she experienced low energy and was unmotivated to perform her usual daily activities. Her mind was overwhelmed by her friend's news. Madam Lee shared that, over the past week, she had once thought to end her life by taking an overdose of medication when she lost her friend. She was certain she did not intend to kill herself at present. Without other physical causes, Madam Lee understands and agrees that she might be suffering from depression. As you highlighted your concerns about her safety, Madam Lee agreed to undergo further assessment and receive individual-based support.

Important remarks for Madam Lee's clinician:

- Suicide risk assessment is crucial even though Madam Lee claimed that she currently had no intention to kill herself. This is particularly important for clients experiencing mental health or mood problems.
- With well-established rapport, the clinician is encouraged to inquire about the personal meaning of suicide for Madam Lee. Some common reasons expressed by older adults include a way to reduce the burden on their family, end physical pain, end grief, and/or take back control. Talking about personal meaning helps helping professionals better understand the psychological pain behind suicide and thereafter address the underlying causes. In Madam Lee's case, both depression and unexpected loss should first be handled.
- Do not leave the client without a safety plan. Even a cue card with encouraging messages can save a life. Both formal and informal social support (e.g., family, friends, or neighbours) can be considered.
- Problem solving skills training can help reduce the risk of suicide. It can be useful for a helping professional to support Madam Lee to deal with her difficulties in restoring good communication with her dear friend.
- Assessment of the client's mental health status (including the nature and severity of depression, suicidality, changes in daily life function and underlying causes) should be well documented.
- Teamwork is necessary for helping professionals to handle at-risk clients.

2.4 Parties to work together (e.g., family, medical sector, professional team)

2.4.1 Family involvement

Tools You Can Use:

- Tool 1.5: Sample psychoeducation materials on warning signs of suicide
- Tool 2.5: Basics about involvement of the client's family
- Tool 2.6: Checklist for professionals to support client's family in suicide prevention efforts

With regards to an individual's suicidal thoughts and/or behaviour, family members commonly react in the following manner (Centre for Applied Research in Mental Health & Addiction, 2007):

- Becoming shocked and incredulous
- Being overcome by distress and/or emotions of anguish and defeat
- Believing that their 'presumed world' has been destroyed, especially when the client's suicidality was the a significant warning sign that something was amiss within the family
  - similar to treating other traumas, helping professionals will need to afford family members appropriate time, information and empathy to deal with their responses
- Feelings of helplessness, even where the client's suicidality had been recurrent
- Self-perceptions of being irresponsible or guilty especially if the family member is a primary caregiver
- Self-perceptions of being blamed by the client or other parties (e.g., relatives, acquaintances or even helping professionals)
- Resentment and anger towards client for their 'selfishness' in contemplating suicide
  - potentially accentuated by anticipatory grief, stemming from apprehensions that the client will ultimately kill themself, 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
- Exhibition of apathy, fatigue, and helplessness, especially if the client had a relatively enduring suicidal history
- Present signs of compassion fatigue, which may be accentuated by actual/perceived inadequate support from relevant institutions and others

CLINICAL REMARKS

Helping professionals will have to provide family members with non-critical and compassionate assistance, notwithstanding their specific reactions. Possible options include offering psychoeducation on suicidality, mood disorders and substance abuse problems, and even utilizing therapy to enhance overall functioning within the family. Cohabitating with a suicidal individual will typically be demanding and stressful - family members may constantly feel on edge and fearful. Subsisting in a high-pressure environment with little sense of control, family members face a heightened chance of developing mental wellness challenges and impediments to their daily functioning (e.g., competently dealing with familial, social, or professional matters).

As helping professionals should always strive to support family-oriented clients, building and maintaining a positive connection with family members becomes crucial. Family members can not only provide supervision and updates on the client' actions and status, they can further lend a hand in ensuring the client's adherence to their established intervention or safety measures (e.g., helping to implement specific measures that aim to minimize suicidal risk).

Literature suggests that family support lowers suicidality through easing the burden of clients on the household and wider social units. Many older adults with greater suicidality face considerable social alienation as there are few people to back them up in real life, or instead have a negatively twisted view of his/her amount of support (e.g., cognition negatively impacted by mood disorder or other psychological issues). In addition, clients may feel further isolated due to battling other challenges (e.g., physical ailments, financial strain, and substance abuse). Helping professionals may encounter significant challenges when facilitating family assistance towards depressed clients, as family members and close acquaintances may not readily offer their love and care or may even be driven away by frustrations regarding the client and their problems.

2.4.2 Team support and other considerations

In order to achieve the best standards of care for clients and maintain optimal clinical practice, helping professionals should deliberate and consult with colleagues and supervisors on matters related to suicide prevention (e.g., routine and official client reviews), and regularly allocate time for reviewing on-the-job decision-making and client management work. Maintaining regular communication with fellow practitioners and supervisors can help towards reducing stress and feelings of powerlessness that not uncommonly arise from managing clients with suicidal risks. A variety of questions is listed below for consideration by helping professionals to aid work self-assessment: when managing suicidal clients

Examples of Reflective Questions for Thinking about Clinical Work with Suicidal Individuals (Centre for Applied Research in Mental Health & Addiction, 2007):

Questions about the nature of the client's suicide risk:

- How will I be able to enhance their safety?
- Do they require hospitalization?
- What purpose or function lies behind their suicidality?
- What other methods could enable them to achieve such purpose or function?
- Can a pattern regarding their suicidality be established? If so, what can positively disrupt such pattern (e.g., tighter supervision; teaching novel skills)?
- What new techniques are perceived by the client as helpful in managing their suicidal behaviours, thoughts and feelings? (e.g., 'capacity to de-escalate the situation when feeling mad'; 'learning how to go out and enjoy leisure activities without feeling down on oneself')

Questions about response and treatment

- Who can I call or inform at the current moment?
- What does the client think will benefit them? If their answer is only suicide, what can I do to reduce such risk? In other words, how may I assist the client to acquire what they desire by utilizing methods other than suicide?
- What measures can effectively reduce the client's distress? In what way can I facilitate such measures? Can I adopt certain measures directly or indirectly?

Questions about team support

- Who will debrief the client with me?
- Who can be added to the professional team to help the client?
- Is there anyone else who the client believes may be able to help them?
- When I am pre-occupied, what other support will be available for the client? What can I do to enable such other support to be readily accessible and usable?

Questions for self-reflection after discharge of the client

- Would I have made the same decisions? What alternative/additional options should I have considered or adopted?
- Did I comprehensively take into account the client's resources, fortitudes and weaknesses?
- How was support within the community deployed?
- How did the helping team realize the tenets of evidence-based practice?
- What were the client's reasons to continue living?

CHAPTER 3. POSTVENTION

Chapter 3. Postvention

3.1 What is postvention and why is it important?

Postvention refers to a range of activities responding to a suicide death that are aimed to support those (suicide survivor) who are directly affected by the suicide in a timely and appropriate manner. This is also to prevent suicide contagion.

The goals of postvention

Postvention aims to reduce distress for suicide survivors. It also aims to educate the community about warning signs of suicide, and raise their awareness of how to seek help. Hence postvention lies on the continuum of suicide prevention activities.

Facts about suicide survivors (adopted from SANE Australia, 2016)

- Suicide survivors face a more severe risk of committing suicide
- Suicide survivors with existing psychological conditions have enhanced susceptibility and hence require further support
- Suicide survivors can undergo enduring and complicated grief responses

Postvention is designed to help families and communities achieve the following goals:

- Help affected individuals recover and reduce their distress
- Identify the at-risk individuals and provide extra support to reduce the chance of copycat suicide attempts
- Equip individuals and organisations to react promptly
- Provide psychoeducation materials and messages to prevent suicide in the community

This chapter will first discuss strategies and clinical skills to support individuals affected by the suicide. For community-wide response and planning, please refer to Section 3.3.3.

3.2 Supporting suicide survivors – targets of postvention

It can be a traumatic event if a suicide happens to someone you know closely. The community can be affected hugely as well (see Figure 1). This is especially true in communities where social networks are tight and 'everyone knows everyone'. Those who are most attached to the deceased require more intensive support. However, it is important to note that each individual's grief response to the suicide death may be different. Therefore, postvention efforts may require regular and appropriate assessment and monitoring.

Chapter 3. Postvention

When you are planning for postvention, consider who may be affected by the suicide and interventions can be targeted accordingly. Consider the range of individuals who may be affected by suicide: those who have lost a family member, a friend, a neighbour, or a service user in the community. In addition, consider the developmental needs of impacted individuals in different life stages: e.g., children and adolescents losing a parent, older adults losing their children.

Support for helping professionals (e.g., social workers, support workers) who have been involved with prior service provision for the deceased need to be in place, as there is established research evidence to show that suicide has an emotional impact on frontline professionals. This will be covered in detail in Chapter 4.

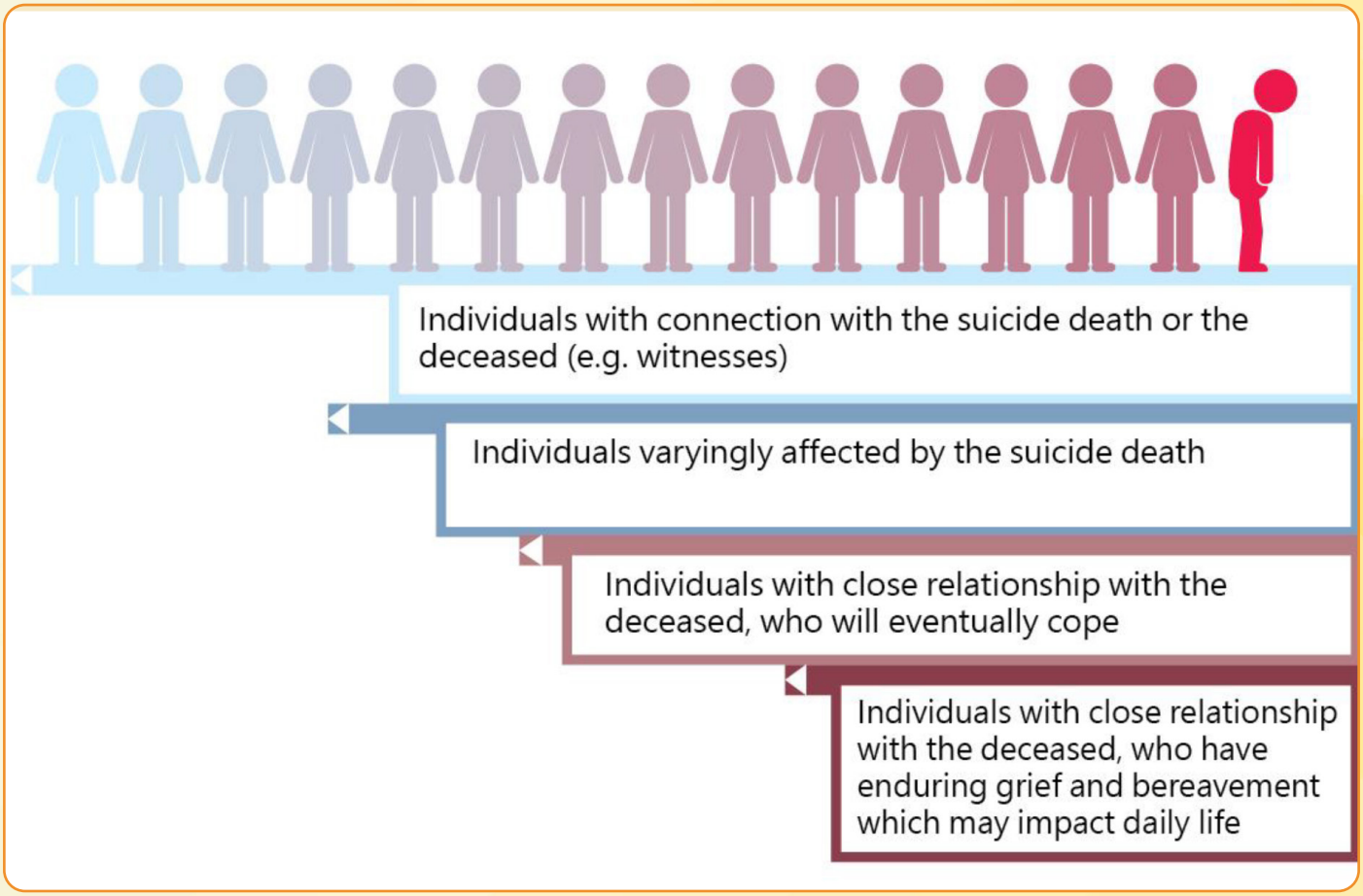


Figure 3.1 — Continuum Model: Effects of Suicide Exposure
(Cerel et al., 2014)

Figure 3.2 may facilitate your decision regarding the level of intervention needed in your community following a suicide (Irish Childhood Bereavement Network, 2017)

LEVEL 1: Universal Preventive Strategy
It is recommended 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-based and Group-based
Groups focusing on grief and bereavement can be provided on a regular basis in the community to support older adults manage death due to causes other than suicide (e.g., sickness). If a member known in the community has committed suicide, when appropriate, a remembrance event can be organized.

LEVEL 3: Individual-based or Bereavement Group
If individuals are displaying depressive symptoms in response to the suicide, consider offering one-to-one support therapy and psychoeducation regardless of their relationship with the deceased. Consider conducting a risk assessment to explore the impact of another individual's suicide on their mood and risk level.

LEVEL 4: Intensive Psychotherapy
If certain individuals are experiencing more severe symptoms (See Section 3.2.3), and the symptoms affect their daily life functioning, more in-depth and frequent emotional support is required. Conduct a risk assessment and also consider referring to specialised mental health professionals.

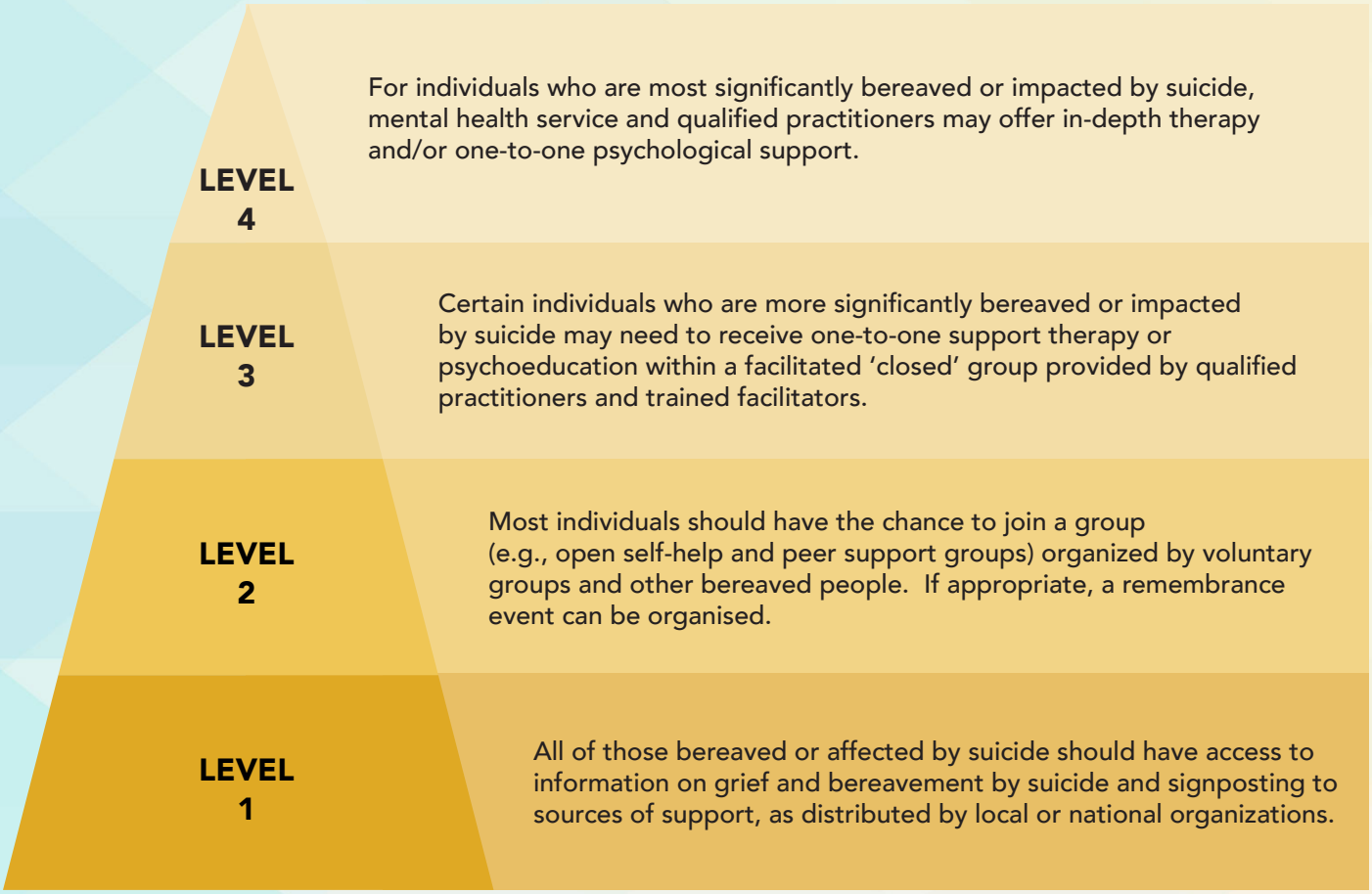


Figure 3.2: Bereavement support triangle

3.2.1 Grief psychoeducation

Grief is an emotional response resulting from loss and bereavement. Losing someone significant evokes grief and emotional pain. The grieving process is more complex, which can be particularly traumatic after a suicide death. This process can be different from grieving other losses. The following can complicate the grieving process:

- Personal or religious beliefs about suicide can affect how an individual respond to the suicide death.
- Certain stigmas are associated with a suicide death. Some people may label those who commit suicide as 'weak', 'selfish', 'cowardly', or 'crazy'.
- It can be more stressful as you may be involved in police investigation regarding the suicide death.
- We may never understand what are the true reasons that led to the suicide.
- The suicide note or message is left for open interpretation which can be stressful.

People react differently to losses. The following tables outline some common and normal reactions people may face after losing someone to suicide. Generally speaking, these reactions to bereavement go through three stages. Please remember that the grief reactions of each individual will be different, and therefore no relevant assumptions should be made (e.g., he/she should have [certain] feelings).

The process of grieving

Stage of normal bereavement	Possible reactions	Possible underlying reasons	Potential area to support suicide survivors
Acclimatization and Adjustment	Shock, numbness, denial, reduced functioning, confusion, memory lapses, being unable to focus	Overwhelming emotions, ruminating about the scene of the suicide incident, questioning 'why' where there is a reason to explain the suicidal death	Finding positive coping skills such as exercise, good diet, writing a journal, gardening, nature walking
Emotional Immersion and Deconstruction	Sadness, guilt, self-blame, anger, anxiety, shame, loneliness, helplessness, and longing	Struggling to accept the loss of relatives, feeling oneself as a victim, believing that they should have been able to save their loved ones, assigning responsibility to a single event/circumstance or person to explain the suicide death, viewing the suicide death as a form of abandonment/rejection, experiencing stigma attached to suicide, fearing uncertainty and changes lying ahead	Contending with reality, development of insight (e.g., reasons contributing to suicide cannot be attributed to one single event), reconstructing personal values and beliefs, embracing acceptance and letting go, exploring the beliefs about suicide and stigma that may contribute to the sense of shame, addressing any practical needs
Reclamation and Reconciliation	Acceptance, relief	Accepting the death of the deceased, feeling if the deceased has been struggling with illness or behaviours for a long time, being able to move on	Guiding to restore and rebuild life, re-engaging with the world around them, encouraging development of social relationships, consolidating decisions about changes in lifestyle

Reference: Temes, 1992

Emotional symptoms of grief

Possible emotional reactions	Possible underlying reasons	Potential area to support the person experiencing such emotions
Profound sadness	• Normal reaction to loss 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 following suicide, the 'killer' and the deceased are the same person. This may cause a very conflicting and confusing set of emotions for survivors that 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 they are 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 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 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 any other traumatic event such as natural disaster or accidental death.	• Acknowledge the shock and facilitate expression of the feeling. • Ask how the person found out about the suicide death.
Guilt and blame	• The impact associated with suicide can be overwhelming; it is described as similar to any other traumatic event such as natural disaster or accidental death. • Some survivors may believe that a single event preceding the suicide have triggered or caused the suicide (e.g., "we had a fight", "I left her alone"). • Assigning responsibility to a single event, circumstance or person 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 choose to commit suicide, but do know that you are not responsible for their death".

... Continued on next page

Possible emotional reactions	Possible underlying reasons	Potential area to support the person experiencing such emotions
Shame	• Feelings of shame can be accompanied by feelings of guilt and self-blame. • Shame is also related to the stigma attached to suicide	• Acknowledge the feelings of shame. • Explore the beliefs about suicide and stigma that may contribute to the sense of shame.
Abandonment and rejection	• Suicide can be seen as a powerful form of abandonment/rejection; from the survivor's perspective, the deceased 'chose' death over a continuous relationship with the survivor. They may also feel that the deceased rejected the help survivors might have offered.	• Acknowledge and validate the feelings of rejection. • Explore possible feelings of isolation and loneliness.
Confusion or disbelief	• Questioning 'why' their loved one chose to commit suicide is central to the experience of many suicide survivors; the absence of an answer can be a heavy burden for the bereaved.	• Acknowledge this feeling and understand the process of searching for an answer or a reason behind suicide will enable the person to overcome these feelings, even though there is unlikely an answer.

Other symptoms of grief (Worden, 1991)

Cognitive reactions

- Loss of concentration and inability to focus
- Preoccupation with thoughts or memories
- Questioning what you or others did or did not do
- Preoccupation with investigation of the suicide death
  - ◆ It is not unusual for suicide survivors to feel compelled to conduct their own 'inquest' into the death – possibly preoccupied with thoughts about why, when, where and how their loved one died
  - ◆ Finding answers, is commonly a difficult but necessary part of the journey for the person bereaved by suicide

Behavioural reactions

- Disturbances in sleep, appetite
- Absent-minded behaviours
- Social withdrawal
- Dreams of the deceased
- Avoiding reminders of the deceased
- Crying
- Restlessness and over-activity
- Visiting places or carrying objects that remind the bereaved of the deceased

CLINICAL REMARKS

Grief is a natural process. It allows a person to make sense of the reality without a loved one. For many clients, grief will resolve itself with the passage of time, although there is no typical timeframe for grieving. Sometimes grief can become complicated, such as when the pain of the loss is so constant that it keeps you away from your life routine (for details, please refer to Section 3.2.3). Grief therapy is then warranted.

Theories around grief process

It is important that helping professionals have a good knowledge and understanding of the processes and stages involved in grief to enable them to support bereaved individuals. In this guide, we have summarized some common theories of grief as below:

- 5 stages of grief (Kübler-Ross Kübler-Rosset al., 1972)
  - Generally speaking, the Kübler-Ross model posits that individuals faced with a significant loss, such as the suicide of a loved one, will go through five stages of grief which typically involve: (i) denial, (ii) anger, (iii) bargaining, (iv) depression, and (v) acceptance
  - It is noteworthy that grieving will always be a deeply personal and unique experience, and the five stages of grief described will not always occur in their entirety or in any predictable linear order
  - Helping professionals must strive to not place undue expectations on their clients' grieving process following suicide, and instead continue to provide any support necessary to enable them to achieve effective coping

- Tasks of mourning (Worden, 1991)
  - Worden sets out four tasks that mourning individuals need to achieve before equilibrium can be re-established: (i) to accept the reality of the loss, (ii) to work through the pain of grief, (iii) to adjust to an environment in which the deceased is missing, and (iv) to find an enduring connection with the deceased while embarking on a new life
  - The importance of these tasks lies in the individual's search for a suitable and lasting connection with the deceased while continuing to live a functional life; what this process entails for one person may differ from others and will fluctuate over time – grief does not fit into neat boxes

- Dual process model (Strobe & Schut, 2010)
  - According to Strobe and Schutt's dual process model of coping, individuals usually cope with bereavement through an oscillating mixture of: (i) loss-oriented grief, and (ii) restoration-oriented grief; those who can face and recognize the loss and its consequences (e.g., thoughts or emotions regarding the deceased), and further confront or focus on post-loss daily realities and struggles will eventually be able to effectively cope and attain stability in their life
  - The takeaway is that all humans will continue to encounter negative and stressful life events while grieving, and they must be aware and ready to deal with such occurrences together in order to recover stability
- Attachment theory (Bowlby, 1969)
  - According to attachment theory, the degree of proximity with the deceased may indicate the level of distress in the absence of an attachment figure. For example, an unhealthy attachment pattern may indicate certain complicated grief reactions.

3.2.2 What you can do

Based on the different theories around loss and bereavement, this section outlines some suggestions as to what helping professionals can do to support suicide survivors.

3.2.2.1 Practical support

Tools You Can Use:

- Tool 3.1: Determine who may be affected by the suicide – The continuum model on effects of suicide exposure
- Tool 3.3: Guide for social workers – how to support the bereaved individual (suicide survivor)

Suicide survivors need to handle different tasks relating to the death itself, as well as tasks required to deal with the necessities of daily life. Practical tasks relating to the death can include handling the personal items of the deceased, notifying family and friends, making funeral arrangements, dealing with details related to official (e.g., police) investigations, managing financial costs arising from the death etc. Additional support may be required to support the needs of children and adolescents.

Making initial contact

- Contact to be made within 48 hours if referred by the police (with consent)
- The initial contact can be made by a trained co-ordinator

In the first contact, the co-ordinator can consider the following:

- Explain the services available, offer condolences
- 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
- Information about support options should be offered

Methods of delivery and support

- Phone call of acknowledgement and support
- Meeting between the family and the service
- Follow up phone calls/meetings over the next few months
- Sharing leaflets about support and resources in the community

CLINICAL REMARKS

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 funeral, dealing with the practicalities etc. Continued and regular contact with survivors and leaving them with a leaflet that contains psychoeducation information and where to seek help if needed will be helpful.

(SANE AUSTRALIA, 2016)

3.2.2.2 Individual sessions

Providing one-to-one counselling to individuals suffering the pain and grief from suicide loss can be emotionally draining for frontline professionals. Be sure your staff have appropriate self-care strategies in place (see more details in Chapter 4). The goal of individual sessions with the suicide survivor is to facilitate the grieving process. The following suggestions are based on the theories around loss outlined in earlier sections.

Tool You Can Use:

- Tool 3.1: Determine who may be affected by the suicide – The continuum model on effects of suicide exposure (Worden, 1991)

a. To accept the reality and recognise the loss

- Acknowledge the death: verbal acknowledgement and behavioural rituals
- Walk alongside the survivor in seeking answers to the question 'Why?'
  - o A suicide can bring about questioning and searching for an answer to "Why would this person end their own life?"
  - o Let survivors know that suicide involves complex factors and is not the result of a single event
  - o Point out that those who die are usually seeking to end unbearable psychological pain that may have been apparent or hidden and not shared. A point was reached where the pain was greater than the person's resources to tolerate it or to see alternative solutions
  - o Be prepared that some questions as to 'why?' may remain unanswered

b. Experience the pain and react to the loss

- Walk alongside the survivor and be an empathic listener
- Support the 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.
- Encourage the survivor to narrate their story of the loss, the events leading up to it, and subsequent events. The purpose of this is to help individuals organize their thoughts and memories into a more coherent story
- Ask the survivor about the personality of the deceased, their perception of the deceased, their relationship with the deceased, or any remarkable memories etc.

CLINICAL REMARKS

Do not expect that the client 'should' have certain feelings. It is very understandable that sometimes as workers we may avoid topics that trigger painful experiences in the client. We may not know what to say in response to painful feelings. However, even though talking about the death can be painful, the facilitation of expression of feelings and the story of the deceased is a necessary process in overcoming grief. Remember our aim is not to find something to say in order to cheer up the individual, it is to keep the individual accompanied and let them know that we are walking alongside them.

c. Adjust to the new environment without the lost person

- Review the memories
- Encourage a personalised way of 'connection' to the deceased
- Change parts of the environment that are reminders of the loss
- The new environment will also include changes in the social environment of the family. Workers are encouraged to discuss with the bereaved individual breaking the news (or not) to those who have not found out about the death
- It is up to the suicide survivor whether they want to share the real cause of death. Workers can weigh up the pros and cons of each option with the suicide survivor. One of the advantages is that the process of opening up will facilitate acceptance of the fact. Remember it is the survivor's decision, and workers can facilitate their decision-making process

d. Reinvest in the new reality

- Learn new skills
- Redirect energy to other parts in life
- Readjust, develop new ways of being and having a renewed sense of self
- Let go of old attachments. Some individuals may be unwilling to throw away belongings of the deceased, or relinquish a previous lifestyle (e.g., the routine of sharing dim sum with the deceased every afternoon). Discussion of the pros and cons of these attachments is encouraged. Some individuals may believe that keeping all the deceased's belongings is the only way to feel emotionally connected to them, and discussion can shed light on alternative ways to maintain the emotional connection (e.g., retaining the deceased's favourite item only)

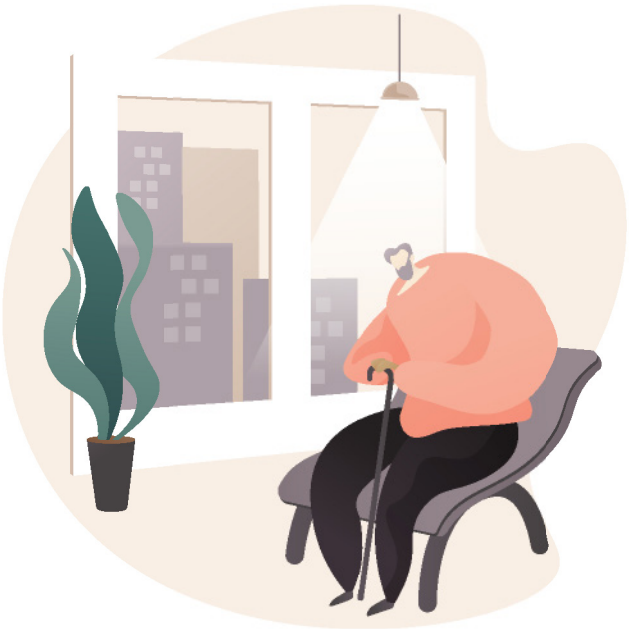
CASE EXAMPLE

- Peter, 75 years old, contacted the District Elderly Community Centre as he has been feeling agitated all the time. He almost got into a fight with his neighbour last week. The worker (Mabel) was assigned to work with Peter and realized that he had a moderate score on the depression scale.

- After the intake assessment, Mabel learnt that Peter lost his wife to suicide three months earlier. Before her suicide, his wife was an active client at the Integrated Family Service Centre. As Mabel gathered information about Peter's background, she learned that his wife had suffered from domestic violence for several years. Peter and his wife were married for 45 years and have three adult sons. Their relationship was stable until ten years ago, but conflicts arose between the couple following Peter's retirement. Eventually these conflicts escalated to verbal and physical abuse.

- Peter's three adult sons had a rather distant relationship with their parents. Before their mother's suicide, the sons occasionally phoned her but rarely spoke to their father. Following their mother's suicide, the three sons had not spoken to the father at all, except on the matter of legal procedures. The worker at the IFSC said that the sons were angry at their father.

- Mabel tried to provide emotional support to Peter but found it quite difficult as he did not speak much about his feelings. Nonetheless, he expressed feeling lonely and felt that everyone had abandoned him, including his family.



CLINICAL REMARKS

- **Willingness to seek help:** The literature provides abundant evidence that men do not express feelings nor seek help easily. This may be particularly evident in Chinese societies. Peter's decision to initiate contact with the DECC in the first place may mean that he feels strongly that he needs help and support. Therefore, repeated validation of his feelings will be helpful towards engaging with him during the initial stage.

- **Timing of distress:** In the first few weeks following a suicide death, survivors are usually very busy dealing with the practical matters of the death. Therefore, they may not feel the emotional impact immediately. Workers must be aware that survivors may only start to feel immense pain after the funeral and practical procedures are taken care of. In Peter's case, he started to feel agitated following his wife's funeral and it may be conceptualized that his anger and irritation masked his feelings of hurt and guilt about his wife's suicide.

- **Adjustment to an empty flat:** Some survivors prefer to stay with friends or families immediately following a suicide. Eventually, survivors need to return home. Coming home to an empty flat is what most survivors find the most difficult. In particular, older adults may need to face an empty flat if their companion has committed suicide. The worker needs to take note of these events and check in on the client from time to time. In Peter's case, living in his empty flat with nowhere else to go was torture for him.

- **Expression of feelings:** Peter has never been good at expressing himself, so Mabel tried to ask him about memorable events to understand more about his relationship with his late wife. In doing so, Peter was able to talk about some of the memories he had and hence indirectly process some of his feelings. Peter was able to talk about events such as wedding anniversaries and birthdays. Mabel took note of the important dates and made sure to check in on Peter on these dates when feelings may be intense.

- **Beliefs about death:** Exploring the survivor's religious or cultural beliefs about death may be helpful to further understand their current mood. For example, some people may believe that they will meet again in heaven, and hence feel more hopeful despite being in a difficult situation currently. Exploring these beliefs may be helpful for survivors to express their yearnings and outline what they can do to find peace (e.g., chanting or praying for the deceased).

- **Worker's personal views about suicide:** It is also important for workers to take note of their own attitudes about suicide and about their own clients. Mabel did not feel comfortable with Peter's angry outbursts and sometimes maintained emotional distance from him. This made validation work more challenging. After finding out Peter's backstory, Mabel regained empathy for him as she learnt that he never learnt about anger management. Peter experienced severe childhood abuse himself and what lie under his anger was extensive pain, shame and guilt about himself.

3.2.2.3 Group work

Depending on the level of impact, workers can consider starting a support group for individuals affected by a suicide death in the community. Unlike other group interventions, there is no strict requirement regarding group size, as long as there are enough individuals sharing the common experience of grief related to the loss and who are willing to share their experience and feelings.

Generalized grief support groups may be helpful -- for example, those offered by a hospice. However, it is important to be clear about what they offer and their experience with suicide support. (Group facilitation [World Health Organization, 2008])

To facilitate a suicide survivor support group, workers may want to provide:

- supportive community where individuals can share their grief and other feelings associated with the suicide death
- a non-judgmental and safe atmosphere for individuals to freely express their fears and worries
- a sense of normality and hope eventually as time passes by
- reminders of how to manage anniversaries or situational concerns
- support the individuals in problem-solving the immediate concerns to regain a sense of control in their lives
- psychoeducational information about grief

CLINICAL REMARKS

Suicide bereavement is complicated and those affected often experience feelings of shame, stigmatization and embarrassment. This may affect the grieving process. For older adults in particular, there may be taboos around discussion of death, especially death by suicide. This makes it more difficult for individuals to express their feelings and process their grief. Check how ready older adults are to talk about their loss before initiating the group.

3.2.2.4 Develop psychoeducational materials

Psychoeducational materials and leaflets that comprise information about suicide and grief may be beneficial. Community centres can design their own leaflets catering to the needs of their own community.

Here are some helpful Chinese materials available in Hong Kong for your reference. This booklet includes some practical information on (Centre for Suicide Research and Prevention (CSRP), 2022):

- After-death and funeral arrangements
- Legal procedures and flow chart
- Tips for helping children deal with grief
- Grief response after suicide loss

For the most updated resources in the community, please refer to Tool 5.

Tool You Can Use:

- Tool 5: General list of resources

3.2.3 Assessment and monitoring for complicated grief response

Tools You Can Use:

- Tool 3.2: Determining the level of intervention required based on the continuum model on the effects of suicide exposure
- Tool 3.4: Assessment and monitoring for complicated grief responses

The theories of grief outlined in section 3.2.1 help us understand what is regarded as a 'normal' grief process. However, some individuals may develop symptoms of complicated grief. Therefore, this section is intended to support professionals in identifying signs and symptoms that need monitoring and referral to mental health professionals when necessary.

Who might be at risk of 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

Some researchers have discussed the conceptual link between grief and trauma. Regehr and Sussman (2004) connected the two concepts and illustrated the relationship between trauma and grief using a Venn diagram (i.e., "exposure to actual or threatened death vs death of loved one with distressing preoccupation vs death of loved one). Depending on the symptoms displayed (e.g., intrusive images, detachment, purposeless, shock, avoidance, reminiscing, irritability/anger, physiological reactivity), interventions to address the trauma or grief response should be tailor-made for the suicide survivor.

Aside from the signs identified by Regehr and Sussman (2004), the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) has proposed more specific criteria to identify symptoms for 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:

- 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
- 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

If your client is displaying these signs and symptoms, please seek help from a trained mental health professional.

CLINICAL REMARKS

Whilst waiting for referral to a mental health professional, you can support the suicide survivor by:

- listening without judgment
- letting them explore their feelings
- allowing open conversation
- avoiding judgmental language

3.3 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 can become a 'survivor' as a whole. This is especially so for organizations or community centres with close knit relationships and that interact with one another on a regular basis.

3.3.1 Criteria to support the decision with expanding support to the wider community

These are some situations where your organisation may decide to take action after a suicide has happened in your community:

- The suicide death involved a person who is well-known in the community
- The suicide event happened in public space of the community
- There is extensive media coverage of the suicide death or when it has created a significant impact in the community where people keep talking about it
- If the death involves homicide-suicide
- If there are multiple suicide deaths in a short period of time.

3.3.2 What you can do at the community level (Survivors of Suicide Loss Task Force, 2015)

Tool You Can Use:

- Tool 3.5: Guide to develop a community based postvention plan

Chapter 3. Postvention

Given the wide-reaching impact in the community of a single suicide death, the objectives of a community-wide response are as follows:

1. Organise effective postvention activities and liaise between different organisations and stakeholders for collaboration

- You can start by forming a response/liaison team that may be responsible for handling media enquiries, supporting the coroner's investigation, liaising with the police, managing confidentiality issues and coordinating clinical work. Be sure that access to a wide variety of services, such as preventative, supportive and clinical services, is available in the community.

2. Provide concise and relevant information about the impact of suicide on individuals and the neighbourhood

- Create an inventory of services and support available for suicide survivors. Customized psychoeducational materials can be developed (refer to 3.2.2.4) and distributed in the community. An additional card that includes the contact name and telephone number for a clinical worker who can help discuss and navigate support options should be attached to the psychoeducational materials. These psychoeducational materials can also be distributed to policy makers or stakeholders in the district (e.g., district officers) from whom residents may seek help.

- Community programmes, including public meetings and forums, can be provided to educate people about the warning signs of psychological distress and process on help-seeking. The event may also facilitate a place in the community for people to process their feelings, discuss concerns and promote recovery.

3. Communicate with the media agencies (including social media) to make sure the way they report the suicide event does not cause unnecessary stress to the individuals bereaved by suicide

- Efforts should be made to ensure that information about suicide includes positive, solution-oriented messages. Consider issuing a public statement or a public health alert. The information should highlight suicide warning signs and list crisis resources.

- The information should use language that counters stigma by targeting judgments and discrimination against people who have committed suicide. Your role can also include monitoring news and/or social media and responding to those as needed.

4. Prepare for postvention support services in advance. Service gap and training needs should be identified such that support can be provided for frontline professionals ahead of time

- Best practice is always to be prepared. Develop a postvention plan before a suicide occurs. The next section outlines the steps for developing a postvention plan.

3.3.3 Step-by-step guide on what you can do before a suicide occurs (National Suicide Prevention Alliance, 2016)

Tool You Can Use:

Tool 3.5: Guide to develop a community based postvention plan

STEP 1

To gather information about your local context and understand the needs

- To inform the design and development of a postvention support service, it will be helpful to understand and gather as much information as possible about suicide deaths that have occurred in the community in the last few (at least two) years
- Here are some questions to consider:

- 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 suicides occur?
- Are any particular locations associated with suicides?

- What is the age, gender, method of suicide and service utilisation of those who have died by suicide in the community?
- What is 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.

- Understand what has happened after each suicide death
- 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?
- Decide 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 having their active involvement is central to any postvention development and delivery
- The key players may include: police, coroner's officers, district officers, housing providers, education providers, mental health services, religious groups etc.
- Multi-agency and multi-disciplinary meetings can be held to discuss: ambition for the service, sense of the need 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 lower the chance of suicide survivors committing suicide.	To de-stigmatise the labels attached to people bereaved by suicide.	For professionals to recognise the unique challenges suicide may cause to survivors and to bring support to them.	To lower the chance of suicide contagion and the formation of suicide clusters.

STEP 4

Set the service scope

- 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 an enhanced service or for improving coordination and support for existing services?
- 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	◆ 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

After setting the service scope, the next step will be laying down the implementation details of the service plan.

STEP 5

Set up the service and make plans to implement

- Planning can take reference from the bereavement support triangle set out in Section 3.2
- Ensure there is support for staff and have regular meetings to follow up staff's wellbeing (e.g., debriefing, 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 amongst suicide survivors

Reference: National Suicide Prevention Alliance, (n.d.)

CLINICAL REMARKS – A SHARING OF LOCAL EXPERIENCE

Usually seen as taboo, it is uncommon for people to publicly discuss a suicidal incident occurring in the community in which they live. Nonetheless, service providers and community leaders should design different strategies for community members to acknowledge the impact of the tragedy to the community and learn positive coping methods for life adversity or mental health problems, to prevent other suicidal clients. For example, social workers can liaise with local neighbourhood organizations to set up temporary mobile service stations to engage community members by:

- Providing positive life education
- Establishing social connection and mutual aid among neighbours
- Allowing expression of views in any creative forms (e.g., Wishing Tree 心願樹)
- Offering simple screening to identify potential at-risk clients or mental health problems
- Providing community resources or making necessary service referrals

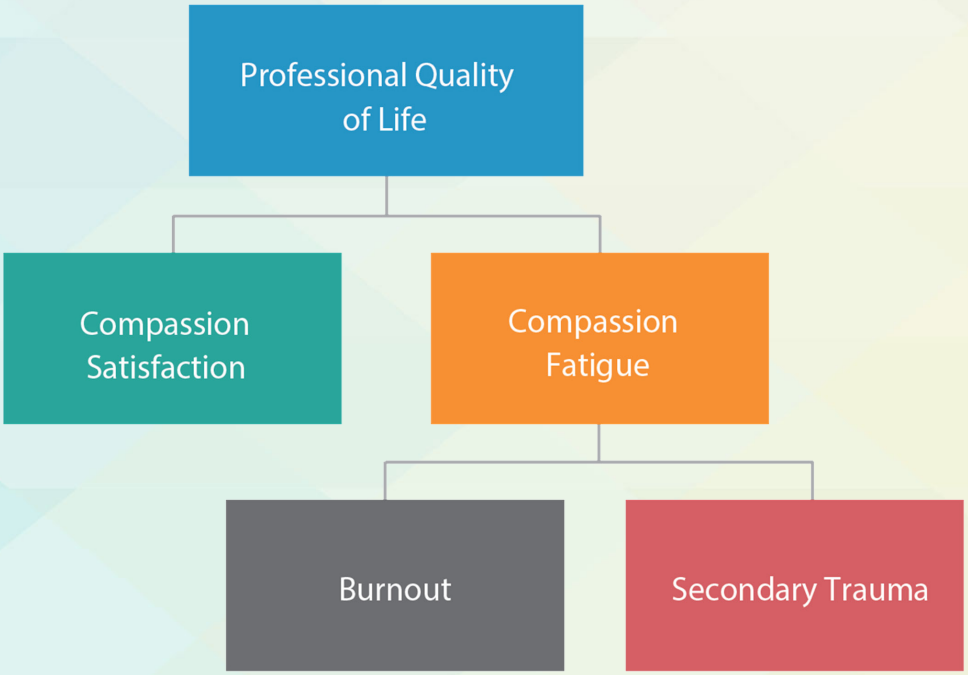
Prevention is always preferred to intervention. Before the occurrence of tragedy, social worker can help local organizations build up neighbourhood support to identify people in need. By adopting a community development approach, volunteers may be recruited and trained (sometimes identified as "Floor Representatives (樓長)" as caring representatives) and form a support group to serve their neighbours. They can also act as a link between those in need and professional services.

CHAPTER 4.
SELF-CARE FOR HELPING PROFESSIONALS

Chapter 4. Self-care for helping professionals

4.1 Definitions

Many frontline professional workers should be familiar with the condition of 'burnout'. Stamm and his team have developed the Compassion Satisfaction and Compassion Fatigue Model (CS-CF Model) to describe concepts including the professional quality of life as a helping professional and burnout. As shown in the figure below, professional quality of life is conceptualized as the combination of the two positive/negative components of "compassion satisfaction" and "compassion fatigue.



Compassion satisfaction

Compassion satisfaction refers to the positive rewards gained from the helping professions. It can be the pleasure you derive from being able to help others or the sense of satisfaction you get from being able to contribute to those vulnerable in the society by caring for them (Stamm, 2005).

Compassion fatigue

Compassion fatigue refers to the emotional exhaustion that helping professionals develop as a result of the constant giving and caring for their suffering clients. Figley (1995) also defined compassion fatigue as a state of tension and preoccupation with the cumulative trauma of clients. Therapists themselves may experience secondary trauma and feel emotionally exhausted. Compassion fatigue and burnout are nonetheless closely related. Compassion fatigue is more relational in nature and is considered a form of occupational hazard in caregiving professions. This is particularly true when positive outcomes or progress are not frequently seen in clients' path to recovery (e.g., relatively common amongst nurses working in cancer care).

Secondary trauma

Secondary trauma refers to helping professionals' exposure to the trauma of clients, even where they are not exposed to the actual danger (Stamm, 2005). The traumatic impact is experienced as a result of hearing clients retell their stories of abuse, of witnessing violence or suicide, etc. Exposure to primary or secondary trauma may lead to post-traumatic stress symptoms (such as chronic tension, irritability, insomnia, or anxiety).

Vicarious trauma

This concept is further investigated by Pearlman and Saakvitne (1995) to explore the impact of trauma work on the therapist. It refers to a shift in the therapist's world view after cumulative working with clients exposed to a variety of trauma. Some therapists or workers may become increasingly numb to the pain and suffering of clients, and may also feel a huge sense of anger about unfairness or injustice in the world.

Burnout

Burnout refers to the stress arising from the work environment which is accumulative in nature (Stamm, 2005). It is not necessarily specific to the caring professions. It describes a state of physical and mental exhaustion due to a reduced ability to cope with the demands in the work environment. Burnout does not necessarily mean that our worldview has been affected.

In the academic literature, researchers have concluded that the above definitions are closely related and it is rather difficult to distinguish the concepts from each other. This makes research in this field somewhat more difficult.

Confusion between depression or compassion fatigue?

Some may describe compassion fatigue as an occupational hazard, which is different from depression, a mental health problem as identified in the DSM-5 manual. Nonetheless, it is possible that healthcare and helping professionals develop depressive symptoms when they experience compassion fatigue. If stress and fatigue have not been resolved over time, chronic compassion fatigue may eventually develop into depression, anxiety, or other types of mental health problems.

4.1.1 Why professional quality of life is important

Not surprisingly, studies have indicated that burnout can potentially reduce the quality of the helping professional's work, including their therapeutic relationship with clients (de Figueiredo, Yetwin, Sherer, Radzik, & Iverson, 2014; Hanson, 2015). For instance, some burned-out helping professionals may feel less patient, empathetic, and more discontent or avoidant. The enhanced lack of certainty towards efficaciously managing the client or ensuing personal impact also contributes to greater levels of stress for helping professionals.

Compassion fatigue may have detrimental effects on helping professionals' work and psychology, such as reliving the client's traumatic experiences or diminished empathy or passion towards clients, leading to feelings of helplessness, stress or even the desire to quit the profession (de Figueiredo et al., 2014; Figley, 1995; Pérez-García et al., 2020; Turgoose & Maddox, 2017). In addition, vicarious traumatization can also increase the risk of helping professionals exhibiting negative cognitive and psychological changes, such as disrupted perceptions, anxiety, suspicion and/or sense of vulnerability (Culver, McKinney & Paradise, 2011; Rasmussen, 2005).

4.2 Self-assessment

Tools You Can Use:

- Tool 4.1: Checklist of indicators for helping professionals' work-related stress
- Tool 4.2: Self-assessment of compassion fatigue - Professional Quality of Life (ProQOL)

This section outlines some indicators of burnout and compassion fatigue in the professional context. For example, helping professionals may show hostility or boredom towards their clients. They may become easily irritable and blame clients for their issues, withdraw from socializing with colleagues, come to work late or work less productively. Moreover, workers may feel exhausted as well as guilty, and may blame themselves for not being able to accomplish more work. If exposed to primary or secondary trauma, they may also experience intrusive thoughts of personal/work related events. Therefore, it is crucial to increase our awareness of changes in behaviour, attitudes and work to prevent compassion fatigue. For more indicators of work-related stress, including burnout or compassion fatigue, please refer to Tool 4.1.

The Professional Quality of Life (ProQOL) is a widely-used scale in the nursing literature (Stamm, 2005). The three domains into which the scale taps refer to compassion satisfaction, burnout and compassion fatigue. The scale has good validity and reliability (Heritage, Rees, & Hegney, 2018). Please refer to Tool 4.2 for the full scale.

Note that this scale is for reference only, it is not to be used as a diagnostic tool.

CLINICAL REMARKS

Do the following descriptions ring a bell with you?

- I feel trapped by my job as a [your profession – e.g., helping professional]
- I am not satisfied with my work
- I think that I might have been affected by the traumatic stress of those I help

For more information on compassion satisfaction, burnout and secondary trauma, please refer to Tool 4.2 for self-assessment.

4.3 What you can do

Tool You Can Use:

- Tool 4.3: Self-care and coping measures

Strategies to manage compassion fatigue can be implemented at three levels: personal, professional, organizational (Section 4.4). Researchers have shown that the following key strategies reduce compassion fatigue:

PERSONAL	PROFESSIONAL
Work-life balance	
Strong social support at home and at work	
Good self-care	Increase job satisfaction
Increased self-awareness	Rebalance caseload
Maintain a good physical health	Appropriately manage secondary or vicarious trauma
Maintain good connections with friends	Undergo good coaching and clinical supervision
Have a variety of enjoyable activities	Attend regular professional training

4.3.1 Develop a personalized compassion toolkit

Shift a row upwards so that there is no space

Here are some prompting questions for you to consider:

- What are my warning signs of fatigue/burnout?
- With regards to the warning signs, on a scale of 1-10, what is a 9 for me? What is a 4 for me?
- A regular check-in (with myself) should be scheduled every week, when will it take place?
- What things do I have control over?
- What things do I not have control over?
- What stress relief strategies do I enjoy? (e.g., taking a bath, going for a massage) (refer to self-care matrix in the next section below)
- What stress reduction strategies work for me?
  - Stress reduction refers to cutting back on stressful things in your life (e.g., reworking your caseload, limiting your daily work hours, avoiding overtime work)
- What are some stress resilience strategies I can use?
  - Stress resilience refers to methods you can practice and develop regularly and possibly implement at work (e.g., meditation, breathing exercises)

To reconnect with rewards of the work you do (compassion satisfaction)

Here are some prompting questions for reflection:

- What made me choose to become a social worker/counsellor/psychologist?
- Given the day-to-day challenges, what keeps me going? What are the things that sustain me as a professional and as a person?
- What practical strategies have allowed me to stay motivated and well? (Strategies at work? Strategies at home?)
- If I were to change something, what might I do differently at work?
- Reflecting on success, how have I made a difference to others?
- Is there a particular client whose story has touched me profoundly in a positive way? What was it about the client's story that moved me?
- Is this still the right job for me?

4.3.2 Develop a compassionate voice

As a helping professional, we have a desire to help the vulnerable in our society. With this desire to help in mind, we try our best to find solutions and offer support to our clients. However, the problems our clients face may be multifaceted and it may be beyond our capacity to solve them all alone. Other times, we may experience burnout and compassion fatigue. When that happens, it is possible that we may criticize ourselves for not being able to help, and we may also feel guilty about our perceived inability.

Mindfulness-based strategies have been found to be effective in reducing stress amongst healthcare professionals (Burton, Burgess, Dean, Koutsopoulou, & Hugh-Jones, 2017).

Supplemental Information

Mindfulness Exercise

Mindfulness exercise: 3-minutes breathing space (Cantonese)
https://www.youtube.com/watch?v=56MkjZa8iuk

Mindfulness bodyscanning exercise
https://www.youtube.com/watch?v=vnn5Xjp0fp0&t=124s

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

The effectiveness of mindfulness strategies is most profound when combined with compassion-based content (Khoury, Sharma, Rush, & Fournier, 2015). Based on the principles outlined in Compassion Focused Therapy (developed by Paul Gilbert), it may be helpful to be aware our self-critical voice, and reframe it into a more compassionate voice.

CRITICAL VOICE	COMPASSIONATE VOICE
I am unmotivated to support my client, I must be a bad social worker	I have tried my best, this is a transient feeling that may mean I am experiencing burnout and I need to take better care of myself first
I should be able to do more	Knowing that even helping professionals have limitations. The desire to do more is out of your desire to help and improve the situation, which is very commendable
My client needs me, she asked me to do… and she has no family or friend's support… so I should help her	Notice your own boundaries as a supporting worker, your role is different from a friend or family member. Acknowledge you have the desire to help, but also be able to say no (in a caring tone) when the client's request exceeds our boundaries
If I visited my client more frequently, they may not have committed suicide…	Be reassured that you have tried your best. There are many reasons that are often complex that lie behind a person's decision to commit suicide

4.3.3 Managing trauma exposure

As helping professionals support clients who may be suicidal or experiencing distress or trauma, it is possible they will share what they have experienced (e.g., graphic details of abuse, war exposure, witnessing accidents). Helping professionals may feel overwhelmed by their clients' trauma and suffering, the cumulative effects of which may be so-called secondhand trauma. According to the American Counseling Association (2001), secondhand trauma is the emotional residue of exposure that helping professionals have from providing counseling to people who have experienced trauma. Therefore, it is important to be aware of the signs and symptoms of secondhand trauma and the potential effects of working with people who have experienced trauma, such as having difficulty talking about their feelings, being worried that they are not doing enough, dreaming of their clients' trauma experiences, etc.

Knowing how to manage our exposure to trauma may be helpful to prevent compassion fatigue or vicarious trauma. It is essential that we remain grounded in our awareness of our own limitations when we work with clients experiencing profound distress.

Research has shown that our body and brain are deeply transformed when we are exposed to trauma. Rothschild (2006), a compassion fatigue researcher, connects empathy with our body and brain mechanisms. She argues that empathy can also be experienced in its somatic form and is named 'somatic empathy'. It means we are empathizing with our body with the client's experience. We may display signs of hyper-arousal that refers to a state when we are on high alert at all times.

Some signs of hyper-arousal may include:

- heart beating faster
- feeling panicky
- stiff neck and shoulders
- sweaty palms

Therefore, Rothschild suggests that we need to increase our body-awareness during sessions with clients. When we notice these symptoms during a session, we know that we may have reached our limits.

If this happens, a logical next step is to acknowledge the client's pain, reflect and summarize their feelings, and complete the session. The next step is to take care of yourself, speak to a clinical colleague to process the feelings arising from the session. A quick 15-minute chat may be helpful. Don't hesitate to reach out. After you have calmed down, consider seeking supervision to discuss how to handle your client.

CLINICAL REMARKS

Helping professionals need to beware not to confuse secondhand trauma with burnout. Secondhand trauma is a state of tension and preoccupation with trauma experiences described by the client. However, burnout is something that happens over time and is accumulative in nature.

4.3.4 Self-care matrix

Tool You Can Use:

- Tool 4.3: Self-care and coping measures

The self-care matrix below documents ideas of what you can do to take better care of yourself. The contents are for reference only. Please use Tool 4.3 as an empty template to create a personalized self-care matrix for your own tailored use.

PHYSICAL

- eat well
- exercise regularly
- get enough sleep
- seek medical care when necessary
- take time off
- massage
- aromatherapy

PSYCHOLOGICAL / EMOTIONAL / SPIRITUAL

- know and live your values
- be aware of your own vulnerabilities, limits and boundaries (and be able to keep them)
- keep a gratitude journal
- keep a log of your strengths and positive qualities
- practice forgiveness
- develop a habit of self-reflection/self-awareness
- be aware of your own emotions
- read a self-help book
- seek counseling if needed
- apply relaxation techniques in a timely manner
- practice mindfulness

PROFESSIONAL

- take a 'wellbeing' day
- take a vacation
- take time for lunch
- take a walk after lunch
- make quiet time to complete tasks
- pursue projects that are exciting and rewarding
- learn to say no
- build a peer support network within work settings
- regularly consult with your clinical supervisor
- actively seek or accept help when necessary

SOCIAL

- foster friendships in personal life and at work
- spend time with family and friends
- get a coffee with colleagues
- travel
- attend peer support groups

4.4 What you can do for your colleagues

As you can imagine, research has shown that cognitive behavioural interventions coupled with relaxation techniques are effective in reducing emotional exhaustion (Maricuţoiu, Sava, & Butta, 2016).

On the other hand, research evidence has shown that organization-based interventions are more likely to reduce burnout amongst helping professionals such as physicians (Panagioti et al., 2017). Organizational intervention refers to structural changes, fostering communication between colleagues, cultivating good sense of teamwork and job control.

If burnout is a common problem in the organization, implementing individual strategies may not be sufficient to address the issue, and organizational level strategies should be considered. For example, organize a yoga group during the lunch break, create a walking/running club, schedule a mindful meditation hour every week, etc.

Compassion, a term derived from Latin, means 'suffering with' (Lopez, 2009). 'Suffering with our clients' becomes a daily part of our work. In extremely stressful situations (e.g., after a client has committed suicide), we continue to support our clients professionally, but we may not be aware of the emotional toll it has taken on us.

Giving healthcare professionals opportunities to share experiences, thoughts and feelings drawn from issues arising from our actual patients have been conducive in garnering their positive feedback. The idea of 'Schwartz Round' was introduced in 1997 and has now been widely implemented in the UK and in 375 healthcare sites across the USA (Robert et al., 2017).

What is a Schwartz Round?

A Schwartz Round provides a structured platform where frontline workers and supporting staff gather regularly to discuss the emotional impact of their work (The Point of Care Foundation, 2021). This is based on the model of hospital ward rounds where clients are presented and discussed with the aim of solution finding. However, a Schwartz Round focuses on staff's personal experiences and reflections arising from their caretaking duties. This may mean the psychological and social impact on them as individuals. Therefore, the Schwartz Round aims to provide a protected space for staff to reflect and share. Cullen (2016) believes that applying Schwartz Rounds in social work will also be valuable.

Evidence of Schwartz Rounds

A UK study collected national data of 402 Schwartz Rounds conducted in 47 organizations and concluded that the experiences were generally very positive (Flanagan et al., 2020). Staff who attended Schwartz Rounds were more responsive to their clients' needs. Participants often valued the opportunity to openly talk about their painful experiences and feelings arising from the work situation. The connection and resonance of experiences commonly shared with other staff also helped them feel less isolated. Having authoritative figures or senior managers willing to talk about their mistakes and failed experiences also helped people feel more compassionate towards themselves and their own limitations.

Principles of the Schwartz Round (The Point of Care Foundation, 2021)

- confidential
- predictable and themed (1 hour)
- facilitated by a professional who understands staff experiences, the structure and the culture of the organization; the facilitator will also manage group dynamics and difficult emotions as they arise
- purpose: a therapeutic and safe space for reflections on the emotional impact of work on healthcare professionals
- emphasize this is not an opportunity to problem solve or generate solutions for each other
- attendees are invited and supported to tell their stories about their own experiences and express feelings, to be curious about and reflect on the stories of others to make connections between them
- topics are theme- or situation-based. Theme-based examples may include 'a client I will never forget', 'unbearable feelings', etc. Situation-based topics may include 'caught between the client and the family', 'dying too young', etc.

Managing traumatic stress

A systematic review (Anderson, Di Nota, Groll, & Carleton, 2020) of 14 studies with over 10,000 participants identified the following effective common interventions undertaken with workers exposed to psychologically traumatic events:

- Critical incident stress debriefing (CISD)
- Critical incident stress management (CISM)
- Peer support
- Psychological First Aid

The outcomes measured the impact of traumatic events, absenteeism, substance use, psychiatric symptoms, suicide rates, stigma, and global assessments of functioning, etc. The review concluded that debriefing intervention has no particular effect. Moreover, it is difficult to draw conclusions regarding the effectiveness of critical incident stress management (CISM) as there is little consistency in the application of the CISM principles.

Among the above interventions, peer support programmes that cultivate supportive relationships characterized by emotional and social support, encouragement and hope between individuals who have experienced trauma appear to be the most promising.

CLINICAL REMARKS

- It is acknowledged that some organizations prefer to hold debriefing sessions after a critical incident (e.g., a suicide). Despite the inconclusive evidence in the literature, such opportunities should be made available for staff who feel they may need them. Note that staff who have direct or indirect contact with the deceased should all be able to access such support.
- Supervisors who may be conducting investigative meetings with staff involved should ensure that such meetings are conducted in an atmosphere where the involved staff do not feel judged or criticized.

(SANE AUSTRALIA, 2016)

CONCLUSION

Suicide is a preventable event and can be 'treated' just like any other physical illnesses. Relative to other age groups, older adults face higher suicidal risk. This book not only covers prevention and management of suicidal risks, it also covers postvention strategies to support mental health professionals design interventions. We hope that the practical tools in this booklet can serve as a guide for helping professionals who encounter older adults at risk of suicide. This is the time to take action and collaborate together as a community, bringing hope for those in need.

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