

An Informational Toolkit for
SENIOR LIVING COMMUNITIES

PROMOTING SUICIDE AWARENESS



This toolkit is donated by the

TODD WAITE LEGACY FOUNDATION

for suicide awareness

www.twlf4suicideawareness.com

Blessed are those who mourn for they will be comforted

Matthew 5:4

The *TODD WAITE LEGACY FOUNDATION* for suicide awareness

was formed by family members on behalf of the Waite family. The Waite family lost their 19 year old son/brother Todd to suicide in July, 2010. They are now dedicated to spreading awareness about suicide so that others will never have to encounter the pain and loss that they feel.

In 2014 famous actor and comedian Robin Williams along with other celebrities took their own life as a result of a mental illness.

What about the shootings by people with mental illnesses at Sandy Hook Elementary School, Fort Hood, and other places around the world?

It is time to put an end to these tragedies!!

We need to start educating people about mental health, suicide awareness and prevention, and where to turn to for help or comfort in an otherwise confusing time. We have put together some informational toolkits and other literature to point people in the direction of areas for help and information.

Our mission is to spread suicide and mental health information and awareness to: churches, first responders, foster parents, funeral homes, the media, medical professionals, military veterans, police departments, retirement homes, schools, suicide victims, survivors of suicide, the workplace, and anyone or anyplace else that can benefit from our information.

Visit our web site at – www.twlf4suicideawareness.com

Our e-mail address is - twlf4suicideawareness@gmail.com

Check out our Facebook page at - www.Facebook.com/twlegacyfoundation

All of our material is free of charge and can be downloaded from our web site.

Please help us to keep spreading the word about suicide awareness. Visit our web site for information on donations. We are a 501 (c) (3) non-profit organization.

20 Best Things to Say to Someone Who Is Depressed

1. "I love you!"
2. "I Care"
3. "You're not alone in this"
4. "I'm not going to leave/abandon you"
5. "Do you want a hug?"
6. "When all this is over, I'll still be here and so will you."
7. "All I want to do is give you a hug and a shoulder to cry on.."
8. "Hey, you're not crazy!"
9. "May the strength of your past reflect in your future."
10. "God does not play dice with the universe." -- A. Einstein
11. "A miracle is simply a do-it-yourself project." -- S. Leek
12. "We are not primarily on earth to see through one another, but to see one another through"
13. "If the human brain were simple enough to understand, we'd be too simple to understand it."
14. "You have so many extraordinary gifts -- how can you expect to live an ordinary life"
15. "I'm sorry you're in so much pain. I am not going to leave you. I am going to take care of myself so you don't need to worry that your pain might hurt me."
16. "I listen to you talk about it, and I can't imagine what it's like for you. I just can't imagine how hard it must be."
17. "I can't really fully understand what you are feeling, but I can offer my compassion."
18. "You are important to me."
19. "If you need a friend..... "
20. "I'll stick with you no matter what."

PROMOTING SUICIDE AWARENESS FOR **SENIOR LIVING COMMUNITIES**

The purpose of this Suicide Prevention Awareness toolkit is to provide information and educate everyone about the causes, and warning signs of mental illness and suicide.

The views and opinions expressed in this toolkit are those of the author who formed this information by researching many of the web sites listed in the back. The information in this toolkit may not reflect the policies of all mental health or suicide organizations.

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TODD WAITE LEGACY FOUNDATION

for suicide awareness.

Copies of this toolkit are available on line at
www.twlf4suicideawareness.com

Despite the high death toll of suicidal and mentally ill people, many people have failed to address the problem as a public health concern. Many people view mental illness and suicide purely in terms of its tragic consequences for individuals, not as a problem plaguing society as a whole. Complicating the issue is the stigma attached to suicide and mental health. As a result people with mental illness and possibly contemplating suicide and their families may be reluctant to seek help. Community members may be apprehensive about taking a proactive stance towards the problem.

Suicide and mental health has lagged behind other social problems, such as child abuse and domestic violence, in gaining recognition as an issue that deserves public attention from individuals, organizations, and society. This kind of public attention is essential in order to identify or create the tools and knowledge to prevent suicide, help the mentally ill, and save lives.

Unlike distress signals resulting from physical trauma, such as a heart attack or deadly disease, the pain of people considering suicide may go unrecognized until it is too late. This is why a public health approach to suicide prevention is so important--targeting or identifying at-risk people before they appear in the emergency department of a hospital. Through increasing awareness in the community-at-large, the signs and symptoms of suicide and mental illness can be recognized and addressed.

More than 90 percent of people who die by suicide have depression and other mental disorders, and/or a substance-abuse disorder.

Suicide and mental illness is at the same level as breast cancer was a few years ago. No one dared talk about it and many women died because of the stigma associated with breast cancer. Suicide and mental illness has to be brought to the public attention. People need to be made aware of the symptoms of suicide.

IT IS TIME TO GIVE MENTAL HEALTH AND SUICIDE PREVENTION THE ATTENTION IT DESERVES!

SUICIDE – The Result of a Mental Health Problem

Much of the information listed on the following 3 pages is from SAMHSA's National Suicide Prevention Lifeline Crisis Centers Conference in Baltimore, MD
• July 27, 2011

A special thank you to Pamela S. Hyde, J.D. SAMHSA Administrator for providing this information. SAMHSA stands for Substance Abuse and Mental Health Administration. (www.samhsa.gov - 1-877-SAMHSA-7 or 1-877-726-4727)

Here are some tough realities of suicide –

36,000 Americans die by suicide each year

1.1 million (.05 percent) Americans (18 & older) attempted suicide in the past year

2.2 million (1 percent) Americans (18 & older) made a plan in the past year

8.4 million (3.7 percent) Americans (18 & older) had serious thoughts of suicide in the past year

30 percent of deaths by suicide involved alcohol intoxication at or above the legal limit

2005-2009: 55% increase in emergency department visits for drug related suicide attempts by men 21 to 34

2005-2009: 49% increase in emergency department visits for drug related suicide attempts by women 50 or older

Every year some 650,000 persons receive treatment in emergency rooms following suicide attempts

50% of those who die by suicide were afflicted with major depression, and the suicide rate of people with major depression is eight times that of the general population

90% of individuals who die by suicide had a mental disorder

2005 – 2009: More than 1,100 members of the Armed Forces took their own lives; an average of 1 suicide every 36 hours

2010 Army suicide rate (active-duty) soldiers is down slightly (2009 = 162; 2010 = 156)

Number of suicides in the Guard and Reserve up by 55% (2009 = 80; 2010 = 145)

More than half of the National Guard members who died by suicide in 2010 had not deployed

Suicide among veterans accounts for as many as 1 in 5 suicides in the U.S.

MISSED OPPORTUNITIES = LIVES LOST

Individuals discharged from an inpatient unit continue to be at risk for suicide

10% of individuals who died by suicide had been discharged from an emergency room within the previous 60 days

8.6% hospitalized for suicidality are predicted to eventually die by suicide

77% of individuals who die by suicide had visited their primary care doctor within the past year

45% had visited their primary care doctor within the month

THE QUESTION OF SUICIDE WAS SELDOM RAISED!!!!!!!!!!

3 PRIORITY AREAS FOR CONSIDERATION

Issue One: Too many missed opportunities to save lives in primary care settings

Issue Two: Millions of Americans still lack access to evidence-based care and health based professionals that can reduce suicidal behavior

Issue Three: Too many discharged from emergency rooms/inpatient units following suicide crisis at significantly elevated risk yet 50% referred to care following discharge do not actually receive outpatient treatment

DAILY CRISIS OF UNPREVENTED AND UNTREATED Medical/Suicide attempts

Any Mental Illness: 45.1 million 37.9% receiving treatment

Suicide attempts: 22.5 million 18.3% receiving treatment

Diabetes: 25.8 million 84% receiving treatment

Heart Disease: 81.1 million 74.6% receiving screenings

Hypertension: 74.5 million 70.4% receiving treatment

PERCEPTION CHALLENGES

60% of people who experience mental health problems & 90% of people who experience substance abuse problems and need treatment do not perceive the need for care

Suicides vs. homicides - Suicides outnumber homicides by 3:2

Suicides vs. HIV/AIDS - Twice the number of people die by suicide than who die as a result of complications related to HIV/AIDS

WHAT AMERICANS KNOW

Most know *or* are taught:

Basic First Aid and CPR for physical health crisis

Universal sign for choking; facial expressions of physical pain; and basic terminology to recognize blood and other physical symptoms of illness and injury

Basic nutrition and physical health care requirements

Where to go or who to call in an emergency

Most do not know *and* are not taught:

Signs of suicide, addiction or mental illness or what to do about them or how to find help for self or others

Relationship of behavioral health to individual or community health or to health care costs

Relationship of early childhood trauma to adult physical & mental/substance use disorders

SO, HOW DO WE CREATE A PUBLIC HEALTH APPROACH THAT:

Engages everyone – general public, elected officials, schools, parents, churches, health professionals, researchers, persons directly affected by mental illness/addiction & their families

Is based on facts, science, common understandings/messages

Is focused on prevention (healthy communities)

Is committed to the health of everyone (social inclusion)

The TODD WAITE LEGACY FOUNDATION for suicide awareness is providing information about mental health and suicide prevention to anyone and everyone who comes in contact with people with mental health issues and suicidal tendencies, and the community-at-large to help identify those at risk, reduce stigma, and take other measures to deter and prevent suicides.

The TODD WAITE LEGACY FOUNDATION for suicide awareness

wants you to know the warning signs of suicide and mental health. They may be listed more than once in this toolkit but they are worth repeating. Everyone needs to learn and know the warning signs You could save a life!!

Warning Signs and Symptoms of Suicide

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawn or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

Additional Warning Signs of Suicide

- Preoccupation with death.
- Suddenly happier, calmer.
- Loss of interest in things one cares about.
- Visiting or calling people to say goodbye.
- Making arrangements; setting one's affairs in order.
- Giving things away, such as prized possessions.

Recognize the warning signs of suicide:

Here's an Easy-to-Remember Mnemonic:

IS PATH WARM?

I Ideation
S Substance Abuse

P Purposelessness
A Anxiety
T Trapped
H Hopelessness

W Withdrawal
A Anger
R Recklessness
M Mood Changes

Warning Signs and Symptoms of Mental Illness

The following are signs that your loved one may want to speak to a medical or mental health professional.

In adults:

- Confused thinking
- Prolonged depression (sadness or irritability)
- Feelings of extreme highs and lows
- Excessive fears, worries and anxieties
- Social withdrawal
- Dramatic changes in eating or sleeping habits
- Strong feelings of anger
- Delusions or hallucinations
- Growing inability to cope with daily problems and activities
- Suicidal thoughts
- Denial of obvious problems
- Numerous unexplained physical ailments
- Substance abuse

In older children and pre-adolescents:

- Substance abuse
- Inability to cope with problems and daily activities
- Changes in sleeping and/or eating habits
- Excessive complaints of physical ailments
- Defiance of authority, truancy, theft, and/or vandalism
- Intense fear of weight gain
- Prolonged negative mood, or thoughts of death
- Frequent outbursts of anger

In younger children:

- Changes in school performance
- Poor grades despite strong efforts
- Excessive worry or anxiety (i.e. refusing to go to bed or school)
- Hyperactivity
- Persistent nightmares
- Persistent disobedience or aggression
- Frequent temper tantrums
- Recognize the warning signs:

2014 Facts & Figures on Suicide

Suicide is a preventable public health problem and a leading cause of death in the United States. More investment in suicide prevention, education and research will prevent the untimely deaths of thousands of Americans each year.

Suicide - Basic Facts:

- ❖ An American dies by suicide every 13 minutes, and more than 40,000 die by suicide every year.
- ❖ 3,000 Americans attempt to take their life each day, resulting in over 1 million attempts each year.
- ❖ 90% of the individuals who die by suicide had a diagnosable psychiatric disorder at the time of their death.
- ❖ Depression, bipolar disorder and substance use disorders are among the leading causes of suicide.
- ❖ For every female suicide, there are four male suicides, but three times as many females as males attempt suicide.
- ❖ Suicide is the second leading cause of death among those 10-24 years old.
- ❖ Veterans make up 22% of suicides

Suicide - The Cost:

- ❖ Suicides in one year cost the U.S. over \$20 billion in lost earnings
- ❖ 1.5 million years of life are lost to suicide annually.
- ❖ Suicide attempts requiring hospitalization cost the U.S. \$44 billion each year in medical and work-loss costs

Facts and Fiction About Suicide:

Perhaps because suicide is rarely talked about openly, there are a lot of misconceptions about issues as to who is at risk, why and under what circumstances, and about how to get help. Knowing the facts is critical to taking action and essential to saving lives.

Fiction: Suicide usually happens with no warning.

Fact: Eight out of ten people who kill themselves give some sort of warning or clue to others, even if it is something subtle.

Fiction: There's always a note left behind when someone commits suicide.

Fact: Actually, in most cases, there is no suicide note.

Fiction: Someone who talks a lot about suicide is just trying to get attention.

Fact: It's just the opposite. More than 70% of people who kill themselves have previously threatened to do so or actually attempted to do so. When someone says they feel this way, take it seriously.

Fiction: People who are suicidal are intent on dying and feel there is no turning back.

Fact: Most people who are suicidal are actually of two minds about it. Part of them wants to die, but part of them doesn't. The main thing they want is to stop their pain.

Fiction: People who attempt suicide once are unlikely to try it again.

Fact: 80% of people who die from suicide have made at least one other attempt already.

Fiction: Someone who survives a suicide attempt is obviously not serious about it.

Fact: Any suicide attempt should be treated as though the person intended to die, and not simply dismissed as an attention-getting device.

Fiction: If you mention suicide to someone who seems depressed, you're just planting the idea in his or her mind

Fact: Discussing it openly can actually help, not hurt.

Mr. and Mrs. Smith moved into an Assisted Living Center. Mr. Smith was pleased with the move, but according to staff, his wife came in “kicking and screaming.” Although Mr. Smith ate in the dining room and began participating in the activities offered to the residents, his wife would not. She took all her meals in her room. In fact, she stayed in her room most of the time. Her husband told the staff he was worried but didn’t know what to do. The staff reassured him she would eventually settle in—but she didn’t. One day Mr. Smith returned from lunch to find his wife lying on the floor. She had cut her wrist with a knife. She was rushed to the hospital. Mrs. Smith survived and received inpatient treatment in the hospital for one month. The event was terribly traumatic for both Mr. and Mrs. Smith, as well as for the staff and the other residents. The staff spent a lot of time wondering what they could have done to prevent that event. Mrs. Smith returned to the Assisted Living Center when her doctor felt she would be safe. Her family started visiting more often. The activities director convinced her to join a book club and to volunteer to welcome new residents. She also agreed to join a life review therapy group facilitated by the social worker. The nursing assistants and housekeepers made a point of chatting with the Smiths when they visited their apartment. And, Mrs. Smith started eating in the dining room. Today, seven years later, the staff says, “You’d never suspect that Mrs. Smith is the person who tried to take her life. She misses her husband, who died two years ago. But at 93 years old, she is one of the most well-liked, engaged, and outgoing residents in the Center!”

Fortunately, the story had a happy ending. But if Mr. Smith had decided to read a newspaper after lunch or had stopped for a conversation before checking on his wife, she could have bled to death.

We do not know how many residents of senior living communities attempt suicide or die by suicide. But, we do know that a suicide in a facility such as yours profoundly impacts the lives of everyone concerned—residents, families, and staff. And we also know there are ways that we—and you—can reduce the risk of suicide. It is our hope that this Toolkit will help prevent your facility from having its own Mrs. Smith’s story.

Who is this Toolkit for?

This Toolkit has resources relevant to any type of senior living community, including nursing homes, assisted living facilities, independent living facilities, and continuing care retirement communities. There is information targeted to professional and paraprofessional staff in all departments, including the executive director, administrators, department managers, and supervisors; nursing, medical, mental health, and social work staff; clergy; activities and wellness staff; and dietary, housekeeping, transportation, maintenance, grounds, and security staff. Everyone in a senior living community has a role to play in promoting emotional health and preventing suicide.

Older adults die by suicide at a higher rate than the national average. Rates go up after age 65, primarily among white men (CDC, 2006). When older adults attempt suicide, they are more likely to die: 1 out of every 4 older adults who attempt suicide dies compared to 1 out of every 100–200 younger adults who attempt suicide. There are few reliable statistics on suicide in senior living communities. However, we do know that residents of these communities have many of the risk factors associated with suicide, such as depression, social isolation, lack of a sense of purpose in life, illness and pain, and family losses.

Suicide Definitions

Suicidal behavior is a spectrum of activities that includes the following:

Suicide—A death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the death.

Suicide attempt—Potentially self-injurious behavior with a non-fatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

Suicidal ideation—Self-reported thoughts about engaging in suicide-related behaviors.

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

Suicide in Senior Living Communities

Suicide rates are higher among older adults than the national average. It is unclear whether suicide death and attempt rates are higher among older adults living in senior living communities or those not in these facilities.

Several studies have shown that suicidal thoughts (ideation) and depression are more common among nursing home residents than among those who are not in nursing homes. This is particularly true for adults recently admitted to a nursing home.

The most common method of suicide among older adults, in general, is firearms. However, the most common means of suicide in nursing homes (in which access to firearms is very limited) are jumping from high places, hanging, taking overdoses of medication, and cutting. Passive suicide, such as refusing to eat, drink, take medications, or follow other treatment plans, and taking unnecessary risks, are also used as a means of suicide in these.

In the general population of older adults, suicide attempts are much more likely to result in death than among younger adults: 1 of every 4 older adults who attempt suicide dies compared to 1 of every 100–200 young people who attempt suicide.

There are several reasons for this difference

Older adults plan carefully and use more deadly methods (such as guns).

Suicide attempts by younger people are more impulsive. They are less likely to use firearms.

Older adults are less likely to be discovered and rescued than younger people.

Many older adults are physically frail. They are less likely to recover from a suicide attempt than younger people.

Risk Factors for Suicide

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

Mental illness

Major depression

Other mood disorders

Psychotic disorders

Substance misuse and abuse

Alcohol

Prescription and over-the-counter (OTC) medication

Physical illness, disability, and pain

Poor physical health

Functional impairments

Pain

Side effects of some medications

Insomnia

Personal and family history of suicide

Previous suicide attempt

A family member who has died by suicide

Current life circumstances

Social isolation

Major life transitions, such as moving to a new setting

Family conflict and loss

Financial problems

Lack of a sense of safety

Losing autonomy, respect, supportive relationships, and participation in civic and social life

Other people having lower expectations for them

Personal characteristics

Inability to adjust to change

Low rating of their own health

Low self-esteem

Hopelessness

Impulsive or aggressive behavior

Cultural or religious beliefs favorable to suicide, especially among older people

Access to means of suicide

Most common means of suicide in nursing homes include:

Jumping from buildings

Hanging

Cutting

Taking an overdose of medication

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

Protective Factors that Can Help Prevent Suicide

Protective factors are a person's attitudinal and behavioral characteristics, life circumstances, and attributes of the environment that reduce the likelihood of suicide. "They enhance resilience and may serve to counterbalance risk factors". Actions that enhance protective factors are essential to preventing suicide. Some actions can be taken by staff in senior living communities and some by friends, family members, and residents themselves.

The following are protective factors for suicide for older adults in senior living communities:

Health care and emotional health care

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

Personal characteristics

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

Living situation

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

Relationships

- Strong connections with family, friends, and the larger community
- Engagement in purposeful activities, including recreational, social, spiritual, intellectual, and creative—designed around the likes and needs of the residents
- Strong connections with staff and volunteers
- Recognizing and reducing risk factors and increasing protective factors, both for individuals and groups, is at the heart of this Guide's approach to preventing suicide

Activities:

Activities and programs that promote the emotional health and well-being of residents build and strengthen the protective factors associated with personal characteristics and coping skills.

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

Health and wellness activities, such as exercise classes or interactive games; walking and gardening; and classes in relaxation, breathing techniques, yoga, Qigong, or Tai Chi.

Disease and injury prevention and chronic disease management classes that promote an ability to take care of one's health.

Intellectual activities, such as book and current events discussions, to stimulate cognitive functioning and enhance self-esteem.

Arts activities, such as creative writing, arts and crafts, music, drama, and dance, to promote creativity, imagination, and self-expression.

Skill-building activities, such as classes in computers, carpentry, cooking, sewing, gardening, financial management, and grand parenting, to increase self-esteem and a sense of competence.

Coping support programs for groups and individuals, including classes and workshops, to help residents face personal issues, such as loss and bereavement, caring for a spouse or partner, interpersonal communication, and problem solving

Spiritual activities, such as religious services, celebrations of religious holidays, prayer groups, and meditation classes, to help residents find meaning, purpose, and value in life.

Volunteer and mentoring activities, such as welcoming and engaging new residents, and intergenerational activities with children, teens, and younger adults, which provide a sense of purpose and meaningful connections with others

Social networks:

Strategies that promote social networks among residents build and strengthen protective factors that are associated with relationships. Social isolation and loneliness can have significant negative effects on emotional health. It is crucial for residents to have a variety of ways to connect with other people, develop social relationships, and receive the emotional support they need.

Creating opportunities for social networking among residents can help buffer the isolation that can exist in senior living communities (especially nursing homes), as residents are removed from day-to-day contact with their family and friends. Building connections between residents and staff is also important. Staff can be engaging and empathetic with residents while maintaining appropriate professional boundaries.

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

Activities and opportunities for individuals to feel welcomed and accepted into the community. Examples include welcoming rituals and events, buddy systems, and “friendship tables” in the dining room, which are designed to encourage singles and couples just beginning to form their network of friends to eat with others. Other activities engage people who are preparing to move to the senior living community, so they can establish social networks before entering the facility and ease their transition to a new living situation.

Caring neighbor activities, in which resident volunteers reach out to other residents. These can include telephone outreach programs, in which residents make calls to other residents to check on how they are doing and to offer support.

Programs or committees where staff partner with residents to assist in building social networks.

Programs that involve residents in the decision-making processes of the senior living community. These can include activities that encourage residents to participate on the resident council, resident committees, or other advisory, governing, or planning bodies. Being involved in decision making that affects the senior living community helps build social networks for both individuals and the community as a whole.

Environment:

Having a physical and social environment that promotes emotional health and wellbeing builds and strengthens protective factors associated with a living situation. A positive environment includes appreciating and actively engaging all residents in the life of the community. The environment should be welcoming to residents with various physical abilities and to those from a variety of ethnic, racial, and economic backgrounds. It should also ensure that residents are protected from possible abuse or violence from other residents or family members. A physical and social environment that is homelike, comfortable, practical, clean, safe, and aesthetically pleasing can have a profound effect on the emotional and physical health of residents. It can provide opportunities for socializing and meaningful activities, enhance both independence and privacy, and support the abilities of residents to accomplish the tasks of daily living. Additionally, the physical and social environment can have powerful protective effects on residents, both directly by affecting their mood and emotional health and indirectly by encouraging social connections and physical activity. It also helps residents feel a sense of belonging if they are consulted about the décor and furniture arrangements and are given alternatives to choose from.

Creating a physical and social environment that helps protect residents from suicide does not have to be expensive. There are a number of reasonably priced ways to make changes in the environment that can enhance the emotional health and functioning of residents. These include the following:

Ensure your senior living community compensates for physical impairments and other accessibility-related factors, including handrails in hallways, large print on signs and menus, and minimal background noise to make conversations easier. Store institutional equipment, such as medicine carts and housekeeping carts, out of sight; remove nurses' stations from resident areas; and make space for residents' personal objects and furniture.

Install indoor plants, artworks, and attractive landscaping and gardens with appropriately designed walking paths, shaded areas, and seating to rest and socialize.

Provide gathering areas for group conversations and activities; arrange dining areas and common spaces to allow small-group interactions.

Provide opportunities to develop intergenerational connections, such as bringing children and teens into the senior living community for different activities.

Foster an environment that is welcoming and inclusive of people of different cultural and ethnic groups.

Lethal means:

An environment in which one has limited access to methods of self-harm has been shown to prevent suicide. Research has shown that having easy access to a lethal means at the time when a person has an impulse to harm or kill himself or herself significantly increases the likelihood that the person will attempt suicide. In addition, when older adults attempt suicide, they are much more likely than people of other ages to die, in part because they use more lethal means. Although residents without access to items such as guns and knives can harm themselves by refusing food and medicine, passive (or indirect) suicide takes much longer to result in significant harm, which allows more time for discovery and treatment. The ability of a senior living community to restrict access to lethal means varies. It is easier to implement restrictions in more structured facilities, such as nursing homes. It is more difficult when residents have their own apartments or homes, as in assisted living and independent living. However, it is usually possible to implement some restrictions on lethal means, such as the following:

Restrict access through policies and procedures—Examples include prohibiting the possession of weapons, including firearms, by residents (in any type of senior living community) and monitoring medications taken by, and in the possession of, residents (more likely in nursing homes and assisted living). Staff, residents, and their families need to be informed about the new restrictions and the reasons for them, as well as the consequences of violating the restrictions.

Restrict access through physical barriers—Examples include keeping facility cleaning supplies in locked cabinets and locking access to areas such as rooftops and unprotected stairwells (which are common locations for suicide attempts in senior living communities because of their relative isolation). Again, not all of these strategies are appropriate for all senior living communities. However, in independent living communities where it may not be possible to control medications or cleaning supplies, another way to address the issues might be to provide education periodically on safety issues and on the side effects of medications.

Staff training:

Working toward the goals outlined in this Guide may require staff members to learn new ways of working and relating to residents. It is essential to provide staff members with the training and information that help them understand the reasons for the new ways of working, as well as the skills needed to effectively work in these new ways. Training in senior living communities often focuses on physical health needs. However, it is essential to provide training to *all* staff on the aging process; risk and protective factors for suicide; the Whole Population Approach; and emotional health issues, particularly depression, substance abuse, and suicide.

Nursing assistants (also called certified nurse aides, nurse aides, geriatric nurse aides, personal care assistants, or direct care workers, depending on the State and the senior living community) are the primary caregivers in nursing homes and assisted living facilities. As a result, training nursing assistants to provide consistent and high-quality care is crucial to residents' well-being and has a significant impact on improving emotional health and decreasing suicide risk.

Professional staff may need additional training in how activities in their areas of responsibility can promote emotional health and well-being and prevent suicide. Training on interpersonal skills, including communication and conflict resolution; team building; attitudes toward depression, substance abuse, and suicide; treating residents with respect; prevention of elder abuse; and self-care, including stress management and coping strategies, may also enhance staff members' ability to work well with residents and other staff.

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

Warning signs:

These warning signs are:

Someone threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself.

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

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

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

Other warning signs that show a person may be considering suicide in the very near future are:

Hopelessness

Rage, uncontrolled anger, seeking revenge

Acting reckless or engaging in risky activities, seemingly without thinking

Feeling trapped, like there's no way out

Increased alcohol or drug use

Withdrawing from friends, family, and society

Anxiety, agitation, unable to sleep or sleeping all the time

Dramatic mood changes

No reason for living, no sense of purpose in life

Every staff member in a senior living community should be able to recognize and know how to respond if a resident displays any of these nine warning signs. Every senior living community should have a formal protocol in place that outlines a clear process for responding to these nine warning signs. This process should include referral to the person on staff with responsibility for the emotional health of the residents.

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

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

Risk factors:

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

Risk factors are medical and emotional health conditions, personal characteristics, life circumstances, and situations that increase a person's risk for suicide.

Examples of risk factors include depression, substance abuse, physical illness, disability, pain, and isolation. No single risk factor alone means that a person will try to take his or her life. But risk factors can provide more information about whether the person may be in trouble.

Protective factors are personal characteristics, life circumstances, and situations that have been shown to have a positive effect on specific medical or psychological problems and that decrease the risk for suicide. They include factors such as good problem-solving skills, strong connections with other people, and access to high quality health care.

Depression:

Depression is a major risk factor for suicide. In a review of studies of depression rates in older adults the following was found:

Symptoms of major depression were present in less than 1–5 percent of older adults residing in the community and in 4–15 percent of residents in nursing homes. Other clinically significant depressive symptoms were present in 3–26 percent of older adults residing in the community and in 17–31 percent of residents in nursing homes. Yet in many nursing homes, rates of correct diagnosis by nursing home staff are low. Residents who are newly admitted to nursing homes are especially vulnerable to depression, yet there is a low rate of diagnosis of depression among them by nursing home staff as well. These findings suggest a strong need for more training for nursing home staff in recognizing depression and referring residents for treatment. Many people with dementia become depressed as their ability to remember and accomplish the functions of everyday life diminish. Dementia itself can lead to symptoms commonly associated with depression, such as apathy, loss of interest in activities, and social withdrawal. Up to 40 percent of people with Alzheimer’s disease suffer from significant depression.

Key Symptoms of Depression in Older Adults include:

Depressed mood most of the time, sad or “empty” feelings

Loss of interest or pleasure in activities

Disturbed sleep (sleeping too much or too little)

Weight loss or gain (changes in appetite)

Fatigue or lack of energy

Feelings of worthlessness or extreme guilt

Difficulties with concentration or decision making

Noticeable restlessness (agitation) or slow movement

Frequent thoughts of death or suicide, or a suicide attempt

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

It is essential that all staff know that depression is a treatable illness, not a normal part of aging. Senior living communities should have a protocol in place so that staff knows how to identify someone at risk of depression, the appropriate referral, who will screen, and who will treat the resident.

Substance abuse:

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

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

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

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

Community connections:

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

Help seeking:

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

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

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

Crisis Response Approach

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

Suicide deaths and attempts also have a profound emotional impact upon other residents, their families, volunteers, and the staff. Attempt survivors and their families can be severely traumatized. Both attempts and deaths can elevate the suicide risk of other vulnerable residents. Therefore, responding to suicide deaths and attempts in an appropriate way can help alleviate the pain caused by these incidents and can prevent a similar attempt by other residents who may be at an increased risk of suicide.

Immediate response:

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

Postvention:

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

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

Dr. Edwin Shneidman, founder of the American Association of Suicidology, coined the term *postvention* to refer to programs and interventions for survivors following a death by suicide. Postvention helps alleviate the suffering of suicide survivors and helps prevent an attempt by those at an elevated risk of suicide. Postvention should follow any suicide death or attempt in a senior living community. The type of support may vary for each of the three categories of survivor: family, close friends and neighbors of the resident; the senior living community at large; and staff.

It Is Vital That Senior Living Communities Know How To Recognize Suicide Risk and Prevent Suicide.

Here are some steps:

1. **Notice if the person appears quiet and withdrawn**, oversleeps, has crying episodes, has loss of appetite and energy, appears disheveled, the gaze is downward, the voice tone is flat, consistently negative comments, irritability, or says things like, "Life's not worth living," or "I hate my life," etc.
2. Ask: "How would you **rate your mood right now** on a scale of zero to ten with zero meaning life's not worth living and ten meaning life is great?"
3. If the person rates the mood as 5 or under, ask: "Have you had any **thoughts of suicide** or of harming yourself?" *
4. If the person indicates yes, go to the next step. If the person says, "**I don't know**," hear this as a "yes" to the question in #3.
5. Ask: "Have you **thought about how you might end your life**?" If the person says yes, the risk is increased.
6. Ask: "**What have you thought about as how you might do it**?" If the means is ineffective or non-lethal, such as cutting wrists, risk is lower. If the means is lethal such as using a gun or jumping from a bridge, etc., risk is higher.
7. Regardless of the means, ask: "**Can we agree together** that if you have thoughts of killing yourself, you will speak to me personally (not my voice mail) before carrying out a plan to harm yourself?"

8. If the person says "no" or "I don't know," to the question in #7, say: "What I am hearing is that you are in a lot of pain right now and thinking of ending your life, so **I am going to take you to get help** right now to help to feel better right away. Will you go? I will make sure you get there safely. Is there a family member or someone I can call to go with you?" Or tell the person you will go with them yourself.

9. Arrange for the person to **be accompanied to a help center**, (a hospital or mental health facility) and **call 911 or 1-800-273-TALK (8255)** to tell emergency staff you are coming.

10. If the person refuses, then ask the person to wait there with someone while you **call police** in another room to report that the person has threatened suicide with lethal means. Ask the police to come and accompany the person to a help center.

***Note: If the person rates the mood as 6 or over (in answer to the question in #3), after feeling consistently depressed, and she/he now reports life is great and she/he is smiling, the risk may be increased because she/he has decided to end their life and have made all arrangements.**

10 Little Known Facts About Suicide

1. The word “suicide” comes from two Latin roots, *sui* (“of oneself”) and *cidium* (“killing” or “slaying”).
2. It is more likely someone will die from suicide than from homicide. For every two people killed by homicide, three people die of suicide.
3. In America, someone attempts suicide once every minute, and someone completes a suicide once every 17 minutes. Throughout the world, approximately 2,000 people kill themselves each day.
4. Suicide is the 8th leading cause of death in the United States.
5. The spring months of March, April, and May have consistently shown to have the highest suicide rate, 4-6% higher than the average for the rest of the year. Christmas season is actually below average. Some studies suggest greater seasonality in suicides in rural rather than urban areas.
6. Over the last decade, the suicide rate among young children has increased dramatically. In 2002, suicide was the sixth leading cause of death of five- to 14-year olds and the third leading cause of death in preteens. Suicidologists are alarmed that children as young as age two are also increasingly attempting suicide.
7. During 2008, 140 American soldiers committed suicide, breaking all previous suicide records in the military. In the first four months of 2009, 91 soldiers committed suicide. If this rate continues throughout 2009, by the end of the year more than 270 soldiers will have killed themselves, leading some scholars to claim there is a suicide epidemic in the military.
8. Although women attempt suicide about three times more often than men, men complete suicide about three times more often than women.
9. Four out of five people who commit suicide have attempted to kill themselves at least once previously.
10. In America, the most common suicide method for both men and women is firearms, accounting for 60% of all suicides. For women, the next most common method is ingesting solid and liquid poison or pills. The next most common method for men is hanging/strangling/suffocation.

Resources & Organizations

American Association of Suicidology
www.suicidology.org 202-237-2280

American Foundation for Suicide Prevention
www.afsp.org 888-333-2377

American Psychiatric Association
www.psychiatry.org 1-888-35-PSYCH or 1-888-35-77924

Kristin Brooks Hope Center
www.hopeline.com 202-669-8500

Mental Health America
www.mentalhealthamerica.net 1-800-969-6642

National Council for Community Behavioral Healthcare
www.TheNationalCouncil.org 1-202-684-7457

National Youth Violence Prevention Resource Center
www.safeyouth.org 301-562-1001

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov 877-SAMHSA-7

Suicide Awareness Voices of Education
www.save.org 888-511-7283

Suicide Prevention Action Network USA Inc.
www.spanusa.org 202-449-3600

Suicide Prevention Resource Center
www.sprc.org 877-438-7772

The Compassionate Friends
www.compassionatefriends.org 877-969-0010

The Jed Foundation
www.jedfoundation.org 212-647-7544

Yellow Ribbon Suicide Prevention Program
www.yellowribbon.org 303-429-3530



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Informational Toolkit Order Form

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Send toolkits to:

Name _____ Address _____

City _____ State _____ Zip _____

email address _____

Mail order form to: Todd Waite Legacy Foundation, 3857 Canal Ave., Grandville, Mi. 49418

email request to: twlf4suicideawareness@gmail.com or fax form to - 616-534-9708

visit our website at www.twlf4suicideawareness.com for more **Free** information