The Hearing Aid Podcasts

Episode 10.2

Approach to self harm and suicide in older adults

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Thanks to reviewers: Leah White, Kellie Gordon

Based partly on a chapter from a forthcoming textbook in Handbook of Old Age Psychiatry with Peter Byrne.

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Trigger warning

Clinical scenario

:

> *Mr Jones is an 83 year old retired mechanic who was admitted post fractured NOF. He fell whilst intoxicated and was found after a long lie, when his neighbour happened to knock on his door to drop some food in. He was found to have a number of spinal crush fractures which had not previously been diagnosed. He has been living alone since his wife died 4 years earlier. Nursing staff have noticed that he seems withdrawn, and he isn't making much effort when the physiotherapist comes to visit him. He is due to be discharged with a reablement package of care but mentions to the FY1 doctor who is taking his bloods that he's had enough.*

The FY1 who has heard this might be thinking several things at this point

- *How to start a conversation about this admission?*
- *When to ask for a review by liason or CMHT?*

Definitions

Suicide = intentionally causing one's own death.
Self harm = The term self-harm is used in this quality standard to refer to any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation

Nice Guideline Quality standard [QS34]Published date: 28 June 2013

Main Discussion

Epidemiology of suicide and self-harm in the UK:

Suicide rates across the whole population have remained fairly steady over the last 10-12 years. The most recent National Confidential Inquiry into Suicide (2007-2017) found 425 deaths/year in people over the age of 75.

- Older adults who died by suicide were likely to have had depression, and a high percentage of these individuals had been ill for less than a year.
- Only 20% were under the care of mental health services, which is lower than in any other age group.

University of Manchester. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report 2019: England, Northern Ireland, Scotland and Wales. 2019.

- A systematic review looking at completed suicide found that around 45% of older people had consulted their GP in the month before they died, whilst only 13.6% had had contact with mental health services in the preceeding month.
- It should be noted that the spectrum of suicidal ideation and behaviour in older adults is very likely to be under-recognised due to presentations such as self-starvation or dehydration being common.
- In terms of recording deaths as suicide, it may also be harder to identify a verdict of suicide in older adults when multi-morbidity, frailty and polypharmacy are present.

Cheung G, Merry S, Sundram F. Medical examiner and coroner reports: Uses and limitations in the epidemiology and prevention of late-life suicide. Int J Geriatr

Kiriakidis SP. Elderly Suicide: Risk Factors and Preventive Strategies. Ann Gerontol Geriatr Res [Internet]. 2015;2(2):1028–32.

Psychiatry. 2015;30(8):781–92. PMID 25962908

A UK study looking at self harm in those over 60 found rates of 65 per 100,000 which is much lower than in those aged 18-59 (380/100,000).

- However, despite this lower incidence, it is very important to understand that the suicide risk after an instance of self harm in an older person is 67 times higher than someone who has not harmed themselves.
- To put this in context we can compare this to the risk of suicide after self harm in someone aged 20-59 years - which is 3 x the risk compared to the general population.
- This is not to dismiss self-harm in any age group, but to illustrate how important it is to take seriously a presentation of self-harm in an older individual.

Murphy E et al. Risk factors for repetition and suicide following self-harm in older adults: Multicentre cohort study. Br J Psychiatry. 2012;200(5):399–404.PMID 22157801.

- A recent systematic review looking at self harm in older adults found around 30% had seen their GP before self-harming, and around 60% had had contact with primary care up to a month before the self-harm. Only 40% had previously received treatment under mental health services, but only 28% were under the care of a mental health service at the time of self harm.
- A study of primary care data found that after an incidence of self harm only 12% of adults over 65 were referred to mental health services.
- 60% of these people were prescribed an antidepressant, of which 12% were prescribed a tricyclic antidepressant. This is worth noting when thinking about future prevention and risk reduction, because tricyclic antidepressants are particularly dangerous in overdose.

Morgan C, Webb RT, Carr MJ, Kontopantelis E, Chew-Graham CA, Kapur N, et al. Self-harm in a primary care cohort of older people: incidence, clinical management, and risk of suicide and other causes of death. The Lancet Psychiatry [Internet]. 2018;5(11):905–12.

Isabela Troya M et al. Self-harm in older adults: Systematic review. Br J Psychiatry.PMID 30789112

Risk factors for suicide in older adults

- Mental disorders
    - Especially depression (often undertreated) and depression with psychotic features (eg: delusions of guilt, poverty, persecution).
    - 'Agitated depression' (depressive disorder with mixed features)
    - Anxiety
    - PTSD.
    - Extreme fear and disorganised behaviour in delirium can also occasionally result in very severe self harm.
- Isolation
- Safeguarding and abuse
- Substance misuse: This is frequently under-recognised as a risk factor for suicide in older adults.

- Insomnia
- Poverty
- Recent bereavement (with highest risk in those who have lost a partner in the last month)
- Caring roles
- Physical impairments, especially those which cause functional impairment, pain and/or loss of autonomy
    - Certain physical conditions are associated with high rates of suicide, and this includes multiple sclerosis and Huntingtons disease.
- A desire for hastened death can occur in palliative populations.
    - Figures vary but most studies have found somewhere between 5-20% of people have this desire, the reasons for which are complex..
    - Meta-ethnographic studies have identified that such thoughts often result from multidimensional or "total" suffering/pain (term coined by Cicely Saunders). This might encompass a sense of being a burden, feelings of isolation, of fear, and a want to regain control, and is associated with depression.
    - Treating depression and providing good palliative care are key interventions here.
- The question of Dignitas is a whole session in itself – but important to recognise sometimes people can be suffering in various ways which could lead to a death wish, and not always as simple as being "tired of life".
- Shame
    - This is an important factor affecting how older adults might access help after self harm.
    - This is particularly relevant when considering what people do when they feel suicidal and what internal judgements they might make of themselves - and how this specifically relates to the older population who may still remember when suicide was a crime.
    - Changes associated with conditions common in older age - causing, for example, things like an increased dependence on others, a requirement for personal care, episodes of incontinence etc - can contribute to feelings of shame.
- "Psycheache" is a concept described by Shneidman: a total, intolerable experience that includes shame, guilt, humiliation, loneliness, fear, and anger that could emerge from frustration of essential psychological needs and is highly associated with suicide
- Adverse childhood experiences are related to physical ill health and suicide risk across the lifespan
- Individual experiences and perceptions associated with self harm and suicidal intentions were found in qualitative studies to include
    - Impaired decision making + coping
    - Loss of control and wanting to regain control
    - threats to identity and continuity
    - disconnectedness, invisibility, alienation
    - meaninglessness.

Conejero I, Olié E, Courtet P, Calati R. Suicide in older adults: Current perspectives. Clin Interv Aging. 2018;13:701–12.PMID 29719381

Royal College of Psychiatrists. Self-harm and suicide in adults. 2020;(July).

Choi JW et al. Poverty and suicide risk in older adults: A retrospective longitudinal cohort study. Int J Geriatr Psychiatry. 2019;34(11):1565–71.

Santos J et al. Pain as a risk factor for suicidal behavior in older adults: A systematic review. Arch Gerontol Geriatr [Internet]. 2020;87(July 2018):104000.

Troya MI et al Understanding self-harm in older adults: A qualitative study. EClinicalMedicine [Internet]. 2019;12:52–61.

Meerwijk EL, Weiss SJ. Toward a unifying definition: Response to "the concept of mental pain." Psychother Psychosom. 2013;83(1):62–3. PMID 24281693

Sachs-Ericsson NJ, Rushing NC, Stanley IH, Sheffler J. In my end is my beginning: Developmental trajectories of adverse childhood experiences to late-life suicide. Aging Ment Heal [Internet]. 2016;20(2):139–65

Monforte-Royo C et al. The wish to hasten death: A review of clinical studies. Psychooncology. 2011;20(8):795–804.PMID 20821377

Monforte-Royo C et al What lies behind the wish to hasten death? a systematic review and meta-ethnography from the perspective of patients. PLoS One. 2012;7(5). PMID 22606228

Rayner L, Higginson IJ, Price A, Hotopf M. The Management of Depression in Palliative Care: European Clinical Guidelines. 2010;1–44.

Hartog ID et al. Prevalence and characteristics of older adults with a persistent death wish without severe illness: a large cross-sectional survey. BMC Geriatr. 2020;20(1):1–14.

Wand APF, Peisah C, Draper B, Brodaty H. Understanding self-harm in older people: A systematic review of qualitative studies. Aging Ment Heal [Internet]. 2017;22(3):289–98

Dementia and suicide and self harm risk

The links between suicide and dementia is complex, and has been an area of interest and research.
:

- A dementia diagnosis in itself does not seem to increase the risk of suicide, however the cognitive impairment may contribute to/cause cognitive

inflexibility, impulsivity, diminished problem solving ability or executive dysfunction.

- Having said this, the risk of suicide in patients with a dementia diagnosis can be increased if there is coexistent depression
- There is some evidence that people who attempt to end their lives may be more likely to develop dementia later (independent of comorbidities and depression)
- It has been highlighted that early or even pre-symptomatic diagnosis of cognitive impairment may raise the possibility of "rational" suicide (9)driven by factors like a fear of what may await them further on into their illness.
- There are some therapies which have been adapted for people with cognitive impairment
    - Problem Solving therapy – PST
    - Problem Adaptation Therapy (PATH)
    - These two examples have been shown to reduce suicidal ideation in adults with depression and cognitive impairment

O'Dwyer ST et al. Suicidal ideation in family carers of people with dementia: a pilot study. Int J Geriatr Psychiatry. 2013;(1997):n/a-n/a. PMID 26161825

Tu Y-A et al. Geriatric Suicide Attempt and Risk of Subsequent Dementia: A Nationwide Longitudinal Follow-up Study in Taiwan. Am J Geriatr Psychiatry [Internet]. 2016;24(12):1211–8

Draper BM. Suicidal behavior and assisted suicide in dementia. Int Psychogeriatrics [Internet]. 2015/04/16. 2015;27(10):1601–11.

. Van Orden K, Deming C. Late-life suicide prevention strategies: current status and future directions. Curr Opin Psychol [Internet]. 2018;22:79–83.

Gustavson KA et al. Problem-Solving Therapy Reduces Suicidal Ideation In Depressed Older Adults with Executive Dysfunction. Geriatr Psychiatry. 2016;21(1):11–7.

Kiosses DN, et al. Problem Adaptation Therapy (PATH) for Older Adults with Major Depression and Cognitive Impairment: A Randomized Clinical Trial Clinical Trials Registration Official Title: A Treatment for Depressed, Cognitively Impaired Elders Identifier: NCT00368940 HHS . JAMA Psychiatry [Internet]. 2015;72(1):22–30

Clinical scenario continued..

Mr Jones describes feeling frustrated and tired. He's lost interest in listening to the radio and food, and has lost some weight though he's not sure how much. He has been sleeping poorly for some months and gradually drinking more over the months in part to manage insomnia and also the anxiety about catching COVID and dying alone. He has felt lost since the death

of his wife and although he was regularly attending the Men's shed, and helping out in the local garden centre that has all been shut down because of covid. He's never been one for the phone and so he's not really spoken to friends from the garden centre since lockdown. His daughter lives in Birmingham and has two children, and the family have sent him an ipad but he couldn't figure out how to use it….

Theories regarding suicidal behaviour in older adults:

There are many different theories of suicide, but the following might be applied to older adults

- The Interpersonal theory of suicide describes two dynamic psychological states.
    1) Thwarted belonging
    2) Perceived burdensomeness.
    - The presence of the two constructs can lead to development of passive suicidal thoughts.
    - Exposure to painful and provocative experiences can then lead to an "acquired capability", leading to a reduced fear of death and elevated pain tolerance.
- Psychodynamic theories focus on shame, narcissistic rage, and extreme splitting where the 'bad' self/body can be killed off, with the fantasy that the good part will live on.
- There is work from Rachel Gibbons, on a theory that an earlier failure to mourn affects the response to events later in life.

Stanley IH et al.. Understanding suicide among older adults: A review of psychological and sociological theories of suicide. Aging Ment Heal. 2016;20(2):113–22.

How to approach discussions and conversations about suicide and self harm:

Asking about depression:

The NICE guidelines recommend that two screening questions can be asked of non-cognitively impaired older people on medical wards:

- "During the past month have you often been bothered by feeling down, depressed or hopeless?" and
- "During the past month have you often been bothered by having little interest or pleasure in doing things?"

Esiwe C et al. Screening for depression in older adults on an acute medical ward: The validity of NICE guidance in using two questions. Age Ageing. 2015;44(5):771–5.

Asking about suicide:

It is important to understand that the risk assessment tools we have have very limited validity and often people who die by suicide have been classified as "low risk" at their last assessment.

- A recent mixed methods systematic review stresses the importance of collaborative work with patients and families.
- Raue makes suggestions about how to ask about suicide risk in primary care which translates well into any other medical setting.
    - This starts with asking about the person's thoughts about their future, followed by whether the person has ever felt if they would be better off dead, and then moving to more specific questions about harm to self, and how imminent this is, methods, access to weapons or medicines.

Graney J et al. Suicide risk assessment in UK mental health services: a national mixed-methods study. The Lancet Psychiatry [Internet]. 2020;7(12):1046–53.

Oxford University Centre for Suicide Research. If a patient dies by suicide: A Resource for Psychiatrists [Internet]. 2020.

Raue P, Ghesquiere AR, Bruce ML. Suicide Risk in Primary Care: Identification and Management in Older Adults. Curr Psychiatry Rep. 2015;16(9):1–14.

If someone is reporting physical suffering (eg GI discomfort, dizziness, pain), as well as things like poor sleep it is worth asking how they are coping, about their mood and about any wish to harm themselves or to die. This is shown in studies from Lapierre and colleagues, where a link between presentations to healthcare with somatic symptoms and a wish to die/dying by suicide was demonstrated..

Lapierre S, et al. Daily hassles, physical illness, and sleep problems in older adults with wishes to die. Int Psychogeriatrics. 2012;24(2):243–52.

Lapierre S et al. A systematic review of elderly suicide prevention programs. Crisis. 2011;32(2):88–98

There are various schools of thought regarding asking about suicide, and the best way will depend on the person you are asking, their history and situation.

Cate suggests that questions which demonstrate empathy and having listened to someone's suffering are also helpful, as well as being open and ready to listen to the responses to the questions you ask..

- Examples include
    - "I understand the pain has been very bad recently and I wonder; does it ever get so bad you feel like you'd rather not be alive."
    - "I can hear things have been really tough recently, what's keeping you going at the moment?.
- A useful tool in regard to safety planning and thinking of the future are questions about what would need to change for life to feel worth living again (the 'magic wand question').

An interesting study from Rose McCabe using conversation analysis looked at how psychiatrists ask about suicide risk.

- Although it looked at a small sample, it found that 75% of questions were phrased negatively (eg: "No thoughts of harming yourself?").
- In primary care there were similar findings, with questions framed to generate a negative response, and also amalgamation of questions about self harm and suicide.
- There was evidence of missed opportunities to empathise, with a tendency noted to make a moral judgement of the effect suicide would have on friends or family.

McCabe R et al.. How do healthcare professionals interview patients to assess suicide risk? BMC Psychiatry. 2017;17(1):1–10

. Ford J et al. Asking about self-harm and suicide in primary care: Moral and practical dimensions. Patient Educ Couns. 2021;104(4):826-835. PMID: 33162274.

It's really important to acknowledge: these are not easy things to talk about, but it is important for people who work in health and social care to be able to start a conversation about these things.

Clinical scenario continued…

He's been wishing he wasn't alive for the last few months and the thoughts have become more intense recently. He has some morphine left over from when his wife died of cancer at home and has thought about taking it but he wouldn't want to hurt his family. He wishes he had died after the hip fracture and wakes up most mornings wishing he had died in the night. So how can we intervene?

Interventions:

1) **Primary prevention**

- This takes place at a population level
- These are universal measures that help everyone, for example...
    - Reducing inequalities
    - Resourcing primary care
    - Fostering social connectedness
    - Reducing isolation

Van Orden argues that addressing ageism is a form of universal prevention, and highlights the role of geriatricians as key to this – as they are a group of professionals trained to optimise physical and cognitive functioning and focus on wellbeing

Van Orden K, Deming C. Late-life suicide prevention strategies: current status and future directions. Curr Opin Psychol [Internet]. 2018;22:79–83

2) **Selective prevention targ**ets groups who are at a higher risk of suicide or self harm, perhaps due to risk factors already mentioned - eg. physical health comorbidities, depression, isolation.

- For the treatment of depression in primary care, integrated approaches work well, and help improve both depressive symptoms and functioning with comorbid physical health issues.
- Multidisciplinary approaches are key.
    - Both IMPACT and PROSPECT interventions utilised depression care mangers (either psychologists, nurses or social workers in this coordinating role), education about treatment options (which included interpersonal or behavioural psychotherapy) as well as follow up and monitoring of depressive symptoms and medication.
    - Both demonstrated reduction in suicidal ideation after 12 and 24 months.
    - The active ingredients thought to be most effective were the personalisation of treatment, the therapeutic alliance and proactive follow up.

As with any other mental disorder, collaborative MDT care is key in alleviating some of the risk factors for suicide and self harm, and in combatting ageism and functional impairments which contribute.

- **Physiotherapy** has an established role in supporting independence, quality of life, reducing pain, isolation and fear in older adults.
- **Occupational therapy** interventions can improve wellbeing and self-efficacy, and also has a role in minimising functional impairments which could contribute to depression and suicidal ideation.
- Ensuring people are able to access the correct benefits and support goes some way to alleviating risk factors such as poverty.
- Befriending and regular social contact also has a role in reducing isolation and loneliness and is a target for future interventions.

Coventry P et al. Integrated primary care for patients with mental and physical multimorbidity: Cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease. BMJ. 2015;350:1–11

Hunkeler EM et al. Long term outcomes from the IMPACT randomised trial for depressed elderly patients in primary care. Br Med J. 2006;332(7536):259–62

Alexopoulos GS et al. Reducing suicidal ideation and depression in older primary care patients: 24-Month outcomes of the PROSPECT study. Am J Psychiatry. 2009;166(8):882–90.

Probst M. Physiotherapy and Mental Health. In: Suzuki T, editor. Clinical Physical Therapy. 1st ed. Rijeka; 2017. p. 179–204.

Toledano-González A, Labajos-Manzanares T, Romero-Ayuso D. Well-Being, Self-Efficacy and Independence in older adults: A Randomized Trial of Occupational Therapy. Arch Gerontol Geriatr [Internet]. 2019;83(May):277–84.

Van Orden KA et al. Strategies to Promote Social Connections Among Older Adults During "Social Distancing" Restrictions. Am J Geriatr Psychiatry. 2020;1–12

Unfortunately we know that ageism affects prescribing and referrals.

- The RCPsych report entitled "Suffering in silence: age inequality in older people's mental health care" published in 2018 looked at direct and indirect discrimination.
- Ageism in itself (like racism and other forms of discrimination) affects health and is internalised.
- Discrimination among older adults was associated with increased symptoms of depression, worse self-rated health, functional limitations and chronic illness.
- Tadros and colleagues in 2013 found that only 1/6 older people with depression receive any treatment whilst 50% of working age adults do.
- Although therapy has broadly the same efficacy in younger and older adults, GPs are much more likely to refer working adults. Yet when older people are referred they are more likely to complete therapy than their younger counterparts
- 85% of older people with depression receive no support from the NHS, and are a fifth as likely to have access to talking therapies but 6x more likely to be on medication

We hope that by highlighting these different patterns in referral and treatment it might stimulate thinking, questioning and reflecting on why this is the case.

- Is access to IT based support and interventions the best way to help older adults who may not be as IT literate?
- Do older adults have different preferences and perceptions regarding treatment options?

The Royal College of Psychiatrists. Suffering in silence: age inequality in older people's mental health care. Coll Rep CR211. 2018;32.

Swift HJ et al. The risks of ageism model: How ageism and negative attitudes toward age can be a barrier to active aging. Soc Issues Policy Rev. 2017;11(1):195–231.

Tadros G et al. Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: The Birmingham RAID model. Psychiatrist. 2013;37(1):4–10.

NHS Digital. Psychological Therapies, Annual Report on the use of IAPT Services [Internet]. NHS Digital. 2018. 1–34 p.

Burns A. Better access to mental health services for older people [Internet]. NHS England Blog. 2015 [cited 2020 Jan 26]. p. 1.

We should have an awareness of cognitive bias amongst health care professionals, something illustrated by a study in 2009 by Linden and Kurtz, which asked 121 doctors to look at case studies of two identical patients with depression, the only difference being age: one was 39, and one was 81. The younger person was more likely to be diagnosed with depression and prescribed psychotherapy, pharmacotherapy and referral for specialist treatment, whilst the older person was given a diagnosis of dementia or a physical illness and prescribed supportive counselling.

Linden M, Kurtz G. A Randomised Controlled Experimental Study on the Influence of Patient Age on Medical Decisions in Respect to the Diagnosis and Treatment of Depression in the Elderly. Curr Gerontol Geriatr Res. 2009;2009:1–4.

Education on suicide and mood disorders for those involved in caring for older people is often recommended, though formal studies have not occurred which directly measure the effect of this on suicide rates.

- Even a brief educational intervention for clinicians working with older adults improved knowledge, confidence, attitudes and participants felt that it was likely to change their practice.
- In an older study, not specifically focussed on older people,GPs were given specific education about depressive disorders and this reduced the frequency of requirement for inpatient care by 30%, and the frequency of suicide. However, after the programme ceased this effect declined, suggesting that education needs to be repeated regularly.

Lapierre S et al. A systematic review of elderly suicide prevention programs. Crisis. 2011;32(2):88–98.
Wand APF, Draper B, Brodaty H, Hunt GE, Peisah C. Evaluation of an Educational Intervention for Clinicians on Self-Harm in Older Adults. Arch Suicide Res [Internet]. 2020;0(0):1–21

Rutz W. Prevention of depression and suicide by education and medication: Impact on male suicidality. An update from the Gotland study. Int J Psychiatry Clin Pract. 1997;1(1):39–46.

3) **Indicated prevention** (for those who are at acute risk):

This involves safety planning, and is tertiary care:

Van Orden and colleagues suggest targeting the 5Ds:
Depression, **Disability** (functional impairment), **Disease** (physical illness and pain), **Disconnectedness** (social isolation), and **Deadly** (access to lethal means).

Conti EC, Jahn DR, Simons K V., Edinboro LPC, Jacobs ML, Vinson L, et al. Safety Planning to Manage Suicide Risk with Older Adults: Case Examples and Recommendations. Clin Gerontol [Internet]. 2020;43(1):104–9.

Back to our clinical scenario….

What would intervention look like for Mr Jones?:
Firstly, asking his permission to refer to liaison psychiatry services.

***Depression**: treatment of depression, discussion with liaison psychiatry, consideration of antidepressant therapy and referral to CMHT/IAPT for talking therapy.*
We need to consider...

- *How he will be monitored whilst the treatment starts and what follow up he will need.*
- *Treating insomnia and thinking about alternatives other than alcohol.*

***Disability**: What support will he need at home? How does he feel about this? Working with OT, physio, social work and considering what he is still able to do, and how to improve his functional ability.*

***Disease**: is he still in pain, what could be done to help with this?*

***Disconnectedness**: how can we help him feel more part of the community, who has he lost touch with, how can we support re-connection?*

***Deadly/access to lethal means**: this involves thinking about the quantity of prescriptions, the lethality of prescriptions and safety planning.*
This also encompasses an anticipation of recurrence of thoughts, and how to put strategies in place to manage with this.

- *Crisis lines are a key resource in this situation, including national charitable organisations that people can call like Samaritans, Silverline or SHOUT (a text service).*
- *Local mental health crisis teams also provide crisis line support, and details for these can be found by searching online, or be provided to people by primary or secondary care services*
- *If the above options are not feasible/sufficient, a 999 call is also an option.*

The effect of the consequences of the COVID-19 pandemic in the UK on the issues discussed in this podcast episode:

The virus itself, the related uncertainty, fear, media coverage and the nationwide lockdown have had widespread social, emotional, physical and financial impacts for many people, but particularly for older adults. Many of the effects will likely compound or result in situations that are risk factors for suicide and self harm (for example, bereavement, isolation, poor physical health, poverty).

We need to be mindful of this as clinicians as we see patients in the coming months/years, and also consider;

- How to be proactive, identifying risk factors and engaging patients to talk about their mood and any feelings of self harm and suicide where appropriate
- How many people have been bereaved and been prevented from being able to grieve in a 'normal' way (eg unable to attend funerals, or be with people when they died).

The RCPsych have produced a resource available via this link to support clinicians following the death of a person by suicide;

Oxford University Centre for Suicide Research. If a patient dies by suicide: A Resource for Psychiatrists [Internet]. 2020.

Curriculum Mapping

NHS Knowledge Skills Framework

- Communication
    - Level 3: adapts communication to take account of others' culture, background and preferred way of communicating

Foundation Programme

- Uses appropriate styles of communication
- Makes clear, concise and timely written and oral referrals to other healthcare professionals within the hospital
- Evaluates patients' capacity to self-care, including mental health aspects

GPVTS

- Older Adults (Life stages)
    - The prevalence and incidence across all ages and any changes over time
    - Risk factors, including lifestyle, socio-economic and cultural factors Psychiatric: anxiety and depression
    - Access to social services, rehabilitation, nursing homes, residential homes and various statutory and voluntary organisations for support of older people in the community, (for example podiatry, visual and hearing aids, immobility and walking aids, meals on wheels, home care services). Note that patients may have preconceived ideas of what 'support' can mean and may not identify themselves as needing support
    - The positive and negative ways in which socio-economic and health features inter-relate (for example poverty, ethnicity and local epidemiology) and the importance of this within the community
    - Respect for the sensitivities of older adults regarding their health attitudes, behaviours and needs; impact of attitudes to treating older adults equitably, with respect for their beliefs, preferences, dignity and rights; issues of confidentiality and consent and sharing information with other agencies

Internal Medicine Stage 1

- Psychiatry
    - Self-harm
    - Depression
    - Suicide and self-harm
- Public health and health promotion
    - Mental health
- Palliative medicine and end of life care
    - Psychosocial concerns including spiritual care and care of family
- Geriatric medicine
    - Depression

Geriatric Medicine Specialty Training

- Comprehensive geriatric assessment
    - Depression
    - Identification of lifestyle changes to positively improve health
- Dementia
    - Impact of dementia on the assessment and management of other illnesses, on nutrition, and on rehabilitation
- Community liaison and practice
    - Carer stress
- Psychiatry of Old Age
    - Working collaboratively with other specialists, particularly old-age psychiatrists, and agencies to manage the older patient with mental ill health
    - Depression