NIHR | Oxford Health Biomedical Research Centre

PRECISION PSYCHIATRY LAB

UNIVERSITY OF OXFORD

Suicide and self-harm - How to prevent, assess and manage the risk of suicide/self-harm during the COVID-19 pandemic.

*Please note all questions within each section are linked to each other and should be read in conjunction. Below each question is the weblink to the source of evidence to support the guidance recommendation. Readers can, of course, focus only on areas of interest, but we would suggest that you read the answers to all questions within a group as the answers complement and overlap with each other.*

*The tables were created with input and guidance from Professor Keith Hawton (Professor of Psychiatry, Centre for Suicide Research, University of Oxford; Consultant Psychiatrist, Oxford Health NHS Foundation Trust), Dr Alexandra Pitman (Honorary Consultant Psychiatrist, Camden and Islington NHS Foundation Trust; Associate Clinical Professor, UCL Division of Psychiatry) and Karen Lascelles (Nurse Consultant, Oxford Health NHS Foundation Trust). We thank them for their helpful contributions and guidance in preparing these tables.*

*Please read the following advice in combination with national UK advice on protection/self-isolation.*

Please note, although there are monitoring programmes for suicidal behaviour and self-harm during COVID-19, the time of initial publication (August 2020) is relatively early on in the course of the pandemic. There are many questions in this area for which there are currently no specific COVID-19 guidelines available. In addition, most of the guidance here has come from studies and developments in higher income countries. It is fully acknowledged that the majority of suicides globally occur in lower and middle income countries (https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf?sequence=1&isAllowed=y). While much of the guidance will be applicable in such countries, limitations on resources, including services, may mean that some of the guidance is less relevant or needs adaptation to different settings. In lower and middle income countries there may, for example, be greater reliance on digital interventions and also on use of lay counsellors to support people with mental health problems and deliver suicide prevention initiatives (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7377764/ for discussion of some of these issues).
Despite these considerations, we felt it was important to start a table. Our aim is to help clinicians by providing as much focussed guidance as we can in one open access resource. The prevention of suicide and self-harm is a central area in mental health, and in the context of COVID-19 it generates urgent clinical questions. Where specific COVID-19 guidance exists, we have provided this. Where it is not available, we have used relevant pre-existing guidance with clear referencing to the original source and provided links to other relevant websites.
We will update this table with more COVID-19 specific guidance as it becomes available. Readers may also wish to consult other sources of evidence, such as systematic reviews (www.crd.york.ac.uk/prospero/) or other sources of living evidence, which are updated in real time and relevant to COVID-19 (https://zika.ispm.unibe.ch/assets/data/pub/search_module/ or https://covid-nma.com/). Of particular interest in this area are the living review https://covid19-suicide-lsr.info/ and https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=178819. As always, we welcome feedback from readers as described in the introductio
(For definitions of 'self-harm' and other related terms, please see footnote 1.)

| Clinical question | Guidance |
|---|---|
| **The impact of COVID-19 on patients/the public who may be at risk of self-harm/suicide.** | |
| **1a. What COVID-19 specific factors may provide extra challenges for patients/the public in terms of risk of suicide/self- harm?**<br>[link1]<br>[link2] | The **World Psychiatric Association** has provided a summary of the impact of the COVID-19 pandemic on risk and protective factors for suicide:<br><br>During the COVID-19 pandemic, it is likely that both risk and protective factors will be affected (both positively and negatively) by either the disease itself or as a result of the implemented social/public health and economic measures.<br><br>**Possible negative impacts of COVID-19** can act through different levels of risk factors and protective factors:<br><br>1. **Societal risk factors:**<br>• Increased pressure on healthcare systems<br>• Increased delegation of resources towards the acute response to the pandemic<br>• Decreased focus on mental healthcare and reduced effective mental healthcare<br>• Increased buying and stockpiling of medication (and firearms in some countries), but also increased barriers to access due to containment measures<br>• Sensationalizing of media impacts on the perception of risks<br>• Barriers to help-seeking behaviour through containment measures<br>• Increased stigma possible in societies with a higher tendency of stigmatizing mental health problems<br>• Decrease of health and welfare programmes due to economic impacts of the pandemic<br><br>2. **Community risk factors:**<br>• Reduced available healthcare in areas of conflict<br>• Increased stress of acculturation and dislocation of individuals fleeing from conflicts or in refugee camps<br>• Decreased access to healthcare and social care<br>• Decreased effectiveness of containment measures in such areas<br>• De-prioritization of mental health<br><br>3. **Relationship risk factors:**<br>• Increased isolation and lack of social support<br>• Increased relationship conflict and discord as additional strains are put on relationships<br>• Decrease in opportunities for contact with people outside of the home who can help<br>• Loss of significant others due to death by COVID-19<br>• Increased interpersonal violence and abuse within families or households<br>• Decreased access to formal and informal help<br>• Reduced opportunities of communal experiences and activities<br><br>4. **Individual risk factors:** |

- Worsened symptoms of mental disorders
- Reduction in well-being through social isolation and quarantine
- Reduced treatment compliance
- Increased use of alcohol
- Increased job or financial loss due to the economic crisis
- Increased hopelessness through potential loss of friends and family, loss of job, and general uncertainty
- Worsened chronic pain through reduced care and increased stress
- Decreased access to community activities
- Negative impact on diet through irregular eating patterns, impaired access to fresh food and frequent snacking, stress and anxiety
- Decreased physical activity due to containment measures
- Increased anxiety and stress due to (in)direct consequences of the pandemic

**NHS Education for Scotland (NES)** describe specific risk factors for suicide/self-harm in the context of COVID-19.

As well as the general risk factors for suicide, the impact of COVID-19 will be unsettling or frightening for many, including:

- People living with **high-risk health conditions** and who have been asked to **isolate for a long period** of time
- People (e.g. those who live with mental ill health) who may already be **vulnerable** and socially/occupationally **isolated**
- **Frontline staff** across all sectors facing COVID-19 and its impact on their patients, colleagues, families and themselves, and their working environment.
- People experiencing **job insecurity or loss** and the effects on **finances** including debt, housing instability or poverty.
- People living in already **difficult, vulnerable or unsafe situations** such as poor or overcrowded living conditions, gender-based violence, being a single parent, having caring roles for family members or friends with health problems or support needs. Services providing face-to-face support may now be reduced or not available.

People who have experienced a **bereavement,** who are dealing with the impact of the bereavement itself, and do not have access to the usual ways we support and acknowledge death and loss.

**1b. What information is available for patients, family and carers during the COVID-19 pandemic**
[link3]
[link4]
[link5]
[link6]
[link7]
[link8]
[link9]
[link10]

UK COVID-19 specific resources:

The RCPsych has produced information for the general public on self-harm and suicide in the context of COVID-19 at this webpage.

Mind has a webpage of information sources for supporting mental health: https://www.mind.org.uk/information-support/coronavirus/

General (non-COVID-19 specific) resources:

UK

[link11]
[link12]
[link13]

The **RCPsych** has general information on self-harm: https://www.rcpsych.ac.uk/mental-health/problems-disorders/self-harm and https://www.rcpsych.ac.uk/mental-health/problems-disorders/feeling-on-the-edge.

It also has information on 'Feeling Overwhelmed' and 'U Can Cope'.

A leaflet for parents and carers in coping with self-harm and a guide for school staff are available.

The **Charlie Waller Memorial Trust** has downloadable leaflets for schools and families, colleges and universities, the workplace and GPs/primary care.

**NHS** information on stress, anxiety, depression and loneliness.

**Direct support is available from:**

- **Samaritans** on 116 123 (freephone) or the Samaritans website
- **NHS 111** (freephone)
- **GP** (family doctor) for an emergency appointment (which might be done over the phone or by video)
- If the person does not feel they can keep safe, and other support isn't enough in an urgent situation, **call 999 or go to the nearest hospital A&E department** (emergency department), or ask someone else to call or take them.
- Contact the **local mental health crisis team**. Further information on accessing NHS help for people in England who self-harm or are in crisis is available on their postcode finder website at: www.nhs.uk/mental-health-support-services

**On-line support is available from:**

- Samaritans website
- Mind's I Need Urgent Help web page or the 4MentalHealth website (from anywhere in the UK)
- **Wales:** Welsh government mental health advice line, '**C.A.L.L.**' (Wales)
- **Scotland:** Breathing Space (Scotland)
- **Northern Ireland:** Lifeline
- Childline: Free national helpline for young people.
- PAPYRUS HOPELine UK: a professionally staffed helpline providing support, practical advice and information to young people and to anyone concerned that a young person may harm themselves.
- CALM: Campaign Against Living Miserably https://www.thecalmzone.net/
- Get Connected: offers help by telephone and email for people under 25 who self-harm.
- Selfharm.co.uk: a project dedicated to supporting young people who are affected by self-harm.
- Self Injury Support: provides a young women's text and email service, any age helpline for women who self harm.
- The Stay Alive App – patients can be supported to complete this over the phone or video call: https://play.google.com/store/apps/details?id=uk.org.suicideprevention.stayalive&hl=en_GB
- The Distract App – provides advice on self-harm and suicidal thoughts, and is available on the NHS apps library: https://www.nhs.uk/apps-library/distract/

- Shout: a text messaging service for anyone in crisis https://www.giveusashout.org/#:~:text=Shout%20is%20the%20UK's%20first,the%20heart%20of%20the%20service.

Support for those caring informally for people experiencing suicidal ideation/at risk of suicide:

- https://www.rethink.org/advice-and-information/carers-hub/suicidal-thoughts-how-to-support-someone/

- https://www.mind.org.uk/information-support/helping-someone-else/supporting-someone-who-feels-suicidal/about-suicidal-feelings/?_ga=2.65549863.803040752.1597743193-846180825.1597743193#.U1fX6qKAhqh

Support after someone may have died by suicide:

- Support After Suicide contains a number of resources including Help is at Hand and Finding the Words.

## USA resources

(Suggested by the American Foundation for Suicide Prevention https://afsp.org/suicide-prevention-resources):

- 24/7 Crisis Hotline: National Suicide Prevention Lifeline Network
- Crisis Text Line to text with a trained crisis counselor from the Crisis Text Line for free, 24/7
- Veterans Crisis Line
- Vets4Warriors
- SAMHSA Treatment Referral Hotline (Substance Abuse)
- RAINN National Sexual Assault Hotline
- National Teen Dating Abuse Helpline
- The Trevor Project
- For carers: https://bottomlineinc.com/health/depression/supporting-a-loved-one-after-a-suicide-attempt

## Canadian resources

Health Canada has a resource page on 'taking care of your mental and physical health during the COVID-19 pandemic' and 'Preventing suicide: Warning signs and getting help'.

The Centre for Suicide Prevention has specific workshops to upskill caregivers working with those at higher risk of suicide, such as the 'River of Life' online workshop for caregivers of Indigenous youth and 'Suicide to Hope'.

The Mental Health Commission of Canada (MHCC) has a 'Resource Hub' for mental health and wellness during the COVID-19 pandemic.

Online support:

- (https://ca.portal.gs/)

- The Kids Help Phone
- Hope for Wellness Helpline
- Crisis Services Canada
- Canadian Association for Suicide Prevention local crisis centres across Canada
- Mental health resources for Canadian Armed Forces and family members
- Mental health and wellness advice for First Nations and Inuit

Australian & New Zealand resources

The Australian Government Department of Health has a resource hub on suicide prevention for the general public.

The Royal Australian and New Zealand College of Psychiatrists have a resource hub called 'Your Health in Mind' (YHM) available for the public with factsheets on mental health conditions and how to get help. There is also a page dedicated to carers helping people with mental illnesses.

For carers: https://www.suicideline.org.au/resource/supporting-someone-after-a-suicide-attempt/

Worldwide:

https://www.psychologytools.com/articles/free-guide-to-living-with-worry-and-anxiety-amidst-global-uncertainty/ has a free guide with practical exercises to manage worry and anxiety, available in multiple languages.

The International Association for Suicide Prevention lists **National Suicide Survivor Organizations across different countries at:** https://www.iasp.info/resources/Postvention/National_Suicide_Survivor_Organizations/, and crisis support centres across different countries at https://www.iasp.info/resources/Crisis_Centres/.

| Challenges in assessments | |
|---|---|
| 2a. What pre-COVID-19 guidance should I continue to follow in assessments?<br>[link14]<br>[link15] | **Pre-COVID-19 guidance on risk assessment procedures should continue during the pandemic, to determine and formulate risk, identify safeguarding issues and establish safety plans.**<br><br>UK<br><br>**Continue to follow NICE (pre-COVID-19) guidance for assessments after self harm as follows** (see NICE CG16 and CG133 for further details):<br><br>**Assessments:** |

- Treat people who have self-harmed **with the same care, respect and privacy** as any patient, taking into account the distress associated with self-harm.
- Ask them to explain their feelings and understanding in **their own words**. The reasons may be different on each occasion and each episode needs to be treated in its own right.
- **Involve those who self-harm in all discussions and decision-making** about treatment and care.
- Allow a **family member, friend or advocate** to join the discussion about assessment and treatment, with the patient's permission (the initial psychosocial assessment should take place with the patient alone).
- Provide emotional support/help to **relatives/carers**.
- Offer a **preliminary psychosocial assessment at triage** (including mental capacity, willingness to remain for further assessment, level of distress and possible presence of mental illness).
- Whilst waiting for a full assessment, provide a **waiting environment** which is safe, supportive and minimises any distress.
- Offer a **comprehensive assessment of needs** (including the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, mental health and social needs assessment). this in the notes and include the service user's agreement.
- **The assessment of needs should include:**
    - skills, strengths and assets
    - coping strategies
    - mental health problems or disorders
    - physical health problems or disorders
    - social circumstances and problems
    - psychosocial and occupational functioning, and vulnerabilities
    - recent and current life difficulties, including personal and financial problems
    - the need for psychological intervention, social care and support, occupational rehabilitation, drug treatment for any associated conditions
    - the needs of any dependent children
- **Assess for risk:** identify the main clinical and demographic features known to be associated with risk of further self-harm and/or suicide, key psychological characteristics associated with risk**, in particular depression, hopelessness and continuing suicidal intent.**
- Identify and agree with the person who self-harms **the specific risks for them**, taking into account:
    - methods and frequency of current and past self-harm
    - current and past suicidal intent
    - depressive symptoms and their relationship to self-harm
    - any psychiatric illness and its relationship to self-harm
    - the personal and social context and any other specific factors preceding self-harm
    - specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
    - coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
    - significant relationships that may either be supportive or represent a threat and may lead to changes in the level of risk
    - immediate and longer-term risks
- **Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm**.

- Consider combining the assessment of risks into a needs assessment framework to produce a **single integrated psychosocial assessment process.**
- **Address modifiable risk factors where possible e.g. untreated mental illness, pain, financial issues**
- All health professionals who undertake psychosocial assessment should be **formally trained and supervised.**
- Assess and understand issues of **consent, mental capacity and mental ill health**.

**USA**

- The Assessment and Management of Suicide Risk Work Group
- The American Psychiatry Association
- CDC

**Australia and New Zealand**

- Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of self-harm (2016).

**World**

- WHO

**2b. COVID-19 specific guidance on assessment of risk of self-harm/suicide.**
[link2]
[link16]

There are only a few sources of COVID-19 specific guidance for assessment in self-harm/suicide prevention currently available:

**NHS Education for Scotland (NES)** have developed a brief learning resource aimed at all staff during COVID-19 who, in the context of their work, may come into contact with people who are experiencing distress, crisis or thoughts of suicide:

Staff are encouraged to watch Ask, Tell - Save a Life (https://vimeo.com/338176393) – with advice on having a conversation and how to support patients in seeking help.

In addition, staff should:

1. Consider both general (pre-COVID-19) and COVID-19 specific **risk factors** (see sections 1a and 2a).
2. Consider any **protective factors** which may be present, including:
    - Resilience (i.e. the ability to 'bounce back' from adversity)
    - Problem solving and coping skills
    - Access to support
    - A sense of hope and optimism, even in times of stress and difficulty
    - Social connectedness and supportive relationships

- Employment and supportive workplaces (or similar for schools/further/higher education for young people)
- A sense of purpose and engagement in activities, such as volunteering or hobbies, which are meaningful for the service user

People who are experiencing thoughts about suicide **can give some signals or signs of changes in their wellbeing**, including:

- Talking about wanting to die; talking about wanting to escape their life; talking about harming themselves or taking their life; talking or writing about death and seeking out methods that can be used to take their lives; and giving away belongings.
- Feelings of hopelessness about their current or future situation
- Feeling trapped, humiliated, guilty or ashamed
- Feeling isolated or alone, or feeling a burden to family or friends
- Changes in mood, including sudden significant improvement in mood after having been feeling low (which may signal an imminent plan to attempt suicide with associated relief) and anxious; losing interest in day to day life; or changes in eating or sleeping habits
- These signs can be even more significant when the person has experienced a recent adverse life event, such as a relationship breakdown, loss of work or income, or bereavement.
- Most people, when they reflect with others on their thoughts about suicide, have said that they didn't actually want to die – they wanted to end their pain, and to end the burden they felt they were being to others, and that suicide was the only way they thought they could achieve this.

Follow your **local guidance**, if this has been developed. For example, Oxford Health NHS Foundation Trust guidance suggests the following:

Remember to look for **static, dynamic, future and protective factors** and consider how these may be affected by the COVID-19 pandemic:

- **Static factors:** past self harm, past mental health issues, family history of suicide, past abuse, bereavement and loss
- **Dynamic factors:** relationship issues, physical health, social circumstances, substance misuse, current mood and mental health, hope
- **Future factors:** anniversaries, criminal proceedings, discharge, loss, unemployment, change
- **Protective factors:** problem solving skills, social and family support, engagement with services, hope, insight.

**Understand the trigger(s)** for the suicidal thoughts.

Patients may express thoughts that they should end their lives because of COVID-19. This might be because of fear and anxiety relating to:

- Contracting the virus
- Passing the virus on to others
- Beliefs about the virus being unstoppable or incurable
- Suffering or dying
- Others suffering or dying
- The future
- Feeling alone and isolated
- Financial implications
- Feeing trapped in an abusive situation

Whilst suicidal thoughts may be attached to beliefs about the virus, the underlying mechanisms of suicidal thinking are likely to be those that we are used to working with.

## Interventions – general principles and therapeutic

**3a. Pre-COVID-19 guidance**

[link14]
[link15]

**UK**

Clinicians should **continue to follow NICE (pre-COVID-19) guidance for making short- and long-term plans for management after self harm as follows** (see NICE CG16 and CG133 for further details):

- Decisions about further care should be **based upon the combined assessment of needs and risk** and taken jointly by the patient and clinician whenever possible. If not possible, this should be explained and written in the notes.
- The assessment should be **written in the case notes and passed onto the GP and relevant mental health services** as soon as possible to enable follow-up.
- **The decision to discharge a person without follow-up** following an act of self-harm should not be based solely upon the clinical impression of low risk of repetition of self-harm or attempted suicide and the absence of a mental illness, because many people may have a range of other social and personal problems that may later increase risk. These problems may be amenable to therapeutic and/or social interventions.
- **Temporary admission may be needed** e.g. if very distressed, where psychosocial assessment is not possible as a result of drug and/or alcohol intoxication or if returning to an unsafe or potentially harmful environment. Reassessment should be undertaken the following day or at the earliest opportunity.
- **Discuss, agree, and document** the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to:
    - prevent escalation of self-harm
    - reduce harm arising from self-harm or reduce or stop self-harm
    - reduce or stop other risk-related behaviour
    - improve social or occupational functioning
    - improve quality of life
    - improve any associated mental health conditions
    - improve any associated physical health problems through appropriate referral.
- **Review the person's care plan with them**, including aims of treatment, at intervals of not more than 1 year.
- Care plans should be **multidisciplinary and developed collaboratively** with the person and, if they agree, with their family, carers or significant others.
- **Care plans** should:
    - identify realistic and optimistic **long-term goals**, including education, employment and occupation
    - identify **short-term treatment goals** (linked to the long-term goals) and steps to achieve them
    - identify the **roles and responsibilities** of any team members and the person who self-harms
    - include a **jointly prepared risk management plan**
    - be **shared with the person's GP** and any other involved professionals

- **Risk management plans** are a clearly identifiable part of the care plan and should:
  - address each of the **long-term and more immediate risks** identified in the risk assessment
  - address the **specific factors** (psychological, pharmacological, social and relational) identified as associated with increased risk, with the aim of reducing the risk of repetition of self-harm and/or the risk of suicide
  - include a **crisis plan** outlining self-management strategies and how to access services when self-management strategies fail
  - ensure that the risk management plan is **consistent** with the long-term treatment strategy and inform the person who self-harms that the plan may be shared with other professionals.

Interventions for self-harm

- Consider offering 3 to 12 sessions of a **psychological intervention** specifically structured for people who self-harm, with the aim of reducing self-harm.
  - The intervention should be **tailored to individual need** and could include cognitive, behavioural, psychodynamic or problem-solving elements.
  - Therapists should be **trained and supervised** in the therapy they are offering.
  - Therapists should be able to **work collaboratively with the person** to identify the problems causing distress or leading to self-harm.
- Do not offer drug treatment as a specific intervention to reduce self-harm.
- Provide psychological, pharmacological and psychosocial interventions for **any associated conditions**.

USA

- The Assessment and Management of Suicide Risk Work Group
- The American Psychiatric Association
- CDC

Australia and New Zealand

Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of self-harm (2016).

World

- WHO

**3b. COVID-19 specific guidance**
[link2]
[link16]

**NHS Education for Scotland (NES)** suggests the following approach for all staff during COVID-19 who, in the context of their work, come into contact with people who are experiencing distress, crisis or thoughts of suicide:

Part of your role in supporting people who you think may be feeling they want to take their own life is to **ask** them about it and to:

- Help the person to **discuss** what is happening and help them develop strategies such as a **safety plan** and develop and use other **problem solving or coping strategies**
- You can **ask them directly about**:
    - Thoughts: How are they feeling about the future? Are they thinking about suicide?
    - Intent: Do they think they would act on these thoughts? Do they feel safe?
    - Plans: Have they made a plan to take their own life? What have they planned to do, and when?
    - Means: Do they have anything with which they plan to use to harm themselves – pills, rope, weapon etc.? Have they planned to visit a specific transport site e.g. bridge, train station?
- **Seek urgent support** if you think the risk of suicide is imminent
    - If the person has expressed **clear intent, made a plan or has access to the means** to take their own life, **seek immediate support**. Stay with the person and contact in the UK: their GP, or NHS 111; or 999 for emergency assistance.
    - Where the person has no intent, plans or means, it should be noted that **this can rapidly change**, so **help the person to seek support** from organisations such as the Samaritans (see section 1b) or ensure that they have the contact details of a range of helplines to choose from.

Strategies to help people who are experiencing thoughts of suicide:

- Encourage the person to talk through their concerns, and support them to:
    - recognise and build on their **protective factors**
    - recognise that they are **not a burden to others** (e.g. loved ones, friends, colleagues, support services)
    - identify aspects of their life that **promote hope, the future and choices**, to reduce a sense of being trapped
    - recognise that feelings such as guilt and shame are **not facts and can change over time**.
- Encourage the person to build a **safety plan** that provides them with:
    - strategies they know have worked before to help them reduce stress or to step back from their worries
    - activities that help improve a sense of personal safety from thoughts of suicide
    - activities and helpful thoughts that help the person to cope day by day
    - supportive contacts
    - https://www.stayingsafe.net/home is a resource that helps people to develop a safety plan

**Follow your local guidance**. For example, Oxford Health NHS Foundation Trust guidance suggests considering a **Perspective Taking Approach for anxiety about COVID-19**: this approach explores beliefs and generates information to challenge or look beyond these beliefs in order to offset the potential for confirmation bias (the tendency to search for, interpret, favour, or recall information which confirms or supports a person's prior beliefs or values). Seeing things through someone else's eyes may help regulate existing perspectives and/or gain new and helpful perspectives.

Strategies to include in perspective taking might include:

- **Framing the problem** of COVID-19 as a global/societal problem and not one that the patient is facing alone. Ask the patient to consider **alternative perspectives** e.g., that of a person with whom they have an interpersonal relationship but who is not experiencing anxiety to the same degree.
- Asking the patient to think about **perspectives of other people** about COVID-19 and which of these are helpful or unhelpful.
- **Sharing the knowledge** that most people who contract COVID-19 experience mild symptoms and asking the patient to think about what the perspectives of others who had such minor symptoms might be.
- Noticing that **scientists** appear confident that if Government advice is followed people are much less likely to contract the virus and asking the patient to consider this perspective.
- Offering **alternative perspectives** e.g. COVID-19 transmission may reduce as social distancing helps to delay its spread, as scientists gain more knowledge and understanding, and new treatments/vaccinations are discovered.
- Suggesting a perspective that considers that the **strategies the Government have put in place** to help people financially might alleviate any anticipated financial stress, even if it may take a bit of time.
- Because of the uncertainty associated with COVID-19 and the inability to provide concrete reassurance, fears about the virus might seem reasonable. However, if fear and anxiety have escalated to such a degree that the patient is considering suicide as a way out, clinicians should focus the dialogue on whether suicide is a reasonable solution/outcome.

**Problem Solving**

Use a problem-solving approach to assist with practical needs such as staying in touch with friends and family using internet platforms, contacting banks or landlords, contacting secondary health services about plans for resuming outpatient care, or seeking advice from Citizens Advice.

**Safety Planning and Resources**

Help the patient recognise **early warning signs and triggers** and how current anxieties associated with COVID-19, such as contagion, social distancing or self-isolation, might exacerbate triggers.

Simple strategies might include:

- **Reducing browsing the internet and social media** for COVID-19 news (note that filters are available).
- **Sharing concerns** with others but also talking about other topics.
- **Planning activities** to help pass time during self-isolation, see MARCH Network – Creative Isolation

**Self-care** – see section 1b above.

## Service models during the COVID-19 pandemic

**4a. Pre-COVID-19 guidance**

[link17]
[link18]
[link19]

UK

**Continue to follow NICE (pre-COVID-19) guidance** (see NICE NG105 and QS189 for further details):

https://www.nice.org.uk/guidance/ng105: Preventing suicide in community and custodial settings.

This guideline covers ways to reduce suicide and help people bereaved or affected by suicide by:

- helping local services work more effectively together to prevent suicide
- identifying and helping people at risk

- preventing suicide in places where it is currently more likely.

https://www.nice.org.uk/guidance/qs189: This quality standard covers ways to reduce suicide and help people bereaved or affected by suicide. It describes high quality care in priority areas for improvement, and includes guidance for multi-agency suicide prevention partnerships, reducing access to methods, media reporting, involving family and friends, supporting those bereaved of affected by a suspected suicide.
It includes 3 flowcharts for services for suicide prevention, self-harm and service users in mental health settings.

Continue to follow recommendations from the **RCPsych** (Self-harm, suicide and risk: Position Statement PS3/2010 July 2010):

- This identifies the need for a public health strategy to cover self-harm and for the suicide prevention strategy to remain a priority in all nations of the UK.
- NHS services, particularly in A & E, need to ensure that people who have self-harmed or tried to kill themselves have proper access to care and treatment by fully trained clinical staff and that the NICE guideline on self-harm is implemented.
- A change in NHS services culture so that staff who encounter people who self-harm are trained and supported.
- Greater recognition and support by the statutory sector of the role of third sector bodies such as the Samaritans and SANE in assisting those who are involved with self-harm or are suicidal.
- Psychiatrists, including liaison psychiatrists, need to have a full role in helping people who self-harm.
- Research on self-harm needs increased funding for research on the causes and treatments, to enable best evidence care and guidance.

**USA**

- CDC: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf
- CDC: https://www.cdc.gov/violenceprevention/suicide/resources.html
- CDC: https://www.cdc.gov/ruralhealth/suicide/policybrief.html
- The Assessment and Management of Suicide Risk Work Group: https://www.healthquality.va.gov/guidelines/mh/srb/index.asp

**Canada**

- Government of Canada: https://www.canada.ca/en/public-health/services/publications/healthy-living/overview-federal-initiatives-suicide-prevention.html
- Government of Canada: https://www.canada.ca/en/public-health/services/suicide-prevention.html

**4b. COVID-19 specific guidance**
[link1]
[link20]

**The WPA (World Psychiatric Association)** suggests a strengthening of the following recommended actions at different organisational levels during COVID-19:

Government (national & regional level)

[link21]
[link22]

- Restrict sales of lethal means (e.g. firearms and pesticides), and amount of medication per person
- Ensure safe storage of firearms and medication (warehouses and home) via public awareness and policies
- Restrict availability of alcohol
- Plan to resume school-based interventions as soon as schools reopen

Healthcare response

- Follow up individuals at risk
- Plan and adjust resources to maintain/improve treatment and follow-up of patients with mental disorders
- Ensure availability of staff for mental healthcare
- Provide mental health support to frontline and healthcare workers
- Adopt and reinforce the use of telemedicine

Local or national healthcare system / mental healthcare providers

- Develop guidance for remote assessment of mental disorders and suicide risk
- Continue treatment and assessment in person or online and increase the assessment of at-risk individuals
- Offer online interventions to manage psychiatric symptoms
- Brief telephone and online therapies may be effective in reducing suicidal outcomes
- Develop guidance for mental health support in workplaces and when to refer to mental healthcare
- Ensure appropriate care for anxiety, depressive, PTSD symptoms, alcohol and drug misuse, suicidal behaviour, psychotic and other psychiatric disorders
- Educate healthcare professionals about mental health resources and appropriate care
- Train staff for mental health responses
- Provide mental health support for survivors of COVID-19
- Use alternative ways of contacting patients (phone contact, letters, or online)

Public health response

- Promote safe drinking
- Use online tools for monitoring alcohol intake
- Continue training during the pandemic either in person with local restrictions or online
- Increase the number of volunteers to participate in the programs through public awareness
- Increase availability of (online) resources for youth
- Use existing guidelines for responsible media reporting (see section 4c for further details)
- Provide economic support to mental health services
- Ensure accessibility to mental healthcare services
- Develop telemedicine and digital services
- Provide tools for self-care online
- Helplines for suicidal patients and individuals affected by the COVID-19 pandemic
- Train volunteer workers in mental health

- Teachers/parents to discuss the virus, possible effects of containment measures, and feelings of children with the help of available resources

Whilst currently there is little official guidance on suicide/self-harm prevention in the context of COVID-19, suicide research groups are starting to publish frameworks suggesting where preventive efforts might be focussed.
(Please note this is not yet official guidance, but suggestions for frameworks which might be helpful).

Guidance from a group of international researchers including the International COVID-19 Suicide Prevention Research Collaboration suggests an interdisciplinary approach to suicide prevention during COVID-19 and beyond, targeting multiple factors contributing to risk:

1. Selective therapeutic interventions for:
    - Mental illness
    - Experience of suicidal crisis - some might not seek help fearing that services are overwhelmed and that attending face-to-face appointments might put them at risk. Others may seek help from voluntary sector crisis helplines which might be stretched beyond capacity due to surges in calls and reductions in volunteers.

2. Universal interventions to address:
    - Financial stressors
    - Domestic violence
    - Alcohol consumption
    - Isolation, entrapment, loneliness, bereavement
    - Access to methods
    - Media reporting (on suicide as well as on the manner of reporting the pandemic, see section 4c)
    - With research and data monitoring throughout.

3. Telepsychiatry and digital interventions:
    - Remote consultation should be implemented more widely. (However, not all patients will feel comfortable with such interactions, have access/ability with such resources, or have the necessary privacy to engage with telepsychiatric consultations).
    - Making evidence-based online resources and interventions freely available at scale
    - Mental health services should develop clear remote assessment and care pathways for people who are suicidal, and provide staff training to support new ways of working.
    - Helplines will require support to maintain or increase their volunteer workforce and offer more flexible methods of working.
    - Digital training resources would enable those who have not previously worked with people who are suicidal to take active roles in mental health services and helplines.
    - Evidence-based online interventions and applications should be made available to support people who are suicidal.
    - Self-guided digital interventions directly targeting suicidal ideation are effective (https://www.thelancet.com/pdfs/journals/landig/PIIS2589-7500(19)30199-2.pdf)

(For general issues related to telepsychiatry/remote psychiatry and digital interventions, please see our guidance table on this topic).

A group of suicide researchers from the US suggest the following interventions to improve suicide prevention during COVID-19:

1. **Physical distance, not social distance**: efforts can be made to stay connected and maintain meaningful relationships by telephone or video, especially among individuals with substantial risk factors for suicide. Social media solutions can also be explored.
2. **Tele–mental health**: remote treatments for individuals with suicidal ideation have lagged behind the telehealth field. Some evidence-based suicide prevention interventions have been designed to be delivered remotely (e.g. some brief telephone-based outreach interventions and the Caring Letters intervention have reduced suicide rates in randomized clinical trials). Follow-up contact may be especially important for individuals who are positive for COVID-19 and have suicide risk factors
3. **Increase access to mental health** care: it is essential to consider the management of individuals with mental health crises. Screening and prevention procedures for COVID-19 that might reduce access to care could include screening for mental health crises.
4. **Media reporting** should follow reporting guidelines (see section 4c).

The **RCPsych Liaison Faculty** has produced a report summarising how units are adapting services to offer Emergency Department (ED) care for those who self-harm and others in crisis at: https://www.rcpsych.ac.uk/docs/default-source/members/faculties/liaison-psychiatry/alternatives-to-eds-for-mental-health-assessments-august-2020.pdf?sfvrsn=679256a_2

The report includes:

**A survey of UK liaison psychiatry services in May 2020**, describing these **alternative models of care** and collecting feedback on their benefits and drawbacks:

- An **alternative care pathway** had been established for over 80% of the 68 EDs included in the survey (approximately 29% of the available EDs).
- Of these, over 2/3 included provision of a separate assessment facility, usually co-located with other mental health services.
- The main **benefits** of the alternative services included: a more appropriate environment for the assessment of patients with mental illness, a reduction in ED workload, greater accessibility to mental health expertise.
- The main **drawbacks** were: the risk of physical illness being overlooked, a potential increase in stigmatisation of mental illness by acute hospital staff, staffing difficulties, and delays in emergency mental health care pathways, often due to the need to transfer patients between sites.

**Recommendations** to inform discussions about the future of these alternative care pathways and assessment units:

1. Evaluation of an existing or planned emergency mental health assessment facility for a wide geographical area should consider **accessibility for patients**.
2. Provision of a **24-hour service for the assessment of children and young people**, whether on a general hospital or mental health site, should be included in urgent and emergency mental health care pathways.
3. The establishment of a separate mental health assessment unit **should not be at the expense of liaison psychiatry staffing.**

4. Where there is a separate mental health emergency assessment facility, it should be borne in mind that patients with mental and physical comorbidity will **still require assessment and care within an ED**. In concordance with national guidelines, **all EDs should have a psychiatric assessment room** that meets standards for safety and privacy.
5. Where patients are transferred from an emergency department to an alternative assessment facility, there should be **protocols for transport with minimal delay, taking account of any significant risks and how staff escort can be provided** when necessary.
6. Where patients with mental illness are diverted from emergency departments, **senior staff on the acute hospital site should be alert** to a reduction in staff expertise, and any indications of staff attitudes and behaviour that are indicative of stigmatisation.
7. Staff working on mental health assessment units should be able **to identify possible acute physical health problems** and use protocols for seeking urgent medical advice and for transferring patients to an ED if necessary.

The **legal status of patients** in a mental health assessment facility, specifically whether they are inpatients or outpatients, should be communicated to staff so that mental health legislation is implemented correctly.

**4c. Media reporting**
[link23]
[link24]
[link25]

The **Samaritans** have issued guidance on reporting of mental and suicide during the COVID-19 pandemic:

- International research has consistently drawn links between certain types of media coverage of suicide and increases in suicide rates.
- This risk significantly increases if details of methods are reported, if the story is placed prominently and if the coverage is extensive or sensationalised.
- A growing number of stories are appearing in the media about the impact on mental health and suicide, relating to COVID-19.
- While there are some important issues that need to be raised at this time, there is a risk that some messaging could be translated by journalists, resulting in unhelpful and sensational media coverage.
- This may increase vulnerable people's concerns and the likelihood of imitative suicidal behaviour.
- It is important that we discourage media from leading on the narrative that a rise in suicide rates is an inevitable outcome of the pandemic.
- Research also shows that positive stories of recovery can encourage vulnerable people to seek help and are associated with fewer suicides.

In any contact with the media, remember to:

- Focus on the potential mental health risks of COVID-19, recognise that it is important to support people's mental health at this time and ensure support is available to those who are distressed.
- Use the opportunity to encourage people to connect with each other, take part in activities that help them to manage their mental health and give people hope.
- Avoid directly referencing suicide and avoid any predictions about the potential impact on suicide rates – journalists may inflate this, resulting in stories over-simplifying the issue.
- Avoid sensationalising suicide by inadvertently promoting the idea that suicidal behaviour is becoming a common response to the difficulties facing the UK population during the COVID-19 pandemic.
- Avoid speculation of causes or simplistic explanations. Remind journalists that suicide is extremely complex - a combination of psychological, social and physical factors contribute to a person's risk of suicide.

Guidelines on media reporting during the COVID-19 pandemic are also contained at:
https://www.iasp.info/pdf/2020_briefing_statement_ABversion_reporting_on_suicide_during_covid19.pdf
These give advice on how to report on

- a specific suicide
- the suicide-pandemic issue
- suicide as a public health issue
- suicide data
- including suicide hotlines/emergency contact information
- suicide related to hospitalisation
- suicide as a policy-related issue

(General (pre-COVID-19) media guidelines are also available from the Samaritans at https://www.samaritans.org/about-samaritans/media-guidelines/)

## Staff issues

**5a. How can we support front line workers (including those completing self-harm and suicide risk assessments) during the COVID-19 pandemic?**
[link24]
[link26]
[link27]
[link28]
[link29]
[link30]
[link31]
[link32]
[link33]

The COVID Trauma Response Working Group has developed guidance for supporting staff in the early stages of the response to COVID.

**Staff may experience a range of normal responses** including anger and irritability, enhanced anxieties, low mood, increased alcohol drinking, smoking and eating, sleeping problems, and burn out.

Aim to foster resilience, reduce burnout and reduce the risk of post-traumatic stress disorder (PTSD):

- Ensure **good quality communication** and **accurate information updates** are provided to all staff in an open, honest and frank way so they are best prepared for what they are going to be asked to do.
- **Rotate workers from higher-stress to lower-stress functions**. Partner inexperienced workers with more experienced colleagues. Implement flexible schedules for workers who are directly impacted or have a family member affected by a stressful event.
- Ensure that the **basic physical needs** of staff are being met including sleep, rest, food and safety (including appropriate access to personal protective equipment). Support staff to take breaks and attend to self-care.
- **Provide training on the potentially traumatic situations** that staff might be exposed to, especially new staff being mobilised to help with the response, such as final year medical students and student nurses.
- **Be flexible** in supporting needs and respond to staff feedback on what is, and is not, helpful.
- Pay attention to staff who may be **particularly vulnerable** (pre-existing experiences or mental health issues, previous traumas or bereavements, or concurrent pressures and loss). Monitor and provide extra support.
- Encourage staff to **actively use social and peer support**.
- **Facilitate team cohesion** and **foster strong supportive links between team members and managers**. Allow staff time to be with and support each other. Encourage activities and discussions including unrelated to COVID-19 where possible. Model a caring and cohesive team approach.
- Consider **more naturalistic forms of 'debriefing' or 'demobilising'** at the end of shifts or at significant points in the response, either individually or in teams. These sessions should be optional and provided during a staff member's shift (not afterwards) so as not to encroach on rest and recovery time.

- Most people are resilient and will manage to cope, but managers should have a **low threshold for referring** staff members to Wellbeing or Psychology Services. Make sure you know who to contact and how.
- Ensure that people delivering any psychological support are appropriately trained, competent and have clinical supervision. **Ensure that any psychological interventions are evidence-based**.
- **Continue to actively monitor and support staff after the crisis begins to recede**. Where necessary, refer on for evidence-based psychological treatment.
- Don't offer single session interventions which involve mandating staff to talk about their thoughts or feelings, or non-specific training programmes such as 'mental strength' training.
- Don't rush to offer direct psychological interventions too soon. NICE guidelines advocate 'active monitoring' during the first month after a major trauma before intervening. However, if staff are showing signs of stress after this time, do refer on to Psychological Services.
- Any psychological intervention should be provided by an appropriately qualified and supervised clinician, at the appropriate time.
- Consider using **'Psychological First Aid'** which aims to provide a calming, comfortable space for the individual to decompress and to feel heard. It is not intrusive, and any discussion of a traumatic event is respondent-led. It does not involve a detailed discussion of what has been happening, analysis of what happened, nor putting events into chronological order. It does not promote a review of the emotional aspects of the traumatic event.

Further guidance on supporting staff and psychological first aid is available from the WHO and from the Interagency Standing Committee.

The International Association for Suicide Prevention (IASP) have produced a guideline for workplaces during COVID-19, and suggest the following key approaches and key statements:

1. **Thank you:** Express gratitude to your workforce.
2. **We see you and want to hear from you.**
3. **We care about you.**
4. **Belonging:** the workplace can be a setting for workers to connect with meaning and purpose through shared goals. Construct online activities around these themes.
5. **Financial assistance:** especially important if you make notifications that impact workers. Create an easy to read guide for workers to take home and discuss with their family.
6. **Provide suggestions on coping and offer resources** (see section 1b above).
7. For workers who have **existing vulnerabilities or are currently struggling with thoughts of suicide,** the following approach may be helpful: **suspend judgement**, set a **positive challenge** to yourself (focus on things you are grateful for, ask for and accept support, use compassion), **'this too will pass'** (don't be afraid to turn the news off, focus on positive relationships, focus on what you can control, be gentle with yourself), address **financial stressors**.
8. **Seek help if your workplace experiences a suicide death or highly public attempt.**
    - Do not assume this was solely the direct result of the COVID-19 crisis.
    - Crisis interventions after a suicide death should follow similar protocols as other health and safety crises, with additional attention towards safe messaging.
    - Acknowledge the complicated grieving response that mourners now face given that in person grieving rituals are likely to be postponed.

- For more guidance on how to manage communication and worker support after a suicide: https://www.sprc.org/resources-programs/managers-guide-suicide-postvention-workplace-10-action-steps-dealing-aftermath

MIND have produced guidance on supporting yourself and supporting your team during COVID-19.

1. **Maintain a positive work/life balance and encourage your team to do the same** (e.g. ensure you take regular breaks, aim to finish work at a specific time)
2. **Check in with team members regularly** (especially if working from home, make sure you have regular formal and informal contact both as an individual and as a team.)
3. **Establish new ways of working** to communicate and support each other through challenges. Reflect on what is working and what is not.
4. **Ask your team to create Wellness Action Plans (WAP)** and encourage them to share this with you. If they already have one, then it would be helpful to review this in light of recent changes during one-to-one meetings. This can be completed by everyone, to ensure all staff have practical steps in place to ensure they are supported when needed.
5. **Take advantage of technology** to connect with colleagues and work together. Try a range of technologies so you are not always typing or looking at a screen.
6. **Encourage your team to use the support tools available** from your organisation.

The Charlie Waller Memorial Trust have produced guidance for managers with staff working from home, including a summary of quick tips to help line managers protect their staff's mental health and wellbeing when working from home.

- **Communicate:** it is more important than ever to keep in touch with both individuals and teams.
  - **Increase one-to-ones**: this helps people feel valued, connected and on-track with their work. It also gives managers the chance to check out how they are managing and what other demands they have.
  - **Have plenty of team meetings,** both formal and informal (e.g. via video conferencing).
  - **Let people know what is going on**: keep staff informed at all times, even if you feel nothing has changed.
  - **Ensure everyone has access** to the right equipment, information and technology.
  - **Set boundaries** around when you are and are not available. Respect your team members' working hours, which may be different from yours.
- **Set expectations:** Be clear about what you expect and have sensitive discussions about how these can be met. Reasonable adjustments will still apply for those with enduring mental health difficulties but will probably be different when working from home.
- **Monitor your staff's mental wellbeing:** This is especially important. Create an environment of psychological safety so employees feel able to talk about any difficulties they may be having and be open to any suggestions they might make. Be alert to any changes in usual behaviour which may indicate that someone is struggling.
- **Have conversations about mental health**: in the same way as you would when not working from home.
- **Encourage and model work-life balance:** The CWMT guide Working from home: Your Wellbeing Action Plan (see below) can help with this.
- **Provide information on digital wellbeing** including the importance of time away from screens or phones.
- **Signposting:** Make sure you have the correct information about where to refer staff who are struggling.
- **Useful Resources**

- Mind – Supporting your own wellbeing and that of your team
- ACAS – https://www.acas.org.uk/working-safely-coronavirus
- Harvard Business Review – https://hbr.org/2020/03/a-guide-to-managing-your-newly-remote-workers
- GOV.UK – https://www.gov.uk/coronavirus/worker-support
- The Charlie Waller Memorial Trust – wellbeing action plans for working from home and for life after lockdown

Footnote 1:

**Self-harm** can be defined as: intentional acts of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent

(Thus, it includes acts intended to result in suicide (sometimes referred to as 'attempted suicide'), those without suicidal intent (e.g. to communicate distress or reduce unpleasant feelings) and those with a mixed or unclear motivation. The term is used in preference to alternative terms used previously, such as: deliberate self-harm, deliberate self-poisoning, deliberate self-injury, self-injurious behaviour, attempted suicide, parasuicide).

(https://www.nice.org.uk/guidance/cg133, https://www.nice.org.uk/guidance/cg16,
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr158.pdf?sfvrsn=fcf95b93_2)