The National Long-Term Care Ombudsman Resource Center

ADVOCATING FOR RESIDENTS WITH MENTAL HEALTH NEEDS

What to do When a Resident Threatens to Harm Themselves

Presenters: *Dr. Patrick Arbore, Institute on Aging; Jamie Freschi, Illinois State Long-Term Care Ombudsman; and Natasha Belli, Illinois program representative.*

December 4, 2018

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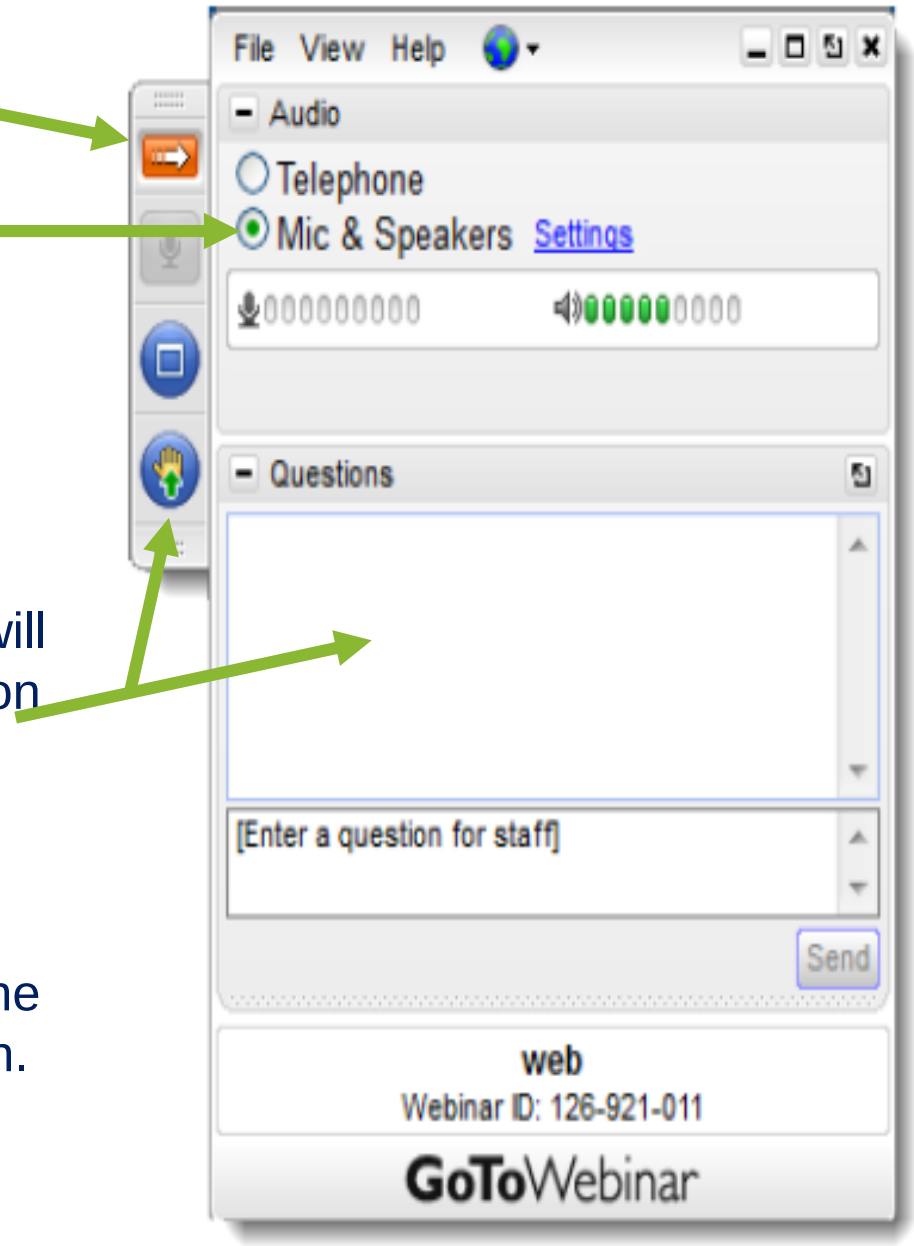


Institute on Aging

MENTAL HEALTH NEEDS OF THE ELDERLY: WHAT WE NEED TO KNOW

Patrick Arbore, Ed.D., Founder & Director, Center for Elderly Suicide Prevention & Grief Related Services, a Program of Institute on Aging, San Francisco, CA

www.ioaging.org

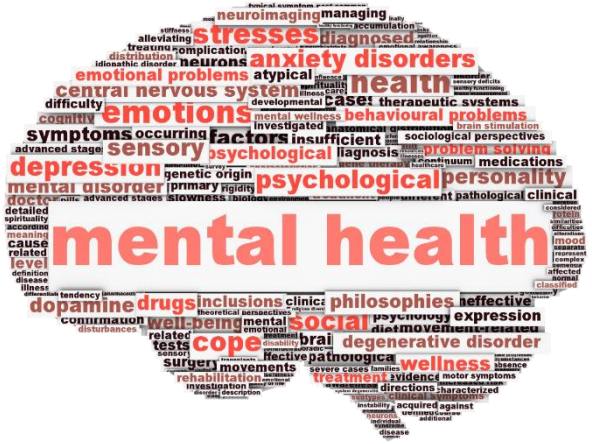
Friendship Line – 800.971.0016

24-Hour Accredited Crisis Intervention **Telephone Hotline/Warm-line** – Founded in 1973:

- Call-In Service – Confidential telephone discussions for people 60+ (their caregivers or younger disabled) who may be lonely, isolated, bereaved, depressed, anxious and/or thinking about death or suicide
- **A caller does not need to be in a suicidal crisis to use the call-in service**
- Traumatic Loss Grief Services
- Patrick Arbore – parbore@ioaging.org or 415.750.4133

Mental Illness

- Mental illness is a health term used for a group of mental conditions that cause severe disturbances in thinking, behavior, feeling and relating, often resulting in a substantially diminished capacity to cope with the ordinary demands of life and distress.
- Mental illness can affect persons **of any age** and social strata and can occur in any family.



Aging and Mental Health

- Older adults experience many challenges and adjustments. What are some these challenges and adjustments?
- Good mental health enables a person to face these changes and deal with them.
- Problems or disease are treated and controlled, and do not interfere with leading a rewarding life.
- Unfortunately, many older people still believe the myth that mental health problems result from personal failure or weakness. This stigma means that they may not want to admit that a problem or symptom exists, and do not seek help.

Common Mental Health Issues Among the Elderly

There is a lot of focus on the mental health of younger people. However, it is equally important for older adults to be referred for treatment, especially for **depression**, which can complicate the treatment of a number of medical conditions including stroke, diabetes, heart disease, and more.

- **Depression** is a type of mood disorder that ranks as the most pervasive mental health concern among older adults
- If untreated, it can lead to physical and mental impairments and impede social functioning
- **Depression** can interfere with the symptoms and treatment of other chronic health problems

Aging and Mental Health.

- Physical health and mental health are very interconnected.
  - Health problems can lead to depression
  - Depression can lead to health problems
    - lack of energy
    - stomach problems
    - difficulty concentrating
- Depression, anxiety and other mental health problems may be mistaken as physical problems.
- Studies have shown many older adults with depression spend as much as three times the amount of money on physical health care as those without depression.

Anxiety Disorders

- Like depression, anxiety is a very common mood disorder among the elderly
- These two problems often appear in tandem
- Statistics from the CDC show that nearly half of older adults with anxiety also experience depression
- Anxiety in seniors is thought to be underdiagnosed because older adults tend to emphasize physical problems and downplay psychiatric symptoms
- Women in this age group are more likely to be diagnosed with an anxiety disorder than men.

Risk Factors for Anxiety Disorders

- General feelings of poor health
- Sleeping problems
- COPD, certain cardiovascular diseases, diabetes, thyroid disease, and related chronic conditions
- Side effects caused by certain medications
- The abuse/misuse of alcohol, street drugs, or prescription drugs

Risk Factors Continued

- Physical impairments limiting daily functioning
- Stressful events like the death of a spouse, serious medical condition, or other life-altering event
- Traumatic or difficult childhood
- Perseveration on physical symptoms

Warning Signs for Anxiety Disorders

- Excessive, uncontrollable worry/(anxiety)
- Edginess, nervousness, or restlessness
- Chronic fatigue or tiring out easily
- Become irritable or agitated
- **Poor quality of sleep or difficulty falling/staying asleep**
- Tense muscles

Trauma

- PTSD is a disorder that usually manifests following a traumatic event that threatens a person's safety or survival, greatly impacting his or her quality of life
- Trauma experienced in childhood can remain dormant during one's younger years, only to surface again in one's later years of life

Warning Signs of Trauma

- Emotional numbness
- Flashbacks to the event
- Nightmares
- Depression
- Irritability
- Easily distracted or startled
- Anger

Aging and Mental Health

- Despite what the statistics reveal, it can be difficult to pick up on mental health issues among older people because of the unique age-related health and life challenges they face
- Sometimes symptoms can be very subtle or attributable to **a variety of other health conditions** or life changes.

According to the Centers for Disease Control

- One major problem in diagnosing and treating seniors with mental illness is that elderly individuals are more likely to report physical issues than they are psychological issues
- Even the typical emotional and physical stresses associated with aging can lead to depression or anxiety.

Caring for Older Adults

- As people who care about older adults, the best thing we can do is to understand the symptoms and risks associated with common mental health problems
- Be diligent in observing and communicating changes or symptoms to the appropriate health care professionals

Possible triggers for mental illness in senior citizens – National Institutes of Mental Health

Chronic pain
- Chronic disease
- Physical impairments like thyroid or adrenal disease that affect emotion, thought, or memory
- Physical disabilities
- Loneliness
- Major life changes
- Grief
- Widowhood
- Certain medications
- Heavy alcohol consumption or drug abuse
- Malnutrition/poor diet
- Dementia-causing illness

According to the National Institutes of Mental Health

If you are working with older adults or have an older loved one in your life, you can help spot indicators of a mental health issue. Here are some common warning signs to look for:

A marked change in appetite, energy level, and/or mood

- Feeling emotionally “flat” or finding it difficult to experience positive emotions
- Trouble sleeping too much, or difficulty falling and staying asleep
- Persistent thoughts of hopelessness, sadness, or suicidal thoughts
-

According to the National Institutes of Mental Health

- A desire or need for drugs or alcohol
  - Feeling on edge, restless, or having trouble concentrating
  - Increased feelings of stress or worry
- Short-term/recent memory loss
  - Anger, agitation, or increased aggressiveness
  - Obsessive-compulsive behavioral tendencies or thoughts
  - Unusual behaviors or thoughts directed towards others
  - Behaviors or thoughts that affect social opportunities, work, or family
  - Persistent digestive issues, pain, or headaches not explained by other health problems
  - Difficulty managing finances or tasks involving numbers
  - Problems with grooming or household maintenance

We Must

- Recognize that a mentally ill person in crisis may be overwhelmed by
  - Sensations
  - Thoughts
  - Frightening beliefs
  - hallucinations

Suicide

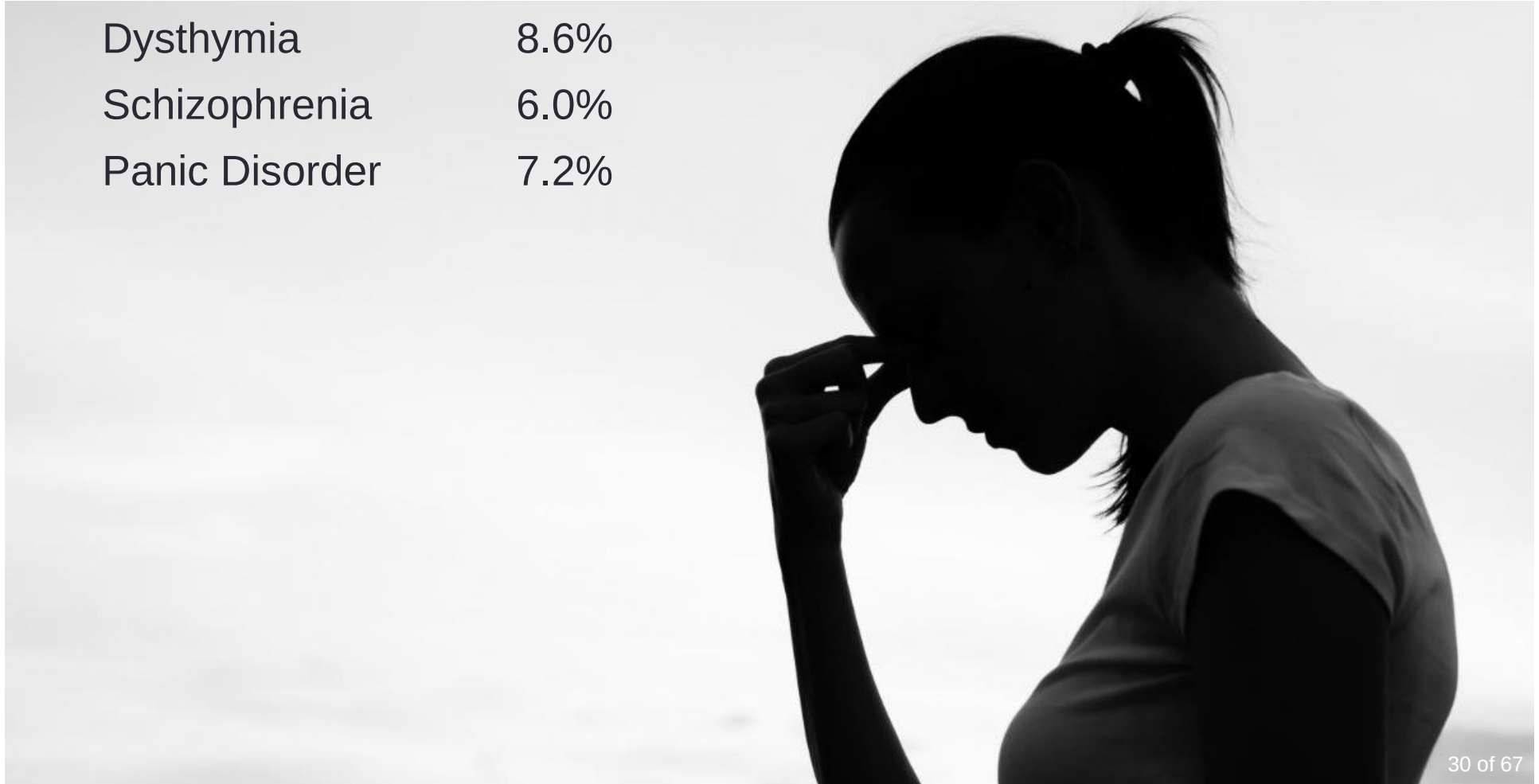
- One of the most common circumstances where social service and law enforcement encounters the mentally ill or others in crisis
- 80-90 suicides occur daily in the U.S.
- 31,655 suicide deaths in 2002 (NCHS) – 44,965 suicide deaths in 2016 (AAS)
- 438,000 emergency room visits (NCHS)
- Suicidal persons pose a substantial risk to everyone involved in the crisis

Suicide Rates

- The rate of suicide for the elderly is one of the highest among adults compared to any other age group
  - suicide rate for persons 85 years and older is the highest of all
  - twice the overall national rate.
- Older adults with mental illness will increase from 4 million in 1970 to 15 million in 2030

Suicidal Risks

Major Depression	14.6%
Bipolar Disorder	15.5%
Dysthymia	8.6%
Schizophrenia	6.0%
Panic Disorder	7.2%

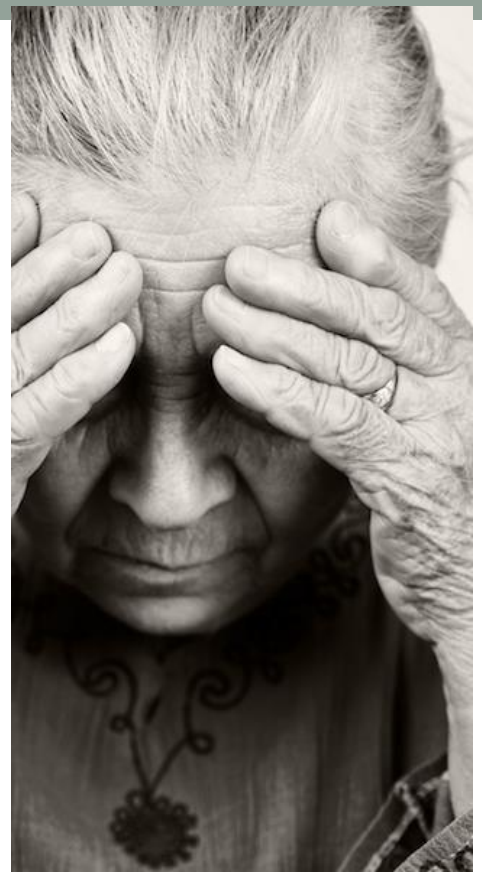


Suicide Risk

- Suicide risk cannot be predicted from any one factor
- Predicting suicide is VERY difficult
- Asking about suicide does NOT increase the risk
- The important issue in Adult Services, is to make certain we make the referral.

Assessing Danger to Self

- Are they talking about suicide?
- Is there a suicide note?
- Are there signs of hopelessness?
- Is there a specific suicide plan?
- Are there means at hand to harm self?
- Has there been a previous attempt?
- Is there evidence of self injury?



Suicide Intervention

- Listen
- Be honest
- Share your feelings
- Ask the person very directly if they want to commit suicide
  - Be graphic and direct

End-Of-Life Concerns – According to the American Psychological Association

- If you are working with any older adult, it is very helpful to inquire about planning for end of life
- End of life is defined as that time period when health care providers would not be surprised if death occurred within about 6 months
- Older Americans with chronic illness think about how they would prefer their lives to end, and want a “good death” without burdensome pain, symptoms and technology

End-Of-Life

- Most Americans die in hospitals (63%), and another 17% die in institutional settings such as long-term care facilities
- Most people are referred too late to hospice or palliative care, so they are unable to get the most benefit possible from these specialized services

Fears at End-Of-Life

- People fear that their pain, symptoms, anxiety, emotional suffering, and family concerns will be ignored
- Many critically ill people who die in hospitals still receive unwanted distressing treatments and have prolonged pain

According to Compassion and Choices – Advance Directive (AD)

- An advance directive is the cornerstone of advance planning
- Typically an advance directive includes a living will (what I want) and a medical durable power of attorney (who will speak for me)
- The AD can be helpful to your physician and others close to you when they must make choices on your behalf

End-Of-Life

- Culture makes a difference in use of advance directives and in decisions about end of life care
- Caucasians and Asians use advance directives more than other ethnic groups
- Often people who do not complete advance directives think they are a good idea but are not urgently needed and their family or physician will somehow know their wishes

Advance Care Planning

- Average ACP conversation in hospital is 5.6 minutes with MDs doing most of the talking; there is little exploration of patient values
- Medical perception is that patient's don't want to talk about this
- Uncertainty regarding prognosis & outcomes
- Perception that palliative care & aggressive care are mutually exclusive

End-Of-Life (EOL) Conversations

Principles:

- EOL conversations are about managing anxiety and decision-making
- Decisions require re-negotiation over time
- Patients need time to cope with anxiety
- Decision-making is a process
- Focus on what is important to the patient rather that on what is important to the physician

End-Of-Life (EOL) Continued

Principles:

Effective, compassionate discussions include:

- Empathy
- Understanding
- Non-abandonment
- Symptom control
- What can be done
- Focus on non-biomedical hopes

Growth and Transcendence at the End of Life – Block (2001)

- The preeminent coping task faced by a dying patient is dealing with loss
- Grief is an intensely painful, but normal, psychological response to loss
- Dying is associated with grief over both current and anticipated losses of health, the future, physical abilities, and roles and relationships

What You Can Do?

- If you suspect that an older adult is struggling with a mental health issue, get in touch with the your supervisor
- He or she can direct help you work with the staff of the facility in which you see the older adult
- They can direct you to the person's primary care physician, geriatric psychiatrist, psychologist, or counselor who can help
- Offer compassionate support to the older person by listening to their concerns

Always Remember to

- Be an active listener
- Use your authority in a positive manner

Resources

- Local Area Agency on Aging
- Institute on Aging's Friendship Line – hot-line/warm-line
- National Suicide Prevention Lifeline
- The Veteran's Crisis Line
- The American Psychological Association
- Your Local Mental Health Association
- Alcoholics Anonymous Home Office in your Community
- National Institute on Mental Health
- National Hospice Foundation
- Association for Death Education and Counseling
- Aging with Dignity

When Residents Threaten to Harm Themselves - An Ombudsman's Guide

Illinois Department on Aging

Background

- Recognized the problem
- Realization no protocol existed in IL
- Research
  - National Ombudsman Resource Center
  - Dr. Susan Wehry's Risk Assessment
  - National and State Resources
  - Dr. Arbore

Tools

- Added a new section to the Policies and Procedures
- Developed a “Pocket Guide” titled:

  “Ombudsman Protocol – a guide for Long-Term Care Ombudsmen when residents threaten suicide”
- Training
  - **Webinars**
  - **Dr. Arbore’s presentation**
  - **Added a module in our required training for new/newer Ombudsmen**

Purpose

- Equip Ombudsmen with steps to take when faced with a resident who verbalizes suicidal thoughts
- Examples:
  - “I wish I were dead”
  - “I’d rather die than stay here”
  - “I’d be better off dead”

Frustration vs. Suicidal Ideation

- Suicidal Ideation
  - wanting to take your own life
  - thinking about suicide
- When do Ombudsmen take the comments seriously?
  - ALWAYS!

Follow Up Questions Help Determine

- Is the person thinking of taking his or her life?
- How likely is he or she to act on those thoughts?
- Does the individual have a plan and have the means to carry out their plan?

Expectation of the Ombudsman

- The Ombudsman is NOT RESPONSIBLE for making the final determination of suicide risk OR for single-handedly protecting a person from his or her suicidal thoughts.
- The Ombudsman IS RESPONSIBLE for asking the appropriate questions and making an appropriate referral.

Basic Steps

- perform a preliminary risk assessment using a standard set of questions provided by the Office
- communicate risk according to protocol
- determine which supports or crisis assistance to involve
- assist resident in accessing supports
- discuss with an Ombudsman supervisor

Ombudsman Protocol when the resident has spontaneously verbalizes thoughts of suicide

- The Ombudsman asks: *Have you told your doctor or anyone about these thoughts?*
- Regardless of the answer, the Ombudsman asks the next question.

- The Ombudsman asks: *Do you feel these feelings and thoughts are a problem for you, or something you might act on?*
  - If the resident answers **NO**, the Ombudsman says: *You know I am not a clinician and I am not qualified to fully evaluate these thoughts and feelings. I'm glad this is something you feel you would not act on, but these thoughts and feelings could be a sign of depression. Is there anyone that you would like to talk to about these feelings?*
  - If the resident answers **YES** or answers equivocally, (such as "I don't know or I'm not sure" to the question: Do you feel these feelings and thoughts are a problem for you, or something you might act on? The Ombudsman says: *You know I am not a clinician and I am not qualified to fully evaluate these thoughts and feelings. I am concerned about you. I would like to ask you a few more questions and then help put you in touch with the professionals who can help you.*

- The Ombudsman then asks: *Have you thought about how you would hurt yourself?* In other words, is there a plan?
  - If the resident answers yes, the Ombudsman asks: *If there is a plan, do you have a way to carry it out?* In other words, is there access to the means to carry out the plan? For example, a resident who plans to overdose may easily hoard medicines.
  - If yes, the Ombudsman asks: *What has helped you not act on these feelings?* In other words, are there any deterrents?
  - If yes, the Ombudsman asks: *How likely do you think you are to act on these thoughts?*

Preliminary Suicide Risk Assessment

Low Risk

- ☐ No plan
- ☐ Has vague plan but has no access or idea on how to carry it out OR has very strong deterrents for not pursuing suicide
- ☐ States NO INTENTION of acting on suicidal thoughts or feelings

Medium Risk

- ☐ Has plan but it is vague
- ☐ Has specific plan but no access to the means for carrying it out
- ☐ Has some deterrents
- ☐ States LITTLE INTENTION of acting on suicidal thoughts or feelings but cannot say for sure

High Risk

- ☐ Has clear plan (how, when, where)
- ☐ Plan involves use of a firearm
- ☐ Has no or few strong deterrents
- ☐ States intention of acting on suicidal feelings regardless of when or where

Low

- No plan
- Has vague plan but has no access or idea on how to carry it out OR has very strong deterrents for not pursuing suicide
- States NO INTENTION of acting on suicidal thoughts or feelings

Medium

- Has plan but it is vague
- Has specific plan but no access to the means for carrying it out
- Has some deterrents
- States LITTLE INTENTION of acting on suicidal thoughts or feelings but cannot say for sure

High

- Has clear plan (how, when, where)
- Plan involves use of a firearm
- Has no or few strong deterrents
- States intention of acting on suicidal feelings regardless of when or where

Next Steps - Low

1) Say something to the resident such as: *I am concerned about you. I understand from what you've told me, that it is unlikely that you would act on the thoughts about suicide you've had. Nonetheless, I think it would be helpful for you to talk to someone. May I help you arrange it? May I let someone on the staff know what you're dealing with?*

2) Document your contact and determination of risk.

3) Seek permission to talk to facility staff, medical personnel, and/or a family member. With resident consent, the Ombudsman then proceeds to schedule a time to talk with someone on the care team or proceeds with making a referral to the nurse or the resident's physician.

Next Steps – Low Risk

4) Advise the resident to tell someone (doctor, nurse, family or friend) if suicidal thoughts become more of a prevalent.

5) Ask the resident what additional supports they have or could use in his or her life. Provide them with the Friendship Line (Center for Elderly Suicide Prevention's warm line) 1-800-971-0016.

6) Give the resident your contact information.

7) If the resident does not give you permission to disclose the nature of the conversation, you may not do so to anyone other than an Ombudsman.

8) Discuss with your Ombudsman supervisor as soon as possible or at least within the work week.

Next Steps – Medium Risk

1) Say something to the resident such as: *I am concerned about you. I understand from what you've told me, that these thoughts of suicide are a problem. I think it would be helpful for you to see your doctor or a mental health professional. Let's ask the staff to schedule an appointment with your doctor now.*

2) Document your assessment and determination of risk.

3) Seek permission to talk to facility staff, medical personnel, and/or a family member. With resident consent, the Ombudsman then proceeds to schedule a time to talk with someone on the care team immediately.

4) Ask the resident if he or she is willing to ask the facility staff to schedule a doctor's appointment.

Next Steps – Medium Risk

5) Facilitate a referral. Before leaving the facility, the Ombudsman should try to have the resident talk with staff and offer to accompany the resident to this meeting. If the resident is unwilling, ask them for an alternate plan. Provide them with the Friendship Line (Center for Elderly Suicide Prevention's warm line) 1-800-971-0016.

6) Give the resident your contact information.

7) If the resident does not give you permission to disclose the nature of the conversation with anyone, you may not do so unless you are speaking with an Ombudsman.

8) Discuss with the Regional Ombudsman or the Office as soon as possible (within 24 hours but no longer than 48 hours)

Next Steps – High Risk

1) Say something to the resident such as: *I am concerned about you. I believe you are at risk for hurting yourself and it is important that we get proper medical attention for you. Do you have a mental health counselor I can call or should we ask the nurse to call your doctor or the crisis clinic?*

2) Document your assessment and determination of risk.

3) Tell the resident the concern for being at risk of harm and state additional assistance is needed.

Next Steps – High Risk

4) Seek permission to talk to facility staff, medical personnel, counselor and/or a family member. Provide them with the Friendship Line (Center for Elderly Suicide Prevention's warm line) 1-800-971-0016 and assist with making the call.

5) Advise the resident of the need to talk with nursing staff and if the resident refuses, call the local crisis service or the Center for Elderly Suicide Prevention's warm line 1-800-971-0016 to discuss the situation and to help determine next steps.

6) Discuss with the Regional Ombudsman or the State Ombudsman before leaving the facility.

High Risk and Others at Harm

- Immediately report:
  - To the person in charge at the facility
  - Your immediate supervisor
  - The State Ombudsman

Disclaimer

- The guidelines and protocol are intended to provide direction but should never be used as the sole determinant.

Ombudsman Perspective of the Suicide Protocol

Natasha Belli, Regional Ombudsman

DuPage County Senior Services

Prior to Suicide Protocol

- Any threat of suicide made by a resident is always taken seriously
- Ombudsman (OMB) would ask the Resident questions about whether or not the Resident had a plan, had they talked to anyone about their feelings
- OMB would ask if they could speak with the staff, would inform Resident of their rights and different options as well of what the facility may choose to do (send Resident out to the hospital)
- OMB were unsure how to handle different situations and how far the OMB should get involved based on being a Resident Advocate

Prior to Suicide Protocol Cont.

- Threats of suicide by a Resident are not only stressful for the Resident but also for the OMB.
- If a Resident did not give OMB consent to talk to staff, OMB were unsure how to handle the situation
- When a Resident threatened suicide, the OMB would always call the Regional Ombudsman for assistance

Case Example after Suicide Protocol

- Ombudsman (OMB) had an open case with a male resident of a SNF who was in the facility under a VA contract.
- Resident had been involved in many “Sweetheart Scams” online through Facebook and had given thousands of dollars to many different women.
- Resident also had many bill collectors calling him for credit card debt that had been charged through these scams
- Resident was extremely lonely

Case Example Cont.

- During a FTF visit with the Resident, Resident made a comment about wanting “to end it all”
- OMB asked Resident what this meant and if he had a plan
- Resident had a plan and stated that he was going to wrap his call light around his neck and continue to pull on it
- OMB asked if Resident had told anyone about his feelings. Resident stated that he had not and stated “they don’t care.”
- OMB wrote down the Friendship Line number for the Resident and offered to call with him.

Case Example Cont.

- OMB also asked for permission to alert staff of his feelings so that they could arrange for someone to talk to him. Resident denied OMB consent to notify staff.
- OMB also asked for permission to notify VA therapist but Resident denied consent
- Resident did not want staff notified because he did not want staff to send him out to the hospital
- Resident stated that he has made these comments before but was adamant that he would not act on his plan
- OMB discussed other options with Resident about getting more involved in the VA activities and activities in the facility

Case Example Cont.

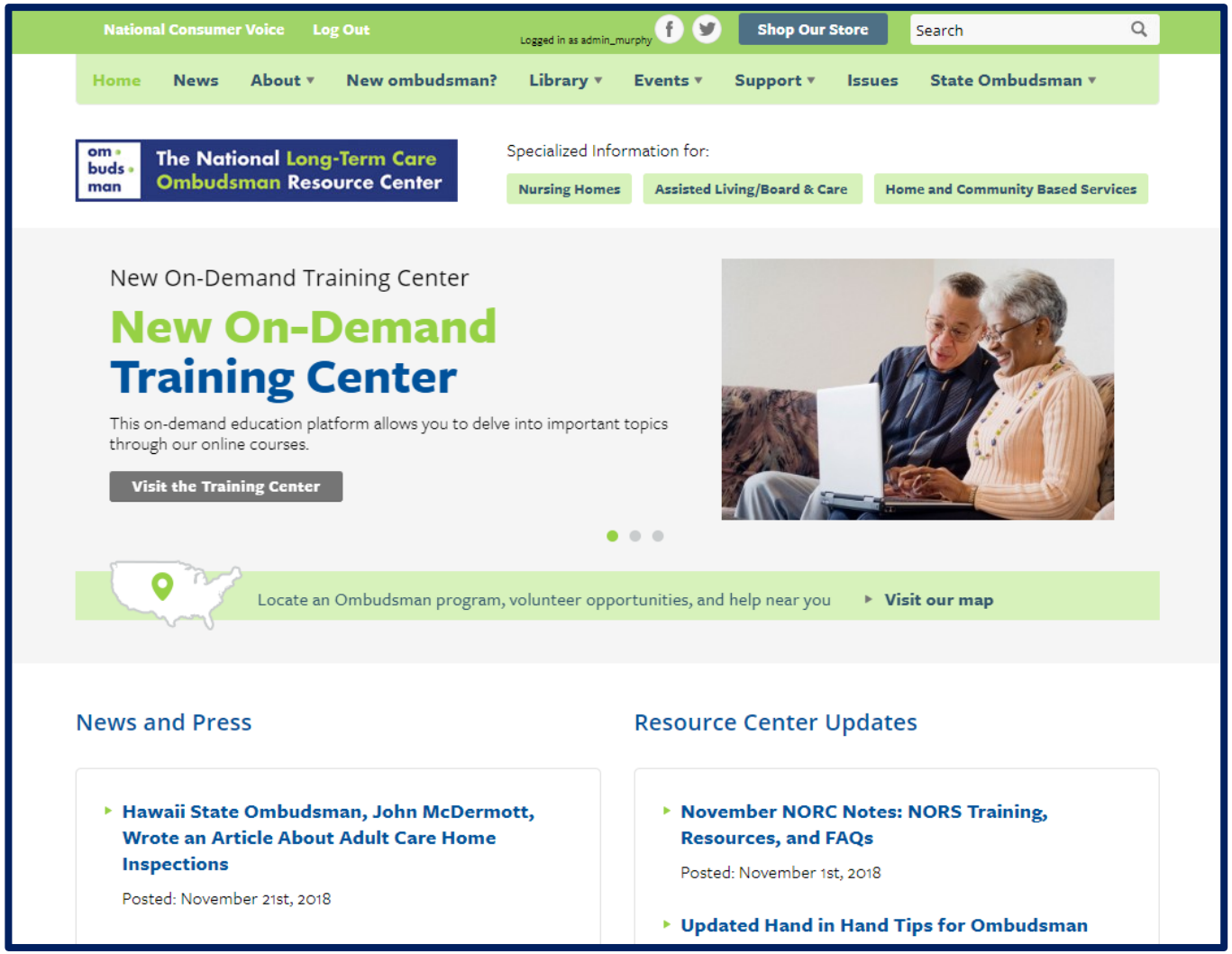
- OMB followed the action steps in the protocol and contacted the Regional OMB to discuss while still at the facility
- Resident was determined to be Low/Medium Risk due to him having a plan which he could carry out but no intention to follow through with his plan
- OMB was in contact with Resident by phone and FTF visit following his statement due to nature of the case
- Resident did follow through with making an appointment with his VA counselor
- Resident also became more involved in VA activities which has helped his feelings of loneliness.
- Resident had expressed that he was glad to have the Friendship Line phone number

How has Suicide Protocol Helped?

- All OMB (including volunteers) are required to carry the pocket protocol with them while at facilities
- The protocol provides the OMB with questions to ask the Resident with actions steps to follow which is very helpful in an already stressful situation
- Friendship Line gives the OMB a resource to immediately give the Resident that we did not have before
- The protocol has given OMB more confidence and support while in facilities
- OMB have a better understanding of their role as an advocate in these situations

RESOURCES

NORC Website

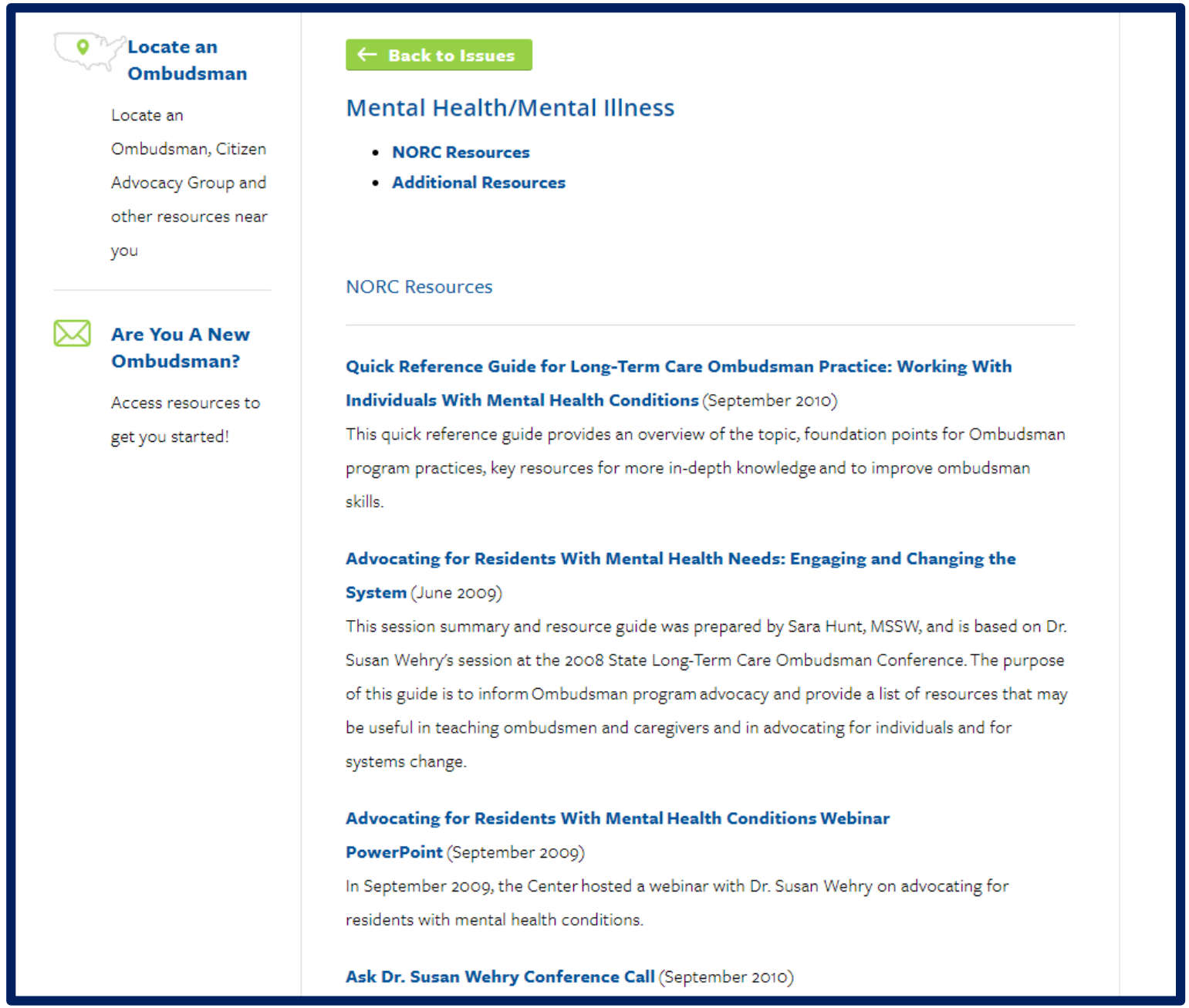


www.ltcombudsman.org

Mental Health/Mental Illness Issue Page

Issue page: https://ltcombudsman.org/issues/mental-health-mental-illness

Ombudsman program examples: https://ltcombudsman.org/omb_support/program-examples



Ombudsman Protocol: A Guide for Long-Term Care Ombudsmen When Residents Threaten Suicide

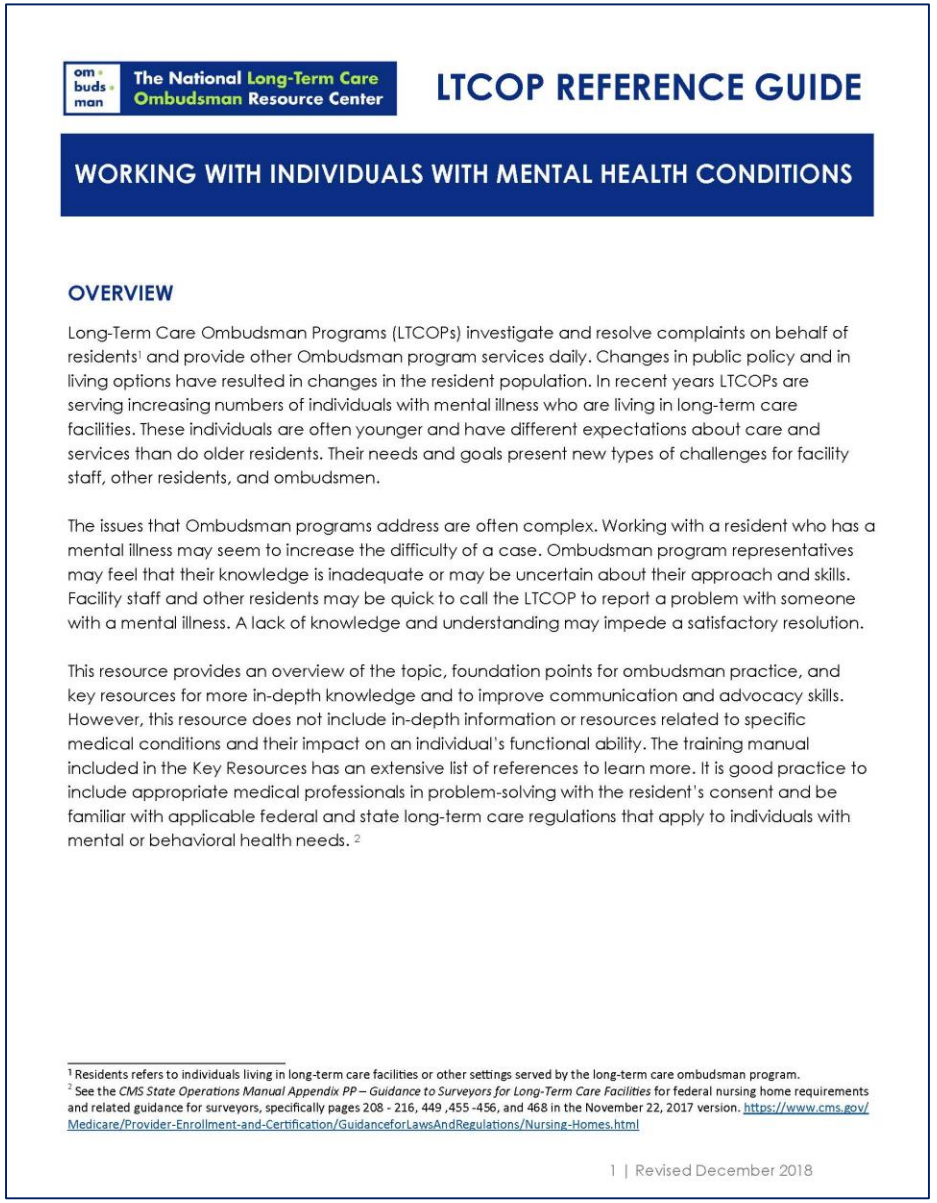
- Created by the Illinois Long-Term Care Ombudsman Program for program representatives to keep with them at all times.

- Available here and with the webinar materials: https://ltcombudsman.org/omb_support/program-examples

Reference Guide

Reference Guide for Long-Term Care Ombudsman Practice: Working with Individuals with Mental Health Conditions

- Provides an overview, foundation points for Ombudsman program practices, key resources for more in-depth knowledge and to improve ombudsman skills.



om buds man The National Long-Term Care Ombudsman Resource Center

LTCOP REFERENCE GUIDE

WORKING WITH INDIVIDUALS WITH MENTAL HEALTH CONDITIONS

OVERVIEW

Long-Term Care Ombudsman Programs (LTCOPs) investigate and resolve complaints on behalf of residents[1] and provide other Ombudsman program services daily. Changes in public policy and in living options have resulted in changes in the resident population. In recent years LTCOPs are serving increasing numbers of individuals with mental illness who are living in long-term care facilities. These individuals are often younger and have different expectations about care and services than do older residents. Their needs and goals present new types of challenges for facility staff, other residents, and ombudsmen.

The issues that Ombudsman programs address are often complex. Working with a resident who has a mental illness may seem to increase the difficulty of a case. Ombudsman program representatives may feel that their knowledge is inadequate or may be uncertain about their approach and skills. Facility staff and other residents may be quick to call the LTCOP to report a problem with someone with a mental illness. A lack of knowledge and understanding may impede a satisfactory resolution.

This resource provides an overview of the topic, foundation points for ombudsman practice, and key resources for more in-depth knowledge and to improve communication and advocacy skills. However, this resource does not include in-depth information or resources related to specific medical conditions and their impact on an individual's functional ability. The training manual included in the Key Resources has an extensive list of references to learn more. It is good practice to include appropriate medical professionals in problem-solving with the resident's consent and be familiar with applicable federal and state long-term care regulations that apply to individuals with mental or behavioral health needs. [2]

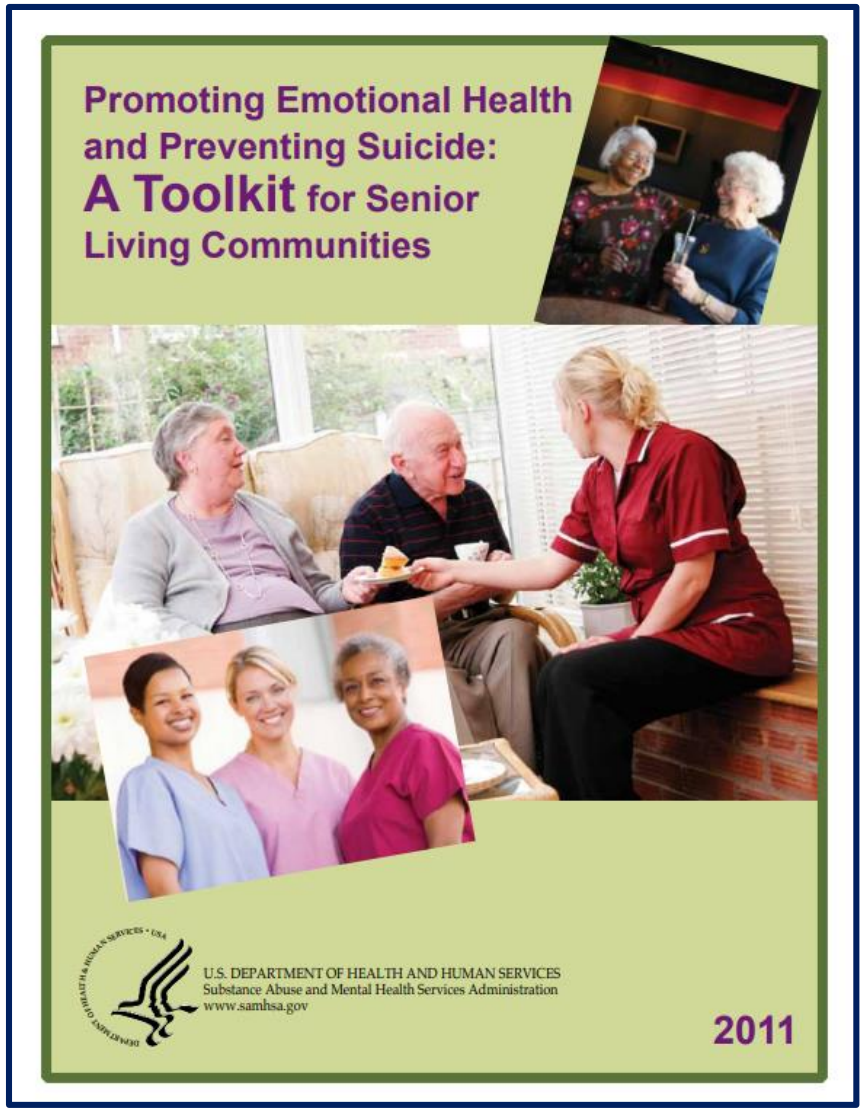
[1] Residents refers to individuals living in long-term care facilities or other settings served by the long-term care ombudsman program.
[2] See the *CMS State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities* for federal nursing home requirements and related guidance for surveyors, specifically pages 208 - 216, 449 ,455 -456, and 468 in the November 22, 2017 version. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

1 | Revised December 2018

Toolkit

Promoting Emotional Health and Preventing Suicide - A Toolkit for Senior Living Communities

- Equip senior living staff with resources to promote mental health and prevent suicide and encourage active participation among residents.
- Includes guidelines for integrating suicide prevention into ongoing programs, hands-on tools, and training manuals.
- https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515



QUESTIONS?

Website and Resources

- Please share your success stories, challenges, state and local newsletters, materials, and resources

- Looking for something? We can help! Contact us at: ombudcenter@theconsumervoice.org

The National Long-Term Care Ombudsman Resource Center (NORC)

www.ltcombudsman.org

Connect with us:

The National LTC Ombudsman Resource Center

@LTCombudcenter

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