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Suicidal Risk Education in Hospice Care

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Suicidal Risk Education in Hospice Care

Shannon Jones

A capstone project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the degree of
Doctor of Nursing Practice

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Submitted by:

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Abstract

It is well-documented that oncology patients experience greater rates of suicidality including suicidal ideation, actions, or completions, as compared to the general population. The small, rural county which was the setting for this project has a higher rate of lung and colon cancers as compared to regional, state, and national rates. A review of the literature revealed best practices for suicide screening including universal education and screening and targeted education and screening for at-risk populations. The rate for suicides in the county is also higher than the rates for the region, state, and nation. The purpose of this project was to implement suicidal risk education for all patients receiving Hospice care at initial contact. Education included information related to signs and symptoms of suicidality and steps for patients and family members to take if suicidality is present or suspected. This project also aimed to implement documentation of education related to suicidality including client and family response to education. Dr. Jean Watson's Theory of Human Caring was the theoretical underpinning for this project. Data collection revealed that implementation was successful, with 100% of newly admitted patients receiving suicidal risk education with documentation of patient and family understanding.

Keywords: suicidality, oncology, hospice, suicidal risk education, theory of human caring, Jean Watson

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Suicidal Risk Education in Hospice Care

Problem Recognition

It is well-documented that oncology patients experience greater rates of suicidality including suicidal ideation, actions, or completions, as compared to the general population. Studies examining the perceptions of health care workers regarding suicidality are sparse and findings vary widely from empathetic reactions to disdain for suicidal patients. Research specifically related to health care workers in the field of oncology regarding perception of patient suicidality is even more wanting and could explain the lack of early recognition and intervention for suicidality in oncology patients (Granek et al., 2019a). One study examining root cause analysis (RCA) reports pertaining to completed suicide in oncology patients found that failure to identify triggers to assess patients for suicidality, lack of communication with patients regarding mental health, and failure to appropriately refer patients at risk for suicide were three categories of root causes (Aboumrad et al., 2018).

The small, rural county in which the project was implemented has a population of 66,701. Suicide is the 8th leading cause of death in the county at a rate of 19.7 per 100,000 residents. This is higher than the rates for the region of the state to which the county belongs and higher than the rates for the state in which the county is established. Of the residents, 23.7% report greater than 7 days of poor mental health in 1 month. Other statistics include: 18.5% report being “dissatisfied with life” and 14.8% report not receiving the mental health care that they needed in 2017. The rate of incidence of lung and colorectal cancers is greater in this county than in the region and the state (Foothills Health Department, 2018).

Considering these facts and the known phenomenon of increased suicidality in oncology patients, identification of the county's oncology patients at risk for suicide, along with early intervention, is crucial. The county's hospice service does not currently use a reliable, evidence-based suicide screening tool during contact with patients. In fact, patients are not screened for suicidality at all unless there is a known pre-existing psychiatric diagnosis or the patient or a family member notifies the team of suicidal threats or behaviors. Due to the lack of a valid, reliable screening tool, members of the Hospice team have expressed difficulty in discerning true risk of suicidality among their patient population (J. Revis, personal communication, May 31, 2019).

Nurses working with oncology patients, including those in hospice care, need a standardized, reliable, evidence-based suicide screening tool to use during patient contacts to identify those experiencing suicidality. A detailed and specific plan should be in place to assist nurses in the next steps when a patient is found to be at risk for suicide. The purpose of this project was to implement suicidal risk assessment for patients receiving Hospice care at each contact rather than the current practice of suicidal risk assessment only in the presence of a known psychiatric diagnoses or report of suicidal ideation, threat, or action. This project also aimed to implement a standardized response to screening results which indicate moderate or high risk for suicide. Dr. Jean Watson's Theory of Human Caring was the theoretical framework selected for this project.

Outcomes objectives for this project were:

- Implementation of an evidence-based suicide risk assessment at each visit for patients receiving Hospice care in a small, rural county by March 31, 2020.

- Implementation of a standardized response to scores indicating moderate to high risk for suicide for patients receiving Hospice care in a small, rural county by March 31, 2020.

Process objectives for this project were:

- Selection of appropriate evidence-based suicide risk screening tool by consensus among the project team by October 31, 2019.
- Consensus among project team members of appropriate standardized response to screening results indicating moderate to high risk for suicide by December 31, 2019.
- Integration of interventions into the Hospice documentation system by January 31, 2020.
- Development of educational materials for Hospice staff by January 31, 2020.
- Scheduling of educational sessions with Hospice staff for the month of February 2020.

This project was intended to assist in the identification of suicidal ideation in patients receiving Hospice care in a small, rural county and to provide staff members with a standardized approach to addressing screening results of moderate to high risk for suicide. Through the implementation of suicide risk screening at each contact and a standardized response to elevated risk, this project was intended to provide support and treatment for patients experiencing suicidality and to decrease the rates of suicide in patients receiving Hospice care.

Project Revisions

Due to complications related to the COVID-19 pandemic and to new processes for employees of Hospice in the county, alterations were required for completion of this project. The revised purpose of this project was to implement suicidal risk education for all patients receiving Hospice care at initial contact. Education included information related to signs and symptoms of suicidality and steps for patients and family members to take if suicidality is present or suspected. This project also aimed to implement documentation of education related to suicidality including client and family response to education.

Revised outcomes objectives for this project were:

- Implementation of education related to signs and symptoms of suicidality and steps for patients and family members to take if suicidality is present or suspected at the initial visit for patients receiving Hospice care in a small, rural county by April 6, 2020.
- Documentation of education and client and family response to education for patients receiving Hospice care in a small, rural county by April 6, 2020.

Revised process objectives for this project were:

- Development of an educational brochure with Hospice approval by consensus among the project team by March 20, 2020.
- Consensus among project team members of appropriate documentation of education and patient and family response by March 20, 2020.
- Integration of interventions into the Hospice documentation system by March 26, 2020.

- Inservice for Hospice staff on the educational brochure and documentation by March 26, 2020.

This project was intended to assist Hospice staff in providing education to patients and families receiving Hospice care in a small, rural county. Through the implementation of suicide risk education at the initial contact, this project was intended to provide education related to support and treatment for patients and family members experiencing suicidality and to decrease the rates of suicide in patients receiving Hospice care.

Resources, Stakeholders, and Team Members

Monetary cost for this intervention included paper and ink for printing brochures, which Hospice staff state had estimated at 10-20 brochures per week. There was no additional cost for documentation as this was built into a pre-existing documentation system by information technologists currently employed by Hospice. Training for patient education and documentation utilizing the brochure was performed by the Education Coordinator for Hospice. Performance of education and documentation related to suicidality takes less than 5 minutes for the care provider to perform. Expected outcomes of the intervention include greater knowledge of Hospice staff, patients, and families of the signs of suicidality and steps to take to receive help for suicidality. The benefits of the expected outcomes were greater than the resource needs for implementation of the intervention.

Stakeholders affected by the intervention include Hospice staff, Hospice patients, patient family members, and staff on the Behavioral Health unit in the community hospital. Team members chosen for this project include the Counseling Services Manager for the community hospice who holds a Master of Social Work (MSW) degree and is an

LCSW and licensed independent social worker-clinical practice (LISW-CP) and who served as Practice Partner to the Project Leader, the Director of Behavioral Health services at the community hospital who holds a Master of Science in Nursing (MSN) and who served as a Committee Member, and a faculty member from Gardner-Webb University who holds a DNP degree and who served as the Project Chair.

Theoretical Underpinnings

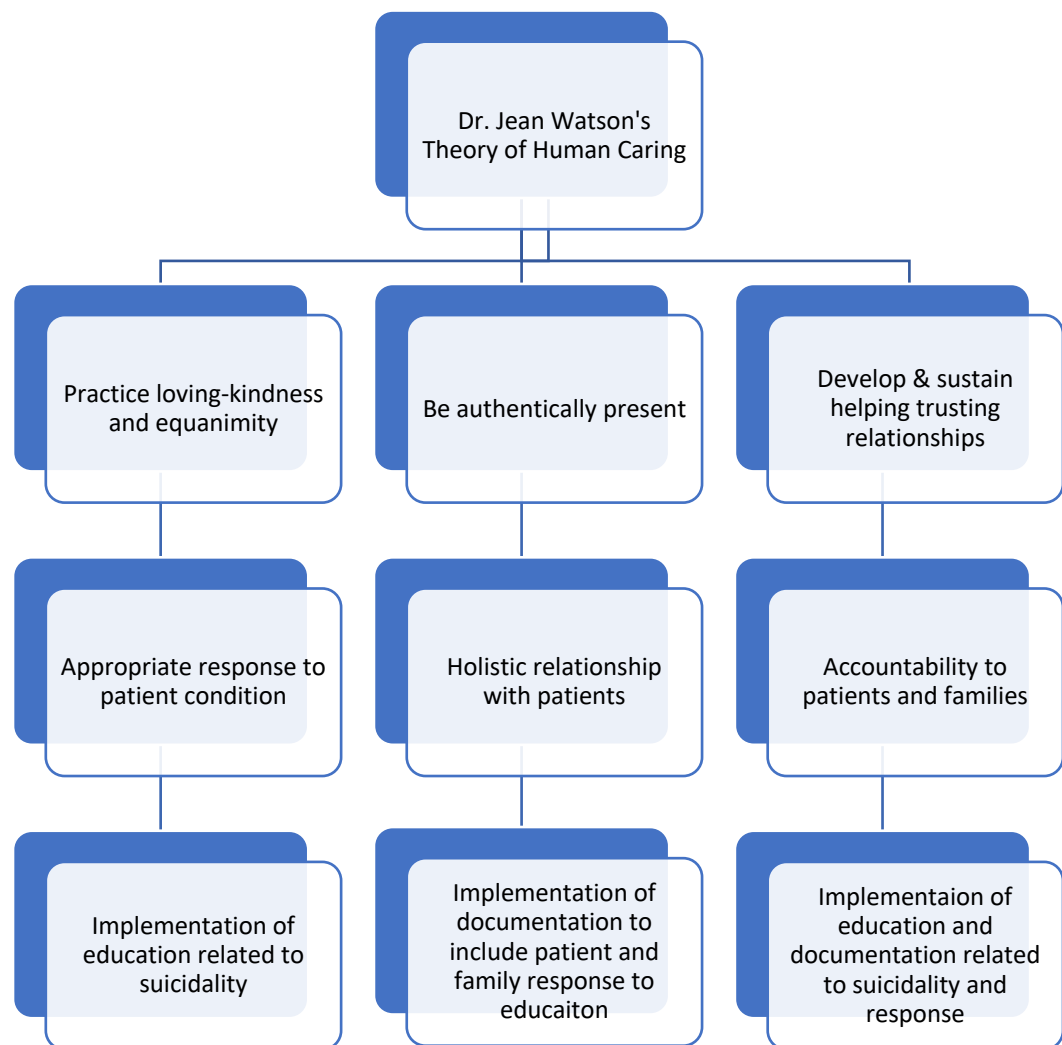
The theory chosen to guide this project was Dr. Jean Watson's Theory of Human Caring. Dr. Jean Watson's Theory of Caring describes 10 caritas processes that can be employed by the nurse during patient interactions to facilitate creation of a deep, transpersonal caring moment that can be transformative for the nurse and patient. The caritas process framework contains a spiritual dimension in which love and caring affect all concepts of the nursing metaparadigm. Watson's theory emphasizes authentic presence with patients in which the nurse is fully present with a patient in the moment of care. The Theory of Human Caring assists the nurse in the development of a loving environment that encompasses the nurse's and the patient's complete self. Deliberate creation of this environment by the nurse within the caring moment may allow the nurse to visualize the patient holistically and can facilitate exploration of all dimensions of well-being including physical, mental, emotional, and spiritual components of an individual (Watson, 2015).

Concepts of Watson's theory can be employed by the nurse to create and sustain a holistic, trusting, authentic relationship with patients receiving hospice care and their families. The practice of authentic presence with each patient can assist the nurse in the assessment, education, and interview process and is critical for the development of a

caring relationship. A caring relationship which encompasses the whole person of both the nurse and the patient may allow for a deeper level of comfort for each when discussing topics such as depression, anxiety, or suicidality.

Figure 1

Conceptual-Theoretical-Empirical Diagram (CTE)



Literature Review

This project was intended to assist Hospice staff in providing education to patients and families receiving Hospice care in a small, rural county. Through the implementation of suicide risk education at the initial contact, this project was intended to provide education related to support and treatment for patients and family members experiencing suicidality and to decrease the rates of suicide in patients receiving Hospice care. A review of the literature was performed using Bulldog OneSearch, CINAHL, and Google Scholar databases. Keywords used by the Project Leader during the search included “hospice”, “suicidality hospice”, “suicidality oncology”, “suicide risk assessment”, “oncology suicide”, “suicide screening”, “suicide education”, “psychosocial needs oncology”, “psychosocial needs hospice”, “theory of human caring” and “hospice suicide”.

Suicidality in Oncology

Symptoms of depression are generally well-recognized by health care professionals, while signs and symptoms of suicidality may go undetected. A 2016 study by Washington et al. aimed to determine the frequency with which hospice and palliative care social workers encounter patients, family members, or others in the patient care setting who exhibited signs and symptoms of suicidality and to explore their perception of preparedness to address suicidality. A cross-sectional survey of hospice and palliative care social workers revealed that 74.4% of the 74 respondents who provided direct patient care had interacted with at least one patient in the previous 12 months who exhibited signs and symptoms of suicidality. Of the respondents, 24.4% reported at least one suicide attempt by a patient in the 12 months prior to the study and 10.9% reported at

least one completed suicide. Regarding perception of preparedness, two factors were found to affect results: educational preparedness and use of standardized scales or questionnaires. While 87.7% of respondents reported recalling educational content related to suicide during their preparation for the role, 93.5% agreed that learning more about suicidality would be beneficial for their practice. Of the respondents, 74.3% indicated that they somewhat infrequently, rarely, or never use standardized scales to assess suicidality in their patient population. These findings are important as they illustrate the need for both suicide education and screening, particularly considering the high percentage of clinicians who reported encountering suicidal signs and symptoms. The researchers listed limitations as small sample size and the use of a convenience sample and they recommend development of a national team of researchers dedicated to this topic which includes hospice and palliative care social workers (Washington et al., 2016).

A 2017 study by Zhong et al. further demonstrates the prevalence of suicidality among oncology patients. The study measured responses from 517 inpatients who had been diagnosed with cancer and did not have a pre-existing diagnosis of a mental health condition. The question: “In the past month, did you think about ending your life?” was asked and answers were recorded along with demographic and other information. Of the respondents, 15.3% endorsed suicidal ideation in the past month, 12.9% of males and 17.6% of females. Factors found to correlate to suicidal ideation included religious beliefs, poor finances, a score of 3-4 on the Eastern Cooperative Oncology Group (ECOG) Performance Status Scale, a family history of a mental health condition, a relative or friend who completed or attempted suicide, symptoms of anxiety or

depression, moderate-to-severe pain, advanced cancer, recent cancer diagnosis, poor performance status, and a current treatment regimen of palliative care or surgery. The site of cancer also influenced scores, with a higher percentage of breast, gynecological, and liver cancer patients endorsing suicidality. Limitations listed by the researchers included use of tertiary hospital sites only, presence of wide variation in scores dependent upon cancer site, the possibility of confounding variables including social support, and the exclusion of patients who were “too ill” to participate, which may have drastically altered scoring (Zhong et al., 2017).

A 2019 retrospective analysis of data from the Surveillance, Epidemiology, and End Results program from the years 1973-2014 was performed by Zaorsky et al. Data for 8,651,569 cancer patients was reviewed revealing that 13,311, or 28.58 per 100,000-person years, died from suicide. Suicides were highest among those who were white (92%) and male (83%). Cancer sites with the highest suicide rates included the lung, head and neck, testes, bladder, and Hodgkin lymphoma. These results are important to consider in development of interventions for suicide prevention in oncology patients (Zaorsky et al., 2019).

While it is widely recognized that oncology patients experience rates of depression, anxiety, and suicidality at a higher rate than the general public, there remains no evidence-based best practice recommendation for suicide screening or education among this population (Granek et al., 2019a). A 2014 study by Fang et al. investigated the link between symptoms of depression versus demoralization in relation to suicidality in oncology patients. Two hundred participants completed questionnaires including the Distress Thermometer (DT), Patient Health Questionnaire-9 (PHQ-9), Demoralization

Scale-Mandarin Version (DS-MV), and the Beck Scale for Suicide Ideation. Tobit regression analysis of data indicated that demoralization more strongly influenced suicidal ideation as compared to depression which demonstrates that depression screening alone is not sufficient for detection of those at risk for suicide among this population. The researchers list no study limitations or recommendations for future studies (Fang et al., 2014).

Granek et al. (2017a) used Grounded Theory (GT) to examine how healthcare personnel working with oncology patients identify suicidality in this patient population. Researchers discussed that findings from analysis of interviews with 61 workers indicated suicidality exists on a continuum from active will to live to active will to die. The study described four phases existing on the continuum: (A) a strong will to live, (B) a decreasing will to live, (C) a readiness to die, and (D) a will to die. Themes identified in phase A included active treatment, seeking second opinions, overtreatment, and alternative treatments. Themes identified in phase B included mental health distress and physical pain and suffering. Themes identified in phase C included mental health distress, previous mental health diagnoses, physical pain, avoiding more suffering, preserving quality of life in old age, nearing end of life, lack of social support, and maintaining a sense of control. Themes identified in phase D included euthanasia and active suicidality. This underscores the importance of education related to suicidal ideation for clinicians as well as patients and family members to that progression through phases, while not always sequential or even progressive, can be identified. The researchers discuss the need to define suicidality more specifically in oncology patients as some study participants viewed the decision to stop treatments as a suicidal act (Granek et al., 2017a).

A study aimed at identifying strategies and barriers in the identification of suicide risk in cancer patients for oncologists, nurses, and social workers was published in 2017 by Granek et al. A GT approach was used to collect and analyze both quantitative and qualitative data collected from 61 health care professionals at two cancer centers. Quantitative results reflected the response that a professional had encountered either suicidal ideation or completed suicide among their patients during their careers. These were reported as 56% and 65%, respectively for oncologists; 55% and 75%, respectively for nurses; and 22% and 66%, respectively for social workers. These results, above all, illustrate that the majority of patients encountered by the participants experienced suicidality that was recognizable by health care professionals. Categories identified related to strategies to identify suicide risk were ability to recognize verbal indicators, explicit actions, patients who were exhibiting mental health distress, disease characteristics, and patient characteristics which increases the likelihood of suicidality. Categories identified as barriers to identifying suicide risk included patient-related factors such as concealment of ideation and missed appointments and healthcare professional-related factors including lack of knowledge related to suicidality, and fear of asking about suicidality. These findings illustrate the need for healthcare professionals to initiate conversations about suicidality and to increase their level of comfort with the topic through education and practice. The researchers listed limitations of the study as use of a convenience sample and voluntary nature of the study which could allow for a higher rate of inclusion for those who feel more comfortable and knowledgeable about suicidality (Granek et al., 2017b).

Granek et al. (2019b) used GT to explore the perceptions of oncologists, oncology nurses, and oncology social workers in relation to suicidality in a 2019 qualitative study. In this study, suicidality was defined to include suicidal ideation, suicidal acts, and completed suicides. Three categories were identified in data analysis: perceptions of suicidality, explanatory models of suicidality, and moral views on suicide. Perceptions of suicidality included cries for help, signs of distress, and attempts at attention seeking. Explanations for suicidality included stemming from biological disease or mental illness and occurrence as an aberration, or as an impulsive, irrational act. Moral views on suicide fell into three categories: acceptance of suicidality which often included empathy, rejection of suicidality with negative correlations, and ambivalence. The results of this study convey the very different attitudes and perceptions of suicidality by oncology healthcare professionals which reinforces the need for a standardized approach. The researchers listed limitations of the study as the use of a convenience sample, voluntary participation, and inclusion of health care professionals who already have an established professional identity (Granek et al., 2019b)

In 2019, Granek et al. published a qualitative study which utilized GT to explore the effects of mental health distress and suicidality of oncology patients on healthcare workers involved in their care. Themes extracted from interviews with oncology personnel were divided into three categories: Impact of Patients' Mental Health Distress and Suicidal Ideation on Healthcare Professionals, Impact of Patient Suicide on Healthcare Professionals, and Coping with the Impact of Patients' Mental Health Distress and Suicidality. Themes identified for Impact of Patients' Mental Health Distress and Suicidal Ideation on Healthcare Professionals included: sadness, depression, worry and

concern, and feeling emotionally overwhelmed. Themes identified for Impact of Patient Suicide on Healthcare Professionals included: trauma, guilt, and surprise. Themes identified for Coping with the Impact of Patients' Mental Health Distress and Suicidality included: colleague support, seeking professional help, and setting boundaries between their work and home life. This study emphasizes the importance of education and open communication with the healthcare team regarding mental health issues and suicide to reinforce coping mechanisms and allow for an increased level of comfort in discussing these topics with oncology patients. The researchers listed a limitation of the study: participation was voluntary, and providers who agreed to participate were thought to be more willing to discuss the issues. This led to the conclusion that the impact among those who chose not to participate could be even greater (Granek et al., 2019a).

Suicide Screening and Prevention

Suicide prevention is complicated, in part, by the fact that screening is not common among patient populations outside of mental and behavioral health and warning signs of suicide are commonly undetected. Rural areas often have fewer resources and other factors that make identification of those at risk for suicide even more difficult. A 2018 study by Lyu et al. aimed to explore factors of suicide attempts to provide data to inform an early warning model that could be used in suicide screening and prevention. Researchers interviewed 659 participants from rural areas who had attempted suicide and applied multivariate logistic regression to extract predictors for suicidality. Univariate logistic regression was applied to demographic data to determine effect on suicidality. Results showed no significant differences based on age, gender, or residential location. Twelve predictors were identified including lower level of education, family history of

suicide, poor health conditions, mental health problem, aspiration strain, hopelessness, impulsivity, depression, and negative life events. Three protective factors were identified including social support, use of coping skills, and “healthy community.” The researchers discussed that the presence of more than one predictor warrants closer observation of patients in rural areas. This study is important as it illustrates that risk factors for suicidality can be identified, and treatment plans can be individualized to address those at higher risk for suicide if these individuals have sought medical care prior to an attempt. Researchers list limitations of the study as a narrow sample range and exclusion of microcosmic aspects such as genetic or chromosomal differences of participants (Lyu et al., 2018).

In 2015, Shepard et al. analyzed the national cost of suicides and suicide attempts in the United States to determine the cost-benefit ratio for measures aimed at suicide prevention including medication, counseling, and linked services. The researchers examined data from the Centers for Disease Control and Prevention (CDC) to obtain numbers for both fatal and non-fatal suicidal acts in the United States in 2013. To determine an estimate of cost, data from 2007 was gathered from the CDC and multiplied by the number of suicidal acts in 2013 as 2007 was the last year in which unrestricted data reporting from the states occurred. Both direct costs (funeral costs, hospital stays, psychiatric care and counseling, medications, etcetera) and indirect costs (time lost from work, loss of future productivity, mental health treatment for survivors, etcetera) were measured and adjusted for inflation and for expected increase in income over time. Interviews were also conducted with healthcare representatives involved in care related to suicidal acts to investigate their perception of measures that could improve outcomes.

The study revealed that a six to one benefit to cost ratio exists and that suicide prevention measures are six times less costly than the cost of suicidal acts. Results were comparable to those found in other countries using similar methodology. Interviews revealed three themes for prevention: suicide screening at hospitals, lack of access to both inpatient and outpatient psychiatric care, and need for improvement in continuity of care. Researchers listed limitations as lack of access to current cost data, use of a single site for interviews, and data discrepancies in previous research consulted during the study. This study makes a strong case for investment into suicide screening and prevention in the United States from a cost-benefit perspective (Shepard et al., 2015).

A 2016 study by Schaffer et al. highlights the need for routine suicide screenings at each patient contact. The researchers extracted data from 2,835 deaths by suicide between 1988 and 2011 in the city of Toronto. Data was analyzed to determine the incidence and nature of care contacts for the 12 months preceding each suicide. Results revealed that 91.7% of suicide decedents had contact with a healthcare provider in the preceding 12 months. Of the 91% who had contact with a healthcare provider, 66.4% were seen by a mental healthcare professional while 25.3% had contact solely with non-mental healthcare providers. Mental healthcare visits were further divided into primary care (54.0%), outpatient psychiatry (39.8%), emergency department visits (31.1%), and psychiatric hospitalization (21.0%). The average number of days between last mental healthcare contact and completed suicide was 18 days. Factors found to be significantly correlated to seeking mental healthcare included female gender, age 25-64 years, absence of a reported recent stressor, diagnoses of bipolar or schizophrenia, a history of a previous suicide attempt, self-poisoning as the suicide method, and the lack of a suicide

note. Limitations listed by the researchers include inability to determine the nature of mental health contacts, possibility of misclassification of deaths by coroner report, ability of the researchers to review only healthcare contacts with physicians, and the wide availability of mental health resources in the Toronto area which cannot be compared to rural or other underserved areas (Schaffer et al., 2016). This study shows the need to specifically screen for suicide at each patient contact to identify those at risk and improve suicide prevention rates.

In 2018, Terpstra et al. conducted an observational study on suicide gatekeeper training in the Netherlands. Gatekeeper training aims to equip individuals to assist citizens in many settings including schools, social services, and in general practitioner offices to address factors affecting suicidality including social, medical, and economic factors. Researchers utilized a pre- and post-test to determine effects of education on knowledge and confidence level related to identification of suicidality and referral behavior. A total of 502 participants completed the pre-test while only 174 completed the post-test. Results were further broken down by employment sector: healthcare, education, socioeconomic, and other. Data analysis reflected that referral behaviors did not significantly change for those who received gatekeeper training, but knowledge and confidence level in identifying suicidality significantly increased across all employment sectors. Researchers list limitations for the study as low post-test response rate, the absence of a control group, possibility of bias due to a lack of collection of demographic data, and the possibility of confounding variables (Terpstra et al., 2018). This study emphasizes the importance of training related to suicidality for those who have contact with individuals in diverse settings.

A 2017 study by Wexler et al. used a pre- and post-test design to measure participant response to Promoting Community Conversations About Research to End Suicide (PC CARES) facilitator training, an intervention designed to create a grassroots community-based effort to identify Alaskan native youths at risk for suicide and implement preventative measures. Thirty-two participants received PC CARES facilitator training and 100% reported increased confidence and commitment to provision of training for community members. Follow-up inquiries revealed that the 20 of the 32 participants had trained a total of 309 community members in PC CARES in 10 of the 11 villages the measure aimed to affect. Modified group quizzes used to assess trainee knowledge of suicidality and suicide prevention in Alaskan native youths revealed 100% accuracy for trainees. Researchers listed limitations of the study as small sample size, variability in village implementation, lack of recording of nonverbal cues for analysis during interviews, and lack of assessment of community learning outcomes (Wexler et al., 2017). This study shows that education related to suicide prevention can be disseminated by trained facilitators to create a network of knowledgeable individuals in the community to assist in suicide prevention measures.

A 2017 qualitative study by Snyder et al. aimed to explore medical inpatients' opinions of suicide screening while hospitalized. As per facility policy, nurses employed on three units within the selected facility (oncology, general medical/surgical, and infectious disease) performed the asQ'em questionnaire on newly admitted patients. This suicide screening tool consists of two questions: "In the past month, have you had thoughts about suicide?" and "Have you ever made a suicide attempt?" If either question generates a "yes" response, a follow-up question: "Are you having thoughts of suicide

right now?” is also asked. For patients who participated in this study, questions related to perception of suicide screening were asked after screening was performed including “Do you think all medical/surgical patients in a hospital should be asked about suicide; why or why not?” and “Do you have any additional comments?” A total of 53 participants were interviewed and post hoc analysis revealed that 81% of respondents supported suicide screening in the medical inpatient setting while 9.5% did not and another 9.5% replied “don’t know.” Of the respondents, 98% reported either positive (79%) or neutral (19%) response to the asQ’em questionnaire while one participant (who screened positive) reported a negative experience related to screening. Three common themes emerged from qualitative data: “patients should be asked directly about suicide;” “mental health should be an integral component of in the delivery of medical care;” and “importance of intervening, protecting, and keeping patients safe in a hospital setting.” Researchers listed limitations of the study including use of a small convenience sample, use of a research hospital as the setting which could affect answers, exclusion of non-English speaking patients, and brevity of answers for analysis. This study indicates that most medical patients may support suicide screening in medical/surgical settings (Snyder, 2017).

In 2018, Na et al. performed a study aimed at validation of a commonly used screening tool for depression, the Patient Health Questionnaire-9 (PHQ-9), for use in identifying those at risk for suicide. Data from 841 patients was analyzed and results from the PHQ-9 were compared to results from an electronic version of the Columbia Suicide Severity Rating Scale (eC-SSRS), which is considered the gold standard of suicide screening. The PHQ-9 has previously been validated as a tool for detection of depression but had not previously been evaluated for accuracy in identification of those at

risk for suicide. Results revealed a significant discrepancy ($p < 0.05$) between those who scored positive for risk for suicide on the PHQ-9 (346 participants, or 41.1%) and those who scored positive for risk for suicide on the eC-SSRS (113 participants, or 13.4%). This discrepancy indicates that the PHQ-9 is not an appropriate tool to use for suicide screening. This is important as it is common practice for healthcare entities to use the PHQ-9 rather than the validated and reliable C-SSRS screening tool to evaluate patients for suicidality. Limitations listed by researchers included homogeneity of the sample used for the study, use of another screening tool for validation rather than actual suicidal acts, and cross-sectional nature of the study which did not allow for evaluation of predictive effect of the PHQ-9 on suicidality (Na et al., 2018).

In 2017, a study by Owens and Charles aimed to determine the effect of distribution of an educational leaflet entitled “It’s safe to talk about suicide” among community agencies. The leaflet contained information related to suicidal ideation, how to begin a conversation with an individual who is suspected of suicidal ideation, specific questions to ask, and steps to take if an individual endorses suicidal ideation. The target audience for the leaflet was laypersons in the community. A total of 15,000 leaflets were disbursed to community members by community healthcare agencies, an initial number of 25 for each individual agency. Three rounds of interviews were conducted with agency staff: the first explored the agency staff’s initial reaction to the leaflet and how agencies planned to utilize leaflets, the second (approximately 6 months later) evaluated effectiveness of the plan and solicited suggestions for improvements, and the third round focused on in-depth interviews with selected agencies to investigate effects of leaflet use. Both quantitative and qualitative data were analyzed. Quantitative data revealed that, of

19 types of agencies who received the leaflets, only two categories (National Health Service [NHS] walk-in sites and county library services) did not request additional copies. Four categories of agencies not included in the initial disbursement (NHS general hospitals, criminal justice settings, Community Safety Partnerships [CSPs], and Regional Zero Suicide Collaborative) requested brochures for disbursement to their target populations. Qualitative data revealed the need for selection of an individual at each agency as a contact person for distribution, the need for inclusion of other agency types such as courts of law and food banks, and reports from agency representatives that the leaflet filled an important gap in communication with individuals in the community regarding suicidality. Participants expressed increased confidence in discussing suicidality with community members. No limitations were discussed by researchers. This study indicates that distribution of educational materials by those who interact with community members may improve communication regarding suicidality, which could ultimately save lives (Owens & Charles, 2017).

Watson's Theory of Human Caring

Watson's Theory of Human Caring was chosen to guide this project as the theory has been shown to affect emotional responses in patients which can affect patient outcomes. A 2017 study by Durgun Ozan and Okumus aimed to explore the effect of a nursing care program based on Watson's Theory of Human Caring on anxiety and distress in patients who have experienced failure in infertility treatment. A total of 86 Turkish women participated in the study: 45 in the intervention group who received nursing care based on Watson's theory and 41 in the control group who received routine nursing care. Treatment was provided to both groups for a period of 8 months, and

follow-up treatment was provided for an additional 4 weeks for those who experienced treatment failure (32 from the intervention group and 35 from the control group). Data was collected and analyzed using Spiel Berger's State/Trait Anxiety Inventory, the Infertility Distress Scale, and Ways of Coping Questionnaire. T-tests were used to compare data among pre-trial responses, responses after embryo transfer (ET), and responses at the end of the 4-week follow-up period. Results of analysis of responses related to anxiety showed no significant difference ($p=0.59$) among the intervention and control groups at pre-trial, but significant differences ($p<0.00$) among the intervention and control groups after ET and at the end of the 4-week follow-up period. Similarly, results identified no significant difference ($p=0.89$) in distress among the intervention and control groups at pre-trial but identified significant differences ($p<0.00$) among the intervention and control groups after ET and at the end of the four-week follow-up period. As anticipated, levels of anxiety and distress were decreased in patients in the intervention group. Results also indicated that those in the intervention group were more likely to utilize coping skills that reflected self-confidence, optimism, and seeking of social support while those in the control group were more likely to utilize coping skills that reflected lack of confidence and submission. Researchers listed limitations of the study including exclusion of male counterparts from data collection, small sample size of follow-up group, and the necessity of completing research within time constraints related to the nature of the sample used. This study illustrates how utilization of Watson's Theory of Human Caring can affect emotional health factors for patients experiencing loss, anxiety, and distress (Durgun Ozan & Okumus, 2017).

A 2017 study by Tektas and Cam explored the effects of nursing care based on Watson's Theory of Human Caring on anxiety, depression, hopelessness, and prenatal attachment of pregnant women who had previously experiencing the loss of a pregnancy. An experimental group of 55 participants received nursing care based on Watson's Theory of Human caring while a control group of 46 participants received standard nursing care. Tools used to collect data during the study included a characteristic information form, the Beck Anxiety Scale, the Beck Hopelessness Scale, the Beck Depression Scale, and the Prenatal Attachment Inventory. No significant differences ($p>0.05$) were found in demographic or other characteristic information among the experimental and control groups. No statistically significant differences were found in anxiety, hopelessness, depression, or prenatal attachment among the experimental and control groups prior to the intervention. A significant difference ($p<0.001$) was found among the experimental and control groups after the intervention. Scores for anxiety, depression, and hopelessness were lower in the experimental group while scores for prenatal attachment were found to be higher. The researchers listed one limitation: the use of quantitative data did not allow for exploration of factors related to nursing care that the participants felt affected their scores. This study reinforces that application of Watson's Theory of Human Caring can affect a patient's mental and emotional health status (Tekas & Cam, 2017).

A 2020 study by Durgun Ozan et al. aimed to explore the effects of a teaching program based on Watson's Theory of Human Caring on coping and anxiety levels of third-year nursing students. Study participants were divided into an intervention group and a control group, each made up of 51 students. The groups were divided among two

clinical sites with the control group attending one site and the intervention group attending another. There were two instructors for each group. Instructors in the intervention group were trained in Watson's Theory and had published works related to Watson's Theory. Tenets of the Theory of Human Caring were applied during clinical experiences for the intervention group while the control group experienced a traditional clinical experience. Spiel Berger's State-trait Anxiety scale and the "Ways of Coping Inventory" were the tools used to collect data for the study. Results showed no significant difference ($p>0.05$) in scores for anxiety and coping in the pre-test between the control and intervention groups. According to post-test results, anxiety was found to be significantly less ($p<0.05$) in the intervention group. The intervention group was found to have significantly increased ($p<0.05$) "self-confident" and "social support-seeking" coping skills as compared to the control group. The control group was found to have significantly increased ($p<0.05$) "unconfident" and "submissive" coping skills as compared to the intervention group. There was no significant difference ($p>0.05$) found in "optimistic" coping skills. Researchers listed limitations of the study including homogeneity of the study sample and small sample size. This study shows that Watson's Theory of Human Caring is applicable in a variety of settings and has positive mental and emotional effects for a diverse target population (Durgun Ozan et al., 2020).

In 2018, a study by Jones aimed to measure the effect of adoption of Watson's Theory of Human Caring on psychiatric nurse perception of the care environment as measured by a modified version of the Combined Assessment of Psychiatric Environments (CAPE) instrument. The CAPE instrument contains 17 Likert-type scale questions that are divided into three categories of measurement related to staff perception

of the care environment: “nurse perception of effectiveness of care provided,” “nurse perception of resources,” and “nurse perception of teamwork.” A pre- and post-test approach was used, and the CAPE instrument was administered to 12 nurses employed on an inpatient psychiatric unit in a rural community hospital before and after unit adoption of Watson’s theory. Following the pre-test, nurses on the unit attended training in Watson’s theory, including the 10 caritas processes, and in how to apply elements of the theory during interactions with patients and co-workers. Posters were placed on the unit with reminders of the concepts of Watson’s theory and examples of application to patient care on the unit. Post-test results revealed a significant increase ($p=0.004$) in scores measuring “nurse perception of effectiveness of care provided.” No significant change ($p=0.243$) was noted in “nurse perception of resources.” A significant decrease ($p<0.001$) was discovered for “nurse perception of teamwork.” Limitations for the study were listed as small sample size and the use of a convenience sample. Two potential confounding variables were identified: turnover of two experienced staff members with two new graduate nurses and modification of the treatment team process. The results indicated that application of Watson’s theory to nursing care could improve nurse perception of effectiveness of care, particularly concerning psychiatric and mental health nursing (Jones, 2018).

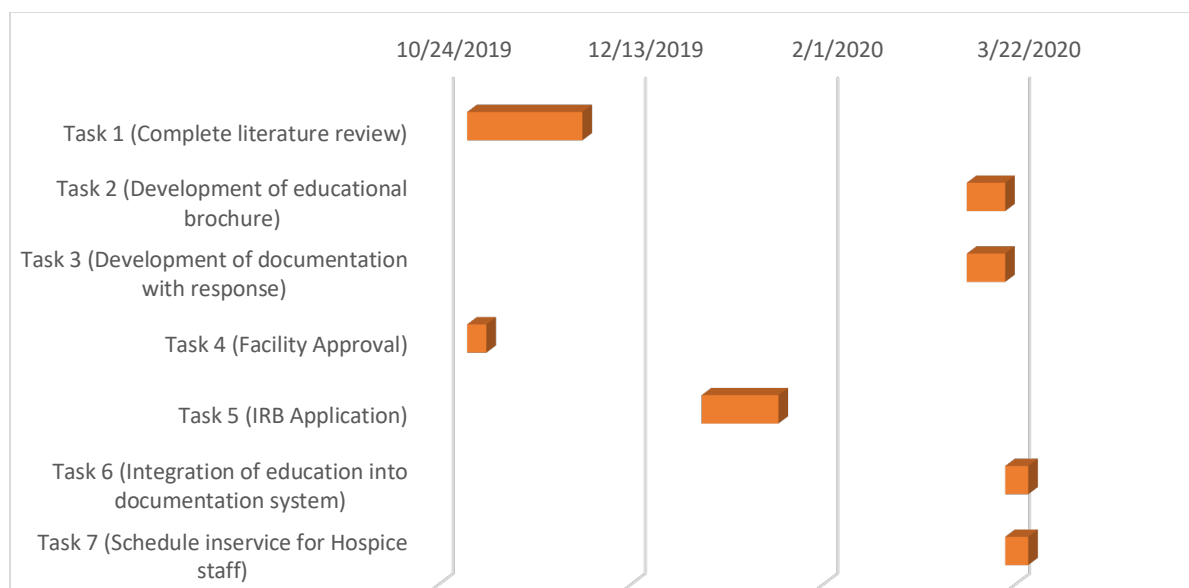
Work Planning

Nurses working with oncology patients, including those in hospice care, need standardized educational materials related to suicidality, which include instructions for patients and families experiencing suicidality, to use during patient contact to ensure patients and families know how to seek help when experiencing suicidality.

Documentation of education and patient and family response should occur to ensure adherence to provision of education. The purpose of this project was to implement suicidal risk education for all patients receiving Hospice care in a small, rural county at initial contact. Education included information related to signs and symptoms of suicidality and steps for patients and family members to take if suicidality is present or suspected. This project also aimed to implement documentation of education related to suicidality including client and family response to education. Figure 2 illustrates the timeline for tasks that were completed prior to and during implementation of the project.

Figure 2

Timeline for Tasks Completed Prior to and During Implementation of Project

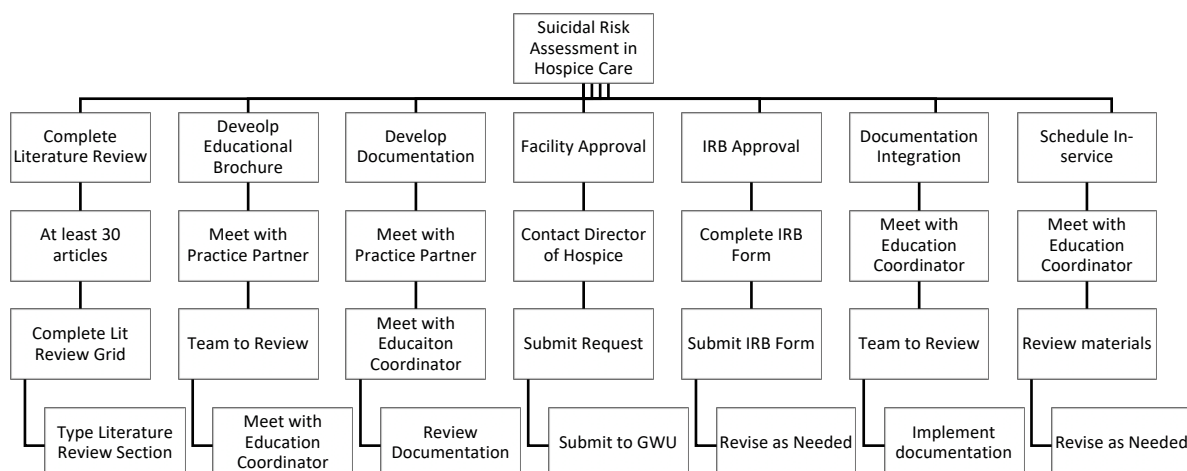


Work Breakdown Structure

Figure 3 depicts a breakdown of the tasks that were completed prior to and during implementation of the project.

Figure 3

Breakdown of Tasks Completed Prior To and During Implementation of Project



Budget

Costs for ink and paper for educational materials were added to the Hospice office's monthly budget. It was anticipated that 10-20 brochures will be needed each week. There was no monetary cost for documentation by staff as it was built into a pre-existing documentation system by information technologists currently employed by Hospice. There were salary costs for those integrating the intervention into the

documentation system, those attending in-services, and those who revised policy to include the educations and documentation.

Evaluation Planning

The purpose of this project was to implement suicidal risk education for all patients receiving Hospice care in a small, rural county at initial contact. Education included information related to signs and symptoms of suicidality and steps for patients and family members to take if suicidality is present or suspected. This project also aimed to implement documentation of education related to suicidality including client and family response to education. The quality improvement model, Figure 4 illustrates the plan for evaluation for this project.

Figure 4

Quality Improvement Model

Plan	<ul style="list-style-type: none"> • Obtain facility approval • Obtain institutional review board (IRB) approval • Development of educational brochure • Development of documentation with response • Scheduling of in-service sessions
Do	<ul style="list-style-type: none"> • Integrate education and response into documentation system • Schedule in-service sessions for hospice staff
Study	<ul style="list-style-type: none"> • Observe for adoption of educational intervention and documentation with patient and family response
Act	<ul style="list-style-type: none"> • Consider revision of educational materials, documentation, or repeat in-service if implementation does not occur or if adherence is low

Implementation

The purpose of this project was to implement suicidal risk education for all patients receiving Hospice care in a small, rural county at initial contact. Education

included information related to signs and symptoms of suicidality and steps for patients and family members to take if suicidality is present or suspected. This project also aimed to implement documentation of education related to suicidality including client and family response to education. Dr. Jean Watson's Theory of Human Caring was the theoretical framework utilized for this project.

After permission was obtained from Hospice and Institutional Review Board (IRB) approval from Gardner-Webb University, an educational brochure was developed by the Project Leader and approved by the Hospice care team. The brochure, found in the Appendix, contained information related to signs and symptoms of suicidality and steps for patients and family members to take in the presence of suicidality. Contact information for the Hospice participating in the project has been covered to protect patients and project participants. A documentation statement was created in the electronic medical record which included verification that the brochure was given, that education was performed, and verbalization of understanding by the patient and family members. The Education Coordinator for Hospice met with the Project Leader to determine the needed content and scheduling for an in-service for staff. In-services were performed by the Education Coordinator and included an explanation of the brochure, instructions for explaining contents of the brochure to patients and their families, and documentation of understanding of education. There was a brief role-playing session at the end of each session for staff to practice performing and documenting education. A statement was added to the pre-existing facility policy that suicide risk education must be performed and documented at initial contact for each patient. Brochures were printed and added to patient admission packets.

Data was collected weekly by the Education Coordinator for Hospice which included the number of admissions and the number of charts containing documentation upon admission of provision of suicide risk education and patient and family response. Data was sent to the Project Leader for analysis weekly. Both the Education Coordinator for Hospice and the Project Leader were available for staff questions and concerns regarding the educational brochure, the process for patient education, and documentation of understanding. Hospice staff members demonstrated understanding of education during the in-service through role-play and denied the need for further education during the course of the project.

Interpretation of the Data

The Education Coordinator for Hospice collected the following data from charts on a weekly basis for a period of 4 weeks: number of admissions to Hospice care in the county and number of charts containing documentation upon admission of provision of suicide risk education and patient and family response. Numbers were emailed to the Project Leader at the end of each week. Results found in Table 1.

Table 1

Suicide Risk Education by Week

Week	Number of Admissions	Documentation of Education Completed
April 6-12, 2020	n=16	n=16, 100%
April 13-16, 2020	n=9	n=9, 100%
April 20-26, 2020	n=7	n=7, 100%
April 27-May 3, 2020	n=9	n=9, 100%

Discussion

The purpose of this project was to implement suicidal risk education for all patients receiving Hospice care in a small, rural county at initial contact. Education includes information related to signs and symptoms of suicidality and steps for patients and family members to take if suicidality is present or suspected. This project also aimed to implement documentation of education related to suicidality including client and family response to education. Data reflected that 100% of admissions to Hospice care in the county between April 6, 2020 and May 3, 2020 received suicide risk education and documentation was completed confirming verbalization of understanding of patients and family members. The purpose and aims of the project were successfully met.

Implications

Results of this study indicated that suicide risk education can be successfully implemented for patients and families receiving Hospice care. Education related to recognition of signs and symptoms of suicidality and steps for family members to take if suicidality is suspected could improve outcomes for patients receiving Hospice care, including oncology patients. The frequent performance of suicide risk education by Hospice staff could improve staff comfort level in discussing suicidality with patients and could improve outcomes for patients receiving Hospice care who are experiencing suicidality.

Limitations and Recommendations

One limitation of this study was the necessity of revising the original plan due to the COVID-19 pandemic and new processes for Hospice staff which made adoption of a new screening tool impossible at this time. Suggestions for future projects include

implementation of a suicide risk assessment and evaluation of staff perception of patients experiencing suicidality before and after implementation of education.

Conclusion

Rates for both suicide and lung and colorectal cancers are comparatively high in the small, rural county which served as the site of this project. Considering that oncology patients experience higher rates of suicidality as compared to the general population, interventions to address suicide risk in oncology patients in this county is important. Education related to the signs of suicidality for patients and family members may prevent suicidal gestures and completions. Open discussion regarding suicidality among staff, patients, and families may assist in decreasing the stigma associated with this topic and empower patients to seek care when experiencing suicidal ideation.

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Appendix



Get help right now if you are experiencing any of these warning signs:

- You feel hopeless or as if you have no reason to live
- You feel that you are a burden to others
- You are sleeping too much or not enough
- You are unable to eat
- You are hearing voices
- You think about hurting yourself or someone else
- You feel trapped or like you “can’t take it anymore”

Tell someone you trust and call your Hospice team.

Call 911 if you feel that you are in danger of harming yourself or someone else.



For Loved Ones

Many people who are Hospice patients may be depressed or anxious. This is normal.

There are signs that your loved one may be having a mental health issue or could be at risk for suicide. Call the Hospice team if your loved one:

- Talks about suicide
- Says they feel “worthless” or “hopeless”
- Shows little or no interest in life
- Becomes withdrawn from loved ones

It is okay to ask, “Are you having any thoughts of hurting yourself?” If the answer is yes, call your Hospice team.

References:

National Alliance on Mental Illness
www.nami.org
 National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org



MENTAL HEALTH MATTERS

When and how to get help for a mental health problem

We are here for you

Your Hospice team can help you when you are having a mental health problem. If you are having thoughts of suicide, call your Hospice team immediately.

Your Hospice team has team members who can help you with many issues you are facing with medications, counseling, physical care, spiritual care, and other support.

Again, if you feel that you are in danger of hurting yourself or someone else do not wait: Call 911!



Above all don't lose hope!

“Hope is being able to see that there is light despite all of the darkness”—
Desmond Tutu

Having hope is important but can be hard at times. We will work with you to help you have hope again.

Do not give up!

Call Hospice first unless you feel that you are in danger of hurting yourself or someone else. In that case, call 911.