

University of Massachusetts Amherst
ScholarWorks@UMass Amherst

Doctor of Nursing Practice (DNP) Projects

College of Nursing

2019

Suicide Education to Support Caregivers in their Abilities to Care for Suicidal Individuals

Cassandra Lipa

Follow this and additional works at: https://scholarworks.umass.edu/nursing_dnp_capstone

 Part of the [Nursing Commons](#), and the [Social and Behavioral Sciences Commons](#)

Lipa, Cassandra, "Suicide Education to Support Caregivers in their Abilities to Care for Suicidal Individuals" (2019). *Doctor of Nursing Practice (DNP) Projects*. 178.
Retrieved from https://scholarworks.umass.edu/nursing_dnp_capstone/178

This Open Access is brought to you for free and open access by the College of Nursing at ScholarWorks@UMass Amherst. It has been accepted for inclusion in Doctor of Nursing Practice (DNP) Projects by an authorized administrator of ScholarWorks@UMass Amherst. For more information, please contact scholarworks@library.umass.edu.

Suicide Education to Support Caregivers in their Abilities to Care for Suicidal Individuals

Cassandra Lipa

University of Massachusetts, Amherst

College of Nursing

DNP Project Chair: Dr. Gabrielle Abelard, DNP

Mentor: Rebecca Phelps-Smith, Director of Acute Crisis Department

Date of Submission: May 9th, 2019

Table of Contents

Abstract..... 3

Introduction..... 4

 Background..... 5

 Problem Statement..... 6

 Organizational “Gap” Analysis of Project Site..... 7

Review of the Literature..... 8

 Suicide Prevention Intervention..... 10

 Interviewing Patients and Caregivers..... 12

 Evidence Based Practice: Verification of Chosen Option..... 13

Theoretical Framework/Evidence Based Practice Model..... 13

Methods..... 14

Results..... 18

 Group A..... 19

 Group B..... 23

Discussion..... 27

Conclusion..... 30

References..... 32

 Appendix A..... 35

 Appendix B..... 36

 Appendix C..... 37

 Appendix D..... 38

 Appendix E..... 39

Abstract

Purpose: Suicide is a preventable act of lethality yet still remains a public health concern. Suicide can affect individuals from a variety of backgrounds and does not discriminate against age, gender, ethnicity, income, or occupation. Efforts to prevent suicide often focus on supporting the suicidal individual however there is a lack of available resources that focus on supporting those closest such as caregivers. Caregivers can play a pivotal role in their loved one's trajectory towards recovery. The purpose of this project was to provide caregivers with a suicide toolkit that encompasses basic education, approaches to supporting a loved one who is suicidal, and community resources on prevention. **Methods:** This quality improvement project included information on evidenced based approaches, and local resources on suicide prevention. A total of twenty caregivers were included in this project that were divided into two separate groups: group A and group B. Ten caregivers were assigned to group A and asked to provide input as to what they felt a toolkit should encompass based on identified needs, this feedback was then used in part to develop a suicide toolkit. Group B consisted of a second set of ten caregivers who were asked to complete a pre and post questionnaire following the review of the suicide toolkit that was developed by the DNP student to see whether or not scores improved. **Results:** Eight out of ten caregivers from group A provided input for toolkit development. Four common themes emerged from this feedback that were included in the development of the toolkit. Ten caregivers in group B completed the pre and post questionnaire following the review of the toolkit and the means between these groups were compared and showed a slight improvement but not to the proposed 25% goal set forth. **Conclusion:** Post questionnaire scores showed improvement in comparison to pre questionnaire scores however several questions reflected no improvement in scores. This data may suggest that providing a toolkit alone does not elicit specific improvements in knowledge, confidence, competence, and perceived caring abilities, rather it can be a component of treatment. Several limitations are discussed including a small sample size used and little to no additional participant identifiers. Future recommendations include increasing the sample size and changing the phrasing of the questionnaire to better reflect caregiver experiences.

Keywords: suicide, caregivers, caregivers' role, preventing suicide

Suicide Education for Caregivers in their Abilities to Care for Suicidal Individuals

Introduction

Close to 800,000 people die by suicide every year, and suicide is the second leading cause of death among 15-29 year-olds (World Health Organization, 2017). During an inpatient psychiatric hospitalization, treatment is often focused on supporting the suicidal individual solely. Whereas, supporting the caregiver's role is sometimes only explored through brief family meetings and phone calls however the caregiver's role should not be underestimated. Caregivers can play pivotal roles in the prevention of future suicide by their loved ones. Studies have found that family caregivers lack the necessary knowledge on how to care for their relatives with suicidal ideation (Chiang, Lu, Lin, Lin, & Sun, 2015). Well informed caregivers can be beneficial for those whom they provide care for. Some caregivers stressed the need for education in the areas of problem solving, maintaining medication supplies, and the appropriate medical service to call depending on the situation as they feel education can be empowering (Angelo, Egan, & Reid, 2013). Suicide recovery and support is not only a difficult process for the patient, but can also be mentally challenging on those closest to suicidal individuals. Milberg and Strang (2011) found that family members felt empowered through learning about disease trajectory, treatments, side effects, daily living aids, as well as opportunities for financial support. A solution to this need could be for health care providers to provide suicide prevention education to support caregivers during their suicidal loved one's hospitalization (Chiang et al., 2015). A toolkit developed from caregiver identified knowledge needs as well as evidence based information on suicide education could be an effective way to directly support those who identify as caregivers.

Background

One of the first steps in addressing suicide prevention involves identifying signs of suicide. There is a significant amount of research identifying knowledge needs of suicide prevention from various professions, however there appears to be a gap in research regarding knowledge of caregivers needs' regarding suicide education. According to Fry (2012) clinical improvements could lead to changes in levels of insight and may partly explain why such a high proportion of suicides occur either before or within days or weeks of discharge from a hospital. It is imperative for caregivers to be educated on these statistics and have the necessary tools and resources needed to identify and mitigate risks for future suicide attempts.

Among all social contexts, parent relationships have been found to be the most consistent protective factor for adolescent suicide even when compared to relationships in peer and school contexts (Hooven, 2013). Caregiver support can also have an influence on disease prognosis and treatment adherence. Angelo, Egan, and Reid (2013) study found the following:

“With parents and caregiver roles being deemed as the single most influential factor, there seems to be a gap in providing the necessary care and support for this population. As the caregivers are in closest contact to their mentally ill family members, they may have significant influence on the patients' attitudes towards psychopharmacotherapy” (p. 387).

The purpose of this project is to present a literature review to demonstrate the evidence supporting implementation of an educational toolkit that can be provided to anyone who identifies as a caregiver to suicidal individuals as well as the importance of supporting caregivers during their relatives' recovery.

Problem Statement

Suicide remains a public health concern despite concerted efforts in prevention approaches leading to readmissions, increased lengths of stay in hospitals, and most importantly completed suicide. The risk of completed suicide remains high as many of these approaches are geared towards supporting suicidal individuals and lacking efforts towards supporting their caregivers' who may play pivotal roles in their recovery. Caregivers' knowledge, abilities to cope with their suicidal loved ones, and their perceived support should be assessed during inpatient psychiatric hospitalization. The research from the following literature review identifies not only the importance of supporting the caregiver's role but also the benefit in strengthening their role as they are the one's closest to the suicidal patient and may help to aid in discouraging future suicide attempts. Increasing caregivers' involvement in treatment may not only help to alleviate caregiver burden but may also result in increased patient compliance and hence, contribute to suicide prevention (Bauer, Spiessl, and Schmidt, 2012).

The DNP student prepared, presented, and evaluated the efficacy in providing a suicide toolkit to caregivers present in two settings within a small community hospital: the psychiatric crisis emergency department and the inpatient psychiatric unit. The toolkit encompassed needs and information that were identified by caregivers themselves regarding education on suicide risk factors, demographics, and communication with local support resources. Providing a succinct suicide toolkit to caregivers is a way to bridge the quality improvement gap in addressing the attention needed in supporting this population.

Organizational "Gap" Analysis of Project Site

The project was implemented in the crisis area of the emergency department as well as the inpatient voluntary psychiatric unit at a small community hospital in western Massachusetts,

Berkshire Medical Center. All of the individuals who were being cared for had to carry a current diagnosis of suicidal ideation. All of the caregivers included in the project were either caregivers stationed in the emergency department beside their loved one or approached in person preceding a scheduled family meeting on the inpatient psychiatric unit.

Although there are several best practice strategies addressing suicide prevention geared towards caregivers, none of these practices were currently implemented. There remains a gap in providing caregiver identified needs, education, and support to those who care for suicidal individuals.

The several best practices that exist currently include, ASIST research (applied suicide intervention skill training program), connect suicide prevention program developed by NAMI-NH, gatekeeper training, and educational resources from American Foundation for Suicide Prevention website (Kato, Suzuki, Sato, Fujisawa, Uehara, Hashimoto, . . . Sawayama, 2010; Swank & Buila, 2010; Sun, Chiang, Lin, Chen, 2013; American Foundation for Suicide Prevention, 2018). The best practices listed however are time consuming and do not include identified needs by the caregivers themselves, rather rudimentary evidence based suicide education. Therefore the project began by first assessing caregivers' baseline knowledge and identified needs and developed a suicide toolkit. Next caregivers were asked to complete a pre questionnaire then provided the suicide toolkit and asked to complete a post questionnaire following this to see if scores improved after reviewing the toolkit.

Review of the Literature

A comprehensive search of literature for suicide prevention was conducted using the following databases that were chosen for their inclusion of scholarly articles and focus in the medical profession: Academic Search Premier, MEDLINE, Health and Psychosocial Instruments, and PsychINFO. The following medical subject headings (MeSH) terms were used as keywords to search and included: “suicide education and caregivers”, “suicide education”, “suicide education and family caregivers” “caregivers role and suicide”, “caregiver self-assessment questionnaire”, “caregiver support”, and “caregiver knowledge and suicide”. Inclusion criteria consisted of full text articles published in the English language. All article publication dates were chosen from current years within 2008-current except for one published in 2001. Information from the World Health Organization (WHO) was also referenced in defining current statistics of annual deaths globally from suicide in 2017. A total of twelve selected articles on suicide prevention were retrieved, however, four were excluded due to only being comprised of a narrative of discussion of recommendations that were based on previous studies and not a formal research study. Leaving only eight to be examined and an additional two more references were included within studies and one reference from the World Health Organization.

Suicide prevention strategies can be categorized as either case finding or risk factor reduction (Swanke & Buila, 2010). Case finding strategy includes interventions focused on increasing awareness, education, and those involving direct screening (Swanke & Buila, 2010). Risk factor reduction focuses on identifying specific patterns that increase a person’s chances of developing suicidal ideation or completed suicide. For the purpose of this literature review, awareness and education were regarded as strategies in suicide prevention specifically geared towards family and caregivers of suicidal patients to help both groups feel more supported, empowered, and knowledgeable.

The following literature review is focused on ten selected articles, with investigation into nine research studies which are randomized control trials, and one article which was a review of literature. All of the articles reviewed included a focus on benefit for caregiver support. Five of the studies focused on implementing a suicide prevention intervention in the form of a video, lecture, or training and providing questionnaires throughout and follow up through phone calls or questionnaires. In addition, one study focused on interviewing individuals on their knowledge of suicide risk, preventative actions, and reporting their attitudes to the training modules. Two studies provided interviewing of ex-patients who were recently suicidal and to the caregivers of those who had those experiences. Another study focused on suicidal individuals who lacked family/caregiver support and compared this group with individuals who had strong caregiver support and identified the association for the individual to engage in future suicide attempts. Lastly, the review of literature focused on healing and recovery for the suicidal patient, deeming caregiver support as the most crucial. This DNP project will bridge the gap by implementing a continuum of care approach that extends beyond the patient at risk by supporting those who often hold the greatest responsibility in preventing future suicide attempts.

Suicide Prevention Intervention

There were two studies that focused on suicide prevention (Kato, Suzuki, Sato, Fujisawa, Uehara, Hashimoto, Sawayama, Hayashi, Kanba, & Otsuka, 2010; Hoover, 2013). One study included a two-hour education program based on Mental Health First Aid (MHFA) for the public was provided to 44 first year medical residents (Kato et al., 2010). The program consisted of one hour of lecture including general knowledge of suicide, empathetic points, and an overview of the five step interventions for suicidal patients. The second hour included role play sessions.

Participants were asked to complete program assessments based on their confidence in treating suicidal patients both before and after the intervention. Results indicated that the majority of the participants rated the intervention positively (quite helpful and extremely helpful).

The second article focused on suicide prevention using a Parents Care (P-CARE) intervention (Hoover, 2013). Sample size included 319 youth and their parents who were randomly assigned to the P-CARE intervention; of those 155 were assigned to the P-CARE “only” group and 164 were assigned to a combination of Counselors-CARE (a two hour assessment/intervention) and P-CARE intervention (Hoover, 2013). Follow up studies revealed that more than two months after parent sessions, parents were reporting that they were still using the parenting skills, in particular active listening and offering support, at fairly high levels (Hoover, 2013). Results indicated that regardless of the intervention, parents rated favorable likings towards the interventions.

The third study focused on Gatekeeper training, defined as education and training of individuals who come in contact with potentially suicidal persons (Swanke & Buila, 2010). Community forums called *Suicide Prevention* were held and open to participants who were contacted through mail. Results indicated that 91% of respondents who participated in the conference reported high or very high agreement that they had a better understanding of regional suicide (Swanke & Buila, 2010). Comparatively, within the caregiver group, 85% reported that they could help someone develop a personal suicide prevention plan or action.

A fourth study focused on exploring the effects of an educational video on parents’ knowledge of suicidal signs, response to suicidal statements, attitude toward suicide, and intention to help suicidal young people (Maine, Shute, & Martin, 2001). A video *Youth Suicide-Rec-*

ognizing the Signs and an educational packet was provided to parents involved and results indicated that parents became more knowledgeable about suicidal signs and could respond to scenarios of behavior indicating suicidal signs more appropriately (Maine et al., 2001).

A fifth study provided a 40 page handbook to 74 caregivers of suicidal family members in the experimental group titled the *Mind Helper* and provided a questionnaire pre and post intervention assessing improved abilities to care (Sun, Chiang, Lin, & Chen, 2013). Scores were compared to those in the control group who received no intervention. Results indicated that the experimental group improved in areas including care ability and suicide attitudes, but did not help to reduce stress level to care. Therefore, the implementation of the handbook increased their understanding of suicide and caring abilities but had no effect on the stress they perceived. The limitations included finding caregivers willing to participate because they did not want other's knowing about their relatives' mental illness. Also, the study followed up with caregivers following the intervention but did not assess their attitudes after a significant amount of time passed.

Interviewing Patients and Caregivers

One of the studies focused on examining the areas of stress due to the caregiver's role and identified the care stress model as being an important factor for supporting the role of the caregiver (Chiang, Lu, Lin, Lin, & Sun, 2015). They identified the caregiver's role as being considered one of the most important towards preventing their loved one from committing suicide. Another study interviewed both family members and ex-patients' perceptions of caring for people who had previously attempted suicide and found that burnout was high and identified theories that could improve perceptions (Sun & Long, 2008).

The second study within this group interviewed 40 members of hospital staff who did not work in mental health and asked them to identify the risks of suicide (Fry, 2012). Results suggest that most participants have reasonable knowledge, however deficits do exist. Given the assumption that some form of suicide education is provided to most healthcare workers, one would assume that if deficits lie within this population, it is likely there are greater deficits among non-healthcare workers.

Another study followed 1804 adolescent participants who had developed suicidal ideation at any time during the last year (LeCloux, Maramaldi, Thomas, & Wharff, 2016). Questionnaires were provided including areas of perceived parental support, presence of a suicide attempt, level of depression, and mental health service use. The findings in this study regarding parental relationships provided strong evidence for the need for additional family-based interventions for this population as low levels of parental support were associated with higher levels of depression and a higher probability of an actual suicide attempt (LeCloux et al., 2016). Limitations included mental health services measuring only in regards to any emotional or psychological counseling, and caregivers in this study were only considered parents who lived alongside the individual in the home, excluding extended family members or other identified caregivers.

The last article was part of a larger research area whose aim was to develop a theory to guide suicidal individuals to aid in healing after their suicide attempt (Sun et al., 2014). Many participants reported that family predicaments or family problems delayed the healing process. The role on how interpersonal relationships can affect ones' trajectory towards wellness supports previous research in identifying the needs of the caregiver as crucial in contributing to their loved ones' recovery.

Evidence Based Practice: Verification of Chosen Option

This quality improvement project was partly constructed by the suggestions and identified areas of knowledge needs provided by caregivers' themselves. Therefore the development of this toolkit reflects caregivers' identified needs of useful suicide information in hopes to improve knowledge deficits and perceived supports within their community.

Theoretical Framework/Evidence Based Practice Model

Callista Roy's Adaptation Model (1976) is one of the nursing theories that has been used to support the caregiver role and will be utilized as the theoretical framework to guide this DNP project (Appendix A). The Roy Adaptation Model outlines several goals of nursing which include: contributing to health, quality of life, and dying with dignity. The model aims to enhance system relationships through acceptance, protection, and fostering of interdependence, and to promote personal and environmental transformations. It is within this context that the criteria for good according Roy (2011) include the need to promote adaptation of individuals and groups, to transform a society to one that promotes dignity, and to sustain and transform the universe (Roy, 2011). Using the Adaptation Model, the caregiver could be identified as a biopsychosocial being who is constantly interacting with the environment and needing to adapt to changes. In order to maintain balance, effective coping skills are necessary as part of the adaptation within the internal and external environment. According to Roy:

The goal of nursing care is to promote integrated processes of the family, to support compensatory processes and to identify compromised adaptation when integrated and compensatory processes are not effective. Nurses use such strategies as teaching resource

management; teaching risk management to sustain a family in crisis; and identifying the occurrence of compromised adaptation (Roy, 2011, p. 347).

This framework was incorporated as part of the approach when delivering and presenting this toolkit through the use of therapeutic communication with a focus on family relationships and adaptation.

Methods

The desired and overarching goal for this quality improvement (QI) project was to provide caregivers with emotional/coping support as well as practical information on suicide. The goal proposed was to increase knowledge and perceived emotional/coping support following implementation of a toolkit for caregivers of clients with suicidal thinking by working with two groups of ten participants each. The first group of ten caregiver participants (group A) were provided with a pre questionnaire. The results of their responses assisted with the development stage, in that their collective feedback was used to create the toolkit. Group A participants were asked to provide feedback on what they felt a toolkit should encompass. The DNP student then used this feedback in addition to evidence obtained from the review of literature to develop a suicide resource support toolkit. Next, a second group of ten caregiver participants (group B) were provided a pre questionnaire to assess baseline knowledge, followed by review of the suicide support resource toolkit created from group A feedback, and completion of a post questionnaire. The pre and post questionnaires were identical so that scores could be compared before and after the presentation of a toolkit. The hope was for group B post questionnaire scores to improve over group B pre questionnaire scores by at least 25%.

This QI project took place at a small community hospital in western Massachusetts. While Massachusetts (MA) as a whole has a suicide rate below the combined national average, several communities in western MA have the highest suicide rates in the state (Donges, 2018). The DNP project took place in the crisis department within the emergency room and also on the voluntary inpatient psychiatric unit. The sample size included a total of 20 caregiver participants over the age of eighteen and whom identified themselves as a caregiver. Caregivers were defined as anyone the suicidal patient identified as a “caring” supportive person, which included one and or multiple-person teams (parents, siblings, relatives, friends, etc.). Out of the 20 caregivers, 15 comprised one person caregivers who presented alone, and the additional five caregivers were self-appointed within a family unit to participate in this project. The five caregivers who were self-appointed completed the questionnaires independently of their family, joining the DNP student in a quiet space apart from their relatives. Data was collected during clinical hours where the DNP student was either stationed in the crisis emergency department or attended a time to meet with a participant following a family meeting on the inpatient psychiatric unit.

The toolkit was developed by the DNP student using input from group A’s feedback. Group A caregivers were equally represented from both settings; five participants were from the crisis emergency department and five participants were from the inpatient psychiatric unit. The toolkit developed over the course of two months, beginning in the week of December 3rd, 2019 and completed by January 25th, 2019. Microsoft Publisher application was used as the template in creating a three tier front and back brochure. Presentation of the toolkit was provided by the DNP student to the caregiver which included an introduction of the QI project as well as a brief overview of the brochure. The DNP student demonstrated the toolkit by opening

the brochure so that all three tiers were visible and flipping it over to showcase the back to familiarize the caregiver of its' entirety. This brief presentation was provided to enhance the caregiver's awareness of all of the content included before delivering it to review on their own.

The DNP student administered a pre and post questionnaire design to group B. The questionnaire was modified by the DNP student for the purpose of this project and is provided in Appendix B, however the template is part of an already established *Caregivers Count too! Toolkit* questionnaire (Family Caregiver Alliance, 2006).

The pre and post questionnaires were identical, including six questions assessing caregiver perceived knowledge, confidence, competence, emotional support, and level of knowledge obtaining resources for education (See Appendix B for questionnaire). Each question had five possible answer choices using a Five Point Likert scale and each response was weighted with a numerical score: (1) not at all, (2) a little, (3) average, (4) more than average, (5) very good. A seventh open ended question was added to group A's questionnaire that asked for input related to knowledge needs that would be used as part of the development of the toolkit.

The total sum of numerical scores that were selected for each response were totaled at the end and compared. The highest possible total scores reflecting a score of 30 (responses of all *very good* with numerical score of 5's chosen) and the lowest possible reflecting a score of 6 (responses of all *not at all* numerical score of 1's).

The DNP student began data collection in September 2018 and concluded in March 2019. A timeline for project development is provided in (Appendix D), data was analyzed during the following weeks from March 3rd -17th. Descriptive statistics was used to compare group B's pre and post mean, standard deviation, and range scores. Group A responses were also analyzed and discussed in further detail regarding emerging themes.

Data was collected for both group A and group B by providing each participant with a questionnaire and pen. Once the participant filled out the questionnaire it was collected by the DNP student and stored in a folder that was kept in a locked cabinet during non-clinical hours. Roughly 8-16 clinical hours were used per week and participants were obtained from two settings. The DNP student stationed herself in both settings from September through March 2019, and was also contacted by phone by various staff members working in these settings to notify the DNP student of potential caregivers. Permission from all caregivers in their willingness to participate in this QI project was obtained by the DNP student prior to initiating the questionnaire.

All participants were protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which, among other guarantees, protects the privacy of patients' health information (Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, 2013). Additionally, the DNP student and practice personnel who carefully conducted this project followed the *Standards of Care* for practice in a primary care office. All information collected as part of evaluating the impact of this project was aggregated data from the project participants and did not include any potential patient identifiers. The risk to caregivers participating in this project was no different from the risks of caregivers not receiving this intervention. Participant confidentiality was assured by all responses being anonymous. All electronic files containing patient identifiable information were password protected to prevent access by unauthorized users and only the project coordinators had access to the passwords. Additional ethical considerations were regarded as this population of patients and caregivers can be particularly vulnerable particularly involuntary admissions. The DNP student will take extra precaution to ensure their privacy is highly regarded and also to ensure that the participants fully understand

what is being asked of them and that the risk to the participants be made clear. There was no IRB approval needed as it was considered a quality improvement project.

Results

This DNP project used a quality improvement model design that included implementing a toolkit for caregivers of clients with suicidal thinking at a medical center in Massachusetts. The participants included 20 caregivers who were divided into two separate groups; Group A and Group B. There were no identifiable demographics between groups except for participants to be of at least eighteen years of age or older and to identify themselves as either caregivers or close caring supporters to individuals who suffered from suicidal ideation.

Group A consisted of ten caregivers who were provided the pre questionnaire and the opportunity to share input on what they felt a toolkit should encompass. Group B consisted of a second set of ten caregivers who were provided the pre questionnaire, toolkit, and post questionnaire. The project officially began in September 2018 where the DNP student was stationed in the emergency department to seek potential caregivers. A decision by the DNP student to expand participant settings occurred in early December as a result of a decreased number of eligible participants present in the emergency department therefore the settings expanded to the inpatient psychiatric unit during the last two weeks in December, see (Appendix D for timeline).

There were four themes identified from group A caregiver responses that were incorporated into the development of the toolkit. The themes included questions related on how to approach and communicate with their loved one, knowledge deficits on identifying risk factors,

knowledge deficits on the available community supports for caregivers and their loved ones', and questions related to lethality of self-harming behaviors.

Group A

Caregivers expressed a lack of necessary communication skills as well as decreased confidence in how to approach their loved one through communication. Four caregivers shared an experience in feeling inept in possessing the necessary skills to communicate effectively with their loved ones. *"I just don't know what to say sometimes, don't know how to make her feel better"*, *"He doesn't want to talk with me about this kind of stuff and so I don't push it or try but it would be nice to learn some skills"*, *"He doesn't talk to me about what he's struggling with so sometimes it's hard to help"*, *"I think he talks to his therapist more than he talks to me about this stuff"*. Based on these responses, a portion titled, *"How best to support your loved one"* was incorporated in the toolkit to address simple and practical approaches on how to communicate with someone who is suffering from suicidal ideation, self harm, or has engaged in a suicide attempt. Toolkit provided in (Appendix E). This shared experience demonstrates how caregivers may feel towards their lack of abilities and confidence in communicating with their loved one who is suffering. It also raises an interesting point in the importance of not assuming that assessing a caregivers confidence and competence in caring abilities necessarily encompasses their confidence in regards to communicating. When comparing responses from the questionnaire that assessed for confidence and competence, caregivers rated their abilities quite highly however when group A caregivers were provided the opportunity for input they identified this specific area as lacking in their overall confidence and skill in providing effective communication.

The second theme included questions surrounding identifiable risk factors to be aware of that can contribute to developing suicidal ideation. These factors were explored and perceived as useful information that would be helpful for caregiver's to know. Two caregivers provided the DNP student with feedback to consider including a section on risk factors to help better educate the community. One caregiver shared that at times they believed their loved one didn't possess the stereotypical risk factor one would assume so wondered if there were more that perhaps they were unaware of. Based on these responses a topic on "*Risk Factors*" was incorporated that identified specific domains within eight categories: demographics, psychosocial, psychiatric, physical illness, psychological dimensions, behavioral dimensions, childhood traumas, and insomnia. These particular risk factors identified were assumed to increase an individual's risk in developing suicidal ideation. A specific risk factor titled *Insomnia* was also listed in bold in its own category with asterisks preceding it to denote the significance among this very common experience and its' potential correlation in the development of suicidal ideation. This feedback demonstrates another interesting question that relates to the phrasing of the questionnaire. Caregivers responded quite highly in their experiences in feeling knowledgeable to care for their suicidal loved one despite a reported lack of knowledge in this area of identifying risk factors. Perhaps a better question could have been phrased that asked, "*How knowledgeable do you feel in identifying risk factors of suicidal ideation?*"

A third theme included an item that defined many of the common self harming behaviors. Language used by many mental health professionals can be confusing to lay people who may not have the knowledge or understanding of the appropriate definitions. Self-harming behaviors for example was addressed by the same two caregivers mentioned previously in their inquiry about it's importance as an identifiable risk factor. Caregivers questioned whether or not they should

be concerned if their loved one is engaging in cutting. A portion on “*Know the Lingo*” was incorporated to provide definitions of common self-harming behavior terminology used amongst advocates who work with the suicide awareness and prevention community, and to also differentiate between acts and gestures related to suicide. The self-harming terms defined included *NSSIB* (non-suicidal self-injurious behavior: the infliction of deliberate damage to body tissue without suicidal intent), *SSIB* (suicidal self injurious behavior defined as an act with the intent to die, *SA* (suicide attempt), *suicide threat*, and *suicide*. These terms hopefully address caregiver knowledge of the differences between gestures and the lethality associated with each in relation to suicide.

Community resources was the fourth theme noted from the pre questionnaire. Additional information on community resources and available spaces to promote community awareness on suicide prevention were identified as areas of interest that caregivers would like to further explore. Two caregivers inquired about the available resources in the community for their loved one and ways to increase community awareness on this topic. Given this feedback local resources were included in the toolkit to address this including a peer support group titled *Alternatives to Suicide* that is an open group to the public, as well as the *Youth Zero Suicide Program* available for individuals aged 10-24 with support following a suicidal crisis. Other resources were included that provide 24/7 access to speak with a mental health professional. This shared interest in inquiring about the available resources and increasing access to community supports may reflect the communities lack of marketing in sharing this information.

The two remaining caregivers in group A did not provide any feedback for toolkit input however did complete the questionnaire and spoke candidly to the DNP student about their experiences. They shared in similar words that they felt quite knowledgeable in this topic as they

themselves have suffered from suicidal ideation before and have received treatment in the past and identified as strong supporters given their own difficult personal experiences. This feedback strengthens the notion that perhaps individuals who are suffering from suicidal ideation seek out other individuals who have shared similar experiences and also the likelihood of a genetic contribution in the developing of suicidal ideation. Therefore the total number of caregivers from group A who provided input for toolkit development that was used and implemented into toolkit development were eight however all ten caregivers completed the questionnaire provided.

Outside of themes that emerged from group A, the DNP student also incorporated important evidence from the literature to the toolkit to help further increase knowledge. The cover design portrayed an image of a semi colon for its' symbolic recognition as a suicide survivor's story, denoting that their story hasn't yet ended (with a period) rather a (semi colon) because it is continuing on. Additional sections were added, the first titled "*Facts*" that incorporated general facts about suicide and included some gender differences as well as statistics on suicide. An example of a gender difference included "*firearms (guns) are the most commonly used method among males (57%), poisoning is the most common method among women (35%)*", whereas an example of a statistical theme included, "*suicide is the 10th leading cause of death worldwide*". A portion on *protective factors* and additional safety planning measures were also included. Protective factors were incorporated for caregivers to become more aware of the potential benefits of these factors and also for caregivers to help their loved one build upon these areas as goals for treatment.

Group B

Quantitative data was collected and analyzed using the comparison of group B's pre and post questionnaires to see whether or not post scores improved following the implementation of a

suicide support resource toolkit. Both the pre and post questionnaire's provided to group B were identical including a total of six questions. Unfortunately, there were no significant differences between the means of both groups. Rather subtle improvements and post group scores did not achieve the proposed 25% increase following the intervention. Additionally, the scores comparing pre and post group on all questions except for question three and five did not change or reflect any improvement following the implementation of the toolkit.

Question One

The first question asked, "*How knowledgeable do you feel about caring for your suicidal relative?*" The comparison of pre and post questionnaire scores for this question did not change therefore responses selected between the two questionnaires were identical. Optimistically, the majority of participants rated themselves at least "*more than average*"; 80% of the ten participants selected "*more than average*" and the following 20% selected "*very good*" yielding a mean score of 4.2. Therefore none of group B's participants chose a response of "*not at all*" or "*a little*" which supports the notion that the majority of caregivers feel quite knowledgeable at least more than average of the time.

Question Two

The second question asked, "*On a scale 1-5, how confident do you feel in your ability to care for a suicidal individual?*" Responses for this question also reflected no change between the pre and post questionnaire suggesting that there was no improvement following the review of the toolkit. Here, 70% of participants chose "*more than average*", 20% "*very good*", and 10% "*average*" yielding a mean score of 4.1. Similar to question one, the majority of caregivers rated their confidence in their abilities to care at least average or more than average.

Question Three

This was one of the two questions that reflected a slight improvement in comparison of scores following the review of a toolkit. It asked, “*What is your level of knowledge in identifying and obtaining resources and information for suicide prevention?*” Here the majority 70% rated themselves as “*more than average*” and the remaining 30% rated themselves as “*very good*”. Following the review of the toolkit the majority of participants changed their responses to select “*very good*” totaling 90%. Only one participant kept their response the same, unchanged. This improvement may suggest that the toolkit provided participants in feeling more knowledgeable in identifying the local resources available as well as gaining information on suicide support.

Question Four

This question asked, “*On a scale 1-5, how would you rate your competency in caring for your suicidal relative?*” 60% of participants rated themselves as “*more than average*”, and 40 % selected “*average*”. Therefore the majority of participants rated their competency in caring as more than average. There was no change in selection of responses from pre to post questionnaire further supporting that a toolkit alone didn’t appear to have an effect on improving perceived competency in caring for their relative.

Question Five

Question five asked, “*On a scale 1-5, how well do you feel emotionally supported in caring for your suicidal relative*”. This question in addition to question three reflected a slight improvement from pre to post questionnaire. Pre questionnaire responses included 60% of participants rating themselves at least “*average*” and 40% rated themselves “*more than average*”. The post questionnaire however revealed that two out of the ten participants who had selected “*average*” improved their selection in the post questionnaire to “*more than average*”. Therefore 80%

of participants felt more than average emotionally supported in caring for their relative following review of the toolkit.

Question Six

This question asked, “*Currently, how well have you been coping with your loved ones’ recovery?*” This question in particular yielded the lowest selection in responses compared to others where two of the participants accounting for 20% selected either “*a little*” or “*not at all*”. 60% of participants selected “*average*” and the remaining 20% selected “*very good*”. This information suggests that the majority of caregivers have been coping at least average with their loved one’s recovery but that the remaining 40% fall on opposite ends of the spectrum either coping very good or a little to not at all.

Below is a table comparing the mean, standard deviation, and range between Group B’s pre and post intervention scores.

Table 1. *Mean, SD, range comparison between questions*

	Pre			Post		
Toolkit	Mean	SD	Range	Mean	SD	Range
Question 1	4.2	0.91894	2.00	4.2	0.91894	2.00
Question 2	4.1	0.73786	2.00	4.1	0.73786	2.00
Question 3	4.3	0.82327	2.00	4.9	0.31623	1
Question 4	3.6	0.69921	2.00	3.6	0.69921	2
Question 5	3.4	1.26491	4.00	3.6	1.17379	4.00
Question 6	3.1	0.87560	3.00	3.1	0.87560	3.00

The standard deviation between groups was less than two which suggests that all of the responses were close to mean scores and are not considered statistically significant. The range between both groups was a two or higher except for question three which suggests that the majority of responders chose a response of three or higher on the likert style questions. Moreover, the pattern of selection of three or higher suggests that participants felt average or above average in identifying and obtaining resources on suicide awareness and prevention.

Discussion

A toolkit for caregivers of clients with suicidal thinking was created based on feedback from ten participants who received toolkit review administered by the DNP student. Findings of the quality improvement project were not significant perhaps to factors such as the language of the questions, limited information on the brochure, limited time to review the toolkit with participants, recruitment of participants, caregiver shame, and small sample size.

Caregivers expressed their appreciation for a tangible toolkit that included community resources and phone numbers. Potential barriers that may have contributed to the lack of improved scores between pre and post responses could have included not engaging in an adequate amount of time to review the toolkit in its' entirety, failing to elicit improved scores.

Although the scores between pre and post group did not reflect significant changes, total mean scores improved from 22.7 in pre group to 23.5 in post group which suggests that after reviewing the toolkit overall scores improved. The standard deviation in the pre group was 2.86 and 2.87 in post group indicating that data points were very close to the mean without much variability.

Overall the use of this toolkit improved post intervention scores. It should be noted from a positive perspective that the majority of caregivers self-rated themselves at least “average” in terms of overall competence and confidence in their caring abilities and knowledge in identifying resources. An area that showed some difficulty included caregivers own experiences in not feeling particularly emotionally supported throughout their care and their experience in coping with their loved ones’ recovery. This data may suggest that the medical center is doing an adequate job in providing knowledge and access to the caregivers in their community but that caregivers themselves may benefit from additional emotional support to assist in their own well being.

There were several limitations to this project, the first being an extremely small sample size. The original project proposed 40 caregiver participants however due to a low number of identified caregivers present in the emergency department with suicidal intent, only 20 caregivers participated in the project in total resulting in ten caregiver responses being available for comparison of scores between pre and post questionnaires. Additionally it would have been helpful to have incorporated additional demographic data of the participants such as gender, age, relationship to the suicidal individual, level of education, number of hospitalizations, etc.

Written language may have also been a factor in the results of participant responses. Perhaps poor phrasing of the questions included in the questionnaire failed to elicit a true shared experience thus impacting the results. In addition, based on the qualitative input from group A which indicated specific knowledge deficits and a desire for additional information on suicide prevention, it may be assumed that if the questionnaire were phrased more specifically, responses would have also showed greater variability.

Another limitation included the variability in recruitment settings that compromised group A and group B participants. Group A participants included five caregivers from the emergency room and five caregivers from the inpatient psychiatric unit. Group B's participants consisted of all ten caregivers from the inpatient psychiatric unit. This variability may make it difficult to generalize all caregivers as sharing equal experiences since the chronicity between the emergency room and inpatient unit patients may be drastically different. In addition, the toolkit itself was limited based on efforts to maintain a one page content balanced brochure; it should be noted that additional topics of interest were not added due to a lack of available space.

It should also be noted that caregivers most often responded favorably then not favorably and may have over reported their experiences due to perceived shame in not wanting to openly express their limitations in caring or being viewed as less than caring for their loved ones. Therefore, it is difficult to know if their responses reflected true personal experiences. Although scores slightly improved following the intervention it can't be assumed that a toolkit alone can improve knowledge, confidence, and competence surrounding care for a suicidal individual. Rather a toolkit for caregivers can be considered an additional component to how suicide is approached through educating the community and providing local support.

The project followed a quality improvement model using Callista Roy's adaptation model, therefore future methods to continue improving the quality of care offered include educating caregivers through advanced training seminars, incorporating them into treatment approaches, and offering continuing education on suicide prevention. It is recommended that future quality improvement projects consider increasing the sample size; only ten caregiver responses were compared which is hardly enough to reflect a population at large. Incorporating

more identifiable demographics to caregivers such as gender, age, relationship to suicidal individual, level of education, etc. could also help to highlight the important differences between participants as well as shared themes among caregivers. It's important to note that a toolkit alone may not be enough in providing significant improvements in knowledge, caring abilities, and perceived confidence but could be utilized as an adjunctive intervention to previous evidence based suicide prevention recommendations. Furthermore, raising awareness on suicide and expanding support to the community of caregivers may help to improve connectedness and improve the way in which suicide risk is approached.

Conclusion

Caregivers who support individuals with suicidal intent may experience complex attitudes related to their caring abilities and may suffer from their own mental issues. Providing a suicide support toolkit may help improve overall health and the quality of care they provide. Implementing an educational and supportive intervention like a suicide toolkit is recommended for use with all caregivers who present with their loved ones to a psychiatric hospital so that a best practice intervention can be implemented.

Although results of this QI project demonstrated slight improvement in results, the project supports previous evidence in suggesting that suicide support interventions like a toolkit can improve caregivers' abilities to care for individuals with suicidal thinking. An approach to increasing community awareness through educating caregivers is recommended as this group is often the first to witness signs of suicidal ideation and are often the most influential people in their loved ones' decision to attempt and or to complete a suicide. Recovery from suicide can be long and difficult, therefore people who have attempted suicide and or experiencing suicidal intent

need support networks from people who can help them to overcome and cope with challenges (Sun et al., 2014). Supporting our caregivers by providing them with practical knowledge and education on suicide prevention resources may result in benefits for the patient and their caregiver. It is the DNP students' recommendation that the toolkit will become part of the the medical center's practice when addressing cases where suicidal thinking and or an attempt is involved.

References

- World Health Organization. (2017). Mental Health. Retrieved from http://www.who.int/mental_health/suicide-prevention/en/
- American Foundation for Suicide Prevention. (2018). Retrieved from <https://afsp.org>
- Angelo, J.K., Egan, R., & Reid, K. (2013). Essential knowledge for family caregivers: A qualitative time study. *International Journal of Palliative Nursing*, 383-388.
- Bauer, R., Spiessl, H., & Schmidt, T. (2012). Are there associations between caregiver information and suicidal behavior in psychiatric inpatients? *International Journal of Psychiatry in Clinical Practice*, (16), 238-242.
- Chiang, C.Y., Lu, C.Y., Lin, Y.H., Lin, H.Y., & Sun, F.K. (2015). Caring stress, suicide attitude and suicide care ability among family caregivers of suicidal individuals: A path analysis. *Journal of Psychiatric and Mental Health Nursing*, (22), 792-800.
- Donges, P. (2018). Professionals Gather in Berkshire County to Address Causes and Prevention of Youth Suicide. Retrieved from: <http://wamc.org/post/professionals-gather-berkshire-county-address-causes-and-prevention-youth-suicide>
- Family Caregiver Alliance. (2006). Caregivers Count Tool! A Toolkit to Help Practitioners Assess the Needs of Family Caregivers. Retrieved from: <https://www.caregiver.org/caregivers-count-too-toolkit>
- Fry, J. (2012). Suicide awareness and prevention training in a high security setting. *Mental Health Practice*, (15), 25-31.
- Hoover, C. (2013). Parents-care: A suicide prevention program for parents of at-risk youth.

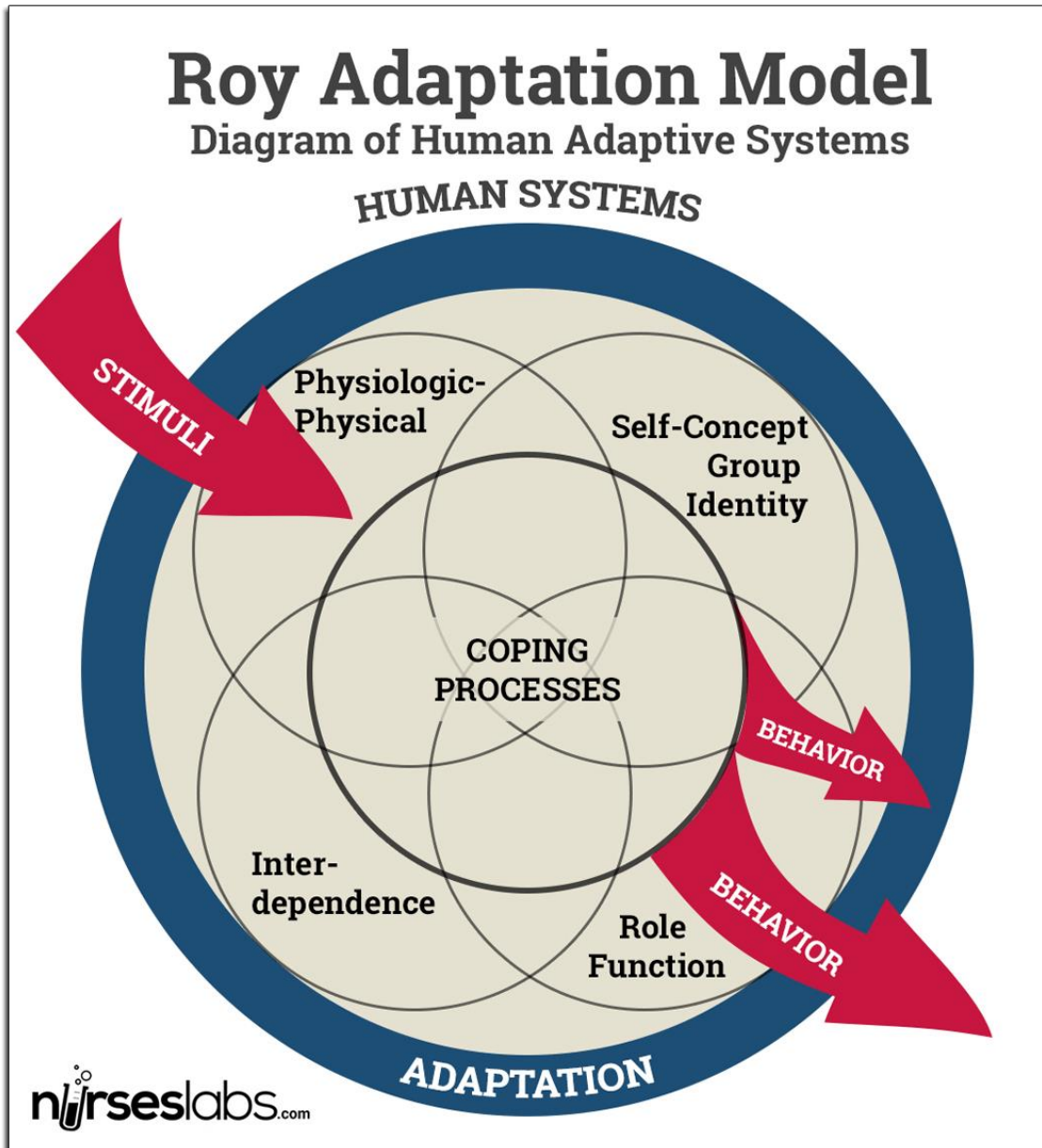
- Journal of Child and Adolescent Psychiatric Nursing*, (26), 85-95.
- Kato, T.A., Suzuki, Y., Sato, R., Fujisawa, D., Uehara, K., Hashimoto, N., . . . Sawayama, Y., (2010). Development of 2-hour suicide intervention program among medical residents: First pilot trial. *Psychiatry and Clinical Neuroscience*, (64), 531-540.
- LeCloux, M., Maramaldi, P., Thomas, K., & Wharff, E. (2016). Family support and mental health service use among suicidal adolescents. *Journal of Child and Family Studies*, (25), 2597-2606.
- Maine, S., Shute, R., & Martin, G. (2001). Educating parents about youth suicide: knowledge, response to suicidal statements, attitudes, and intention to help. *Suicide and Life-Threatening Behavior*, (31), 320-332.
- Milberg A, & Strang, P (2011) Protection against perceptions of powerlessness and helplessness during palliative care: the family members' perspective. *Palliative Support Care*, 9 (3), 251–262.
- Roy, C. (2011). Extending the Roy Adaptation Model to meet changing global needs. *Nursing Science Quarterly*, 24, 345-351.
- Substance Abuse and Mental Health Services Administration (2009). United States Department of Health and Human Services. *Best Practices Registry (BPR) For Suicide Prevention*. Retrieved from http://www.sprc.org/featured_resource/bpr/index.asp
- Sun, F.K., Chiang, C.Y., Lin, Y.H., & Chen, T.B. (2013). Short-term effects of a suicide education intervention for family caregivers of people who are suicidal. *Journal of Clinical Nursing*, (23), 91-102.
- Sun, F.K., Long, A., Tsao, L.I., & Huang, H.M. (2014). The healing process following a suicide attempt: context and intervening conditions. *Archives of Psychiatric Nursing*, 28, 55-61.

Sun, F.K. & Long, A. (2008). A theory to guide families and carers of people who are at risk of suicide. *Journal of Clinical Nursing*, (17), 1939-1948.

Swank, J.R. & Buila, S.M.D. (2010). Gatekeeper training for caregivers and professionals: A variation on suicide prevention. *Advances in Mental Health*, (9), 98-104.

Appendix A

Roy Adaption Model



Appendix B

Pre/Post Assessment Questionnaire

1) How knowledgeable do you feel about caring for your suicidal relative?

not at all a little average more than average very good

2) On a scale 1-5, how confident do you feel in your ability to care for a suicidal individual?

not at all a little average more than average very good

3) On a scale 1-5, what is your level of knowledge in identifying and obtaining resources and information for suicide prevention?

not at all a little average more than average very good

4) On a scale 1-5, how would you rate your competency in caring for your suicidal relative?

not at all a little average more than average very good

5) On a scale 1-5, how well do you feel emotionally supported in caring for your suicidal relative?

not at all a little average more than average very good

6) Currently, how well have you been coping with your loved ones' recovery?

not at all a little average more than average very good

7) Please provide input as to what you feel a suicide education toolkit should include and any identified areas of needs that you feel should be addressed. Also are there any additional questions or areas that you felt were important but were not asked?

*** number 7) was omitted from group B's questionnaire.

Family Caregiver Alliance. (2006). Caregivers Count Too! A Toolkit to Help Practitioners Assess the Needs of Family Caregivers. Retrieved from:
<https://www.caregiver.org/caregivers-count-too-toolkit>

Appendix C
Budget/ Cost Analysis

Items	Cost \$
Paper	\$10
Ink	\$20
Copying	.10 cents/page
Pens	\$5
Misc.	\$10
Total expected =	\$55
Total paid =	\$0

Appendix D
Project Timeline

Task	Sept	Oct	Nov	Dec	Jan	Feb	March
Recruitment of eligible A participants/pre test	x	x	x	x	x		
Data collection, analysis of findings				x			
Development of Toolkit				x	x		
Recruitment of eligible B participants/pre test						x	x
Intervention					x	x	x
Post test					x	x	x
Dissemination of findings							x

Appendix E

Toolkit

FACTS

- **10th** leading cause of death worldwide
 - **2nd** leading cause of death among 15-29 year olds
 - **1 million suicides** per year occur worldwide, highest rate in men >65
 - **Firearms (guns)** are the most commonly-used method among males (57%), Poisoning is the most common method among women (35%)
 - **494,169** people treated in emergency departments on average each year for self-indicted injuries
 - **Females** attempt suicide more than males, **Males** complete suicide more than females
 - **Caregivers** can play pivotal roles in the prevention of future suicide attempts and their roles as supportive caregivers have been found to be the **most consistent protective factor** for adolescent suicides
 - A high proportion of suicides occur either before or within days or weeks of discharge from a hospital
- Know the "Lingo"**
- **NSSIB:** (Non-suicidal self-injurious behavior: the infliction of deliberate damage to body tissue without suicidal intent (SI)
 - **SSIB:** (Suicidal Self injurious behavior) Is an act with the intent to die. Essentially a **suicide attempt (SA)** : unsuccessful self injurious behavior with intent to die
 - **Suicide threat:** verbal or non verbal actions that communicate a suicidal or planned act
 - **Suicide:** self-directed injurious behavior with an intent to die as result of the behavior

References

- American Psychiatric Association [APA], (2013). Diagnostic and statistical manual of mental disorders: DSM-5 (5th ed.). Washington, DC: Author.
- Brausch, A.M., & Gutierrez, P.M. (2010). Differences in non-suicidal self-injury and suicide attempts in adolescents. *Journal of Youth and Adolescence*, 39, 233-242.
- Centers for Disease Control and Prevention. (2016). Definitions of self-directed violence. Retrieved from www.cdc.gov/ViolencePrevention/suicide/definition.html
- Comtois, K.A., & Linehan, M.M. (2006). Psychosocial treatments of suicidal behaviors: A practice-friendly review. *Journal of Clinical Psychology*, 62(2), 161-170.
- <http://www.cdc.gov/nchs/fastats/suicide.htm>
- <http://www.nimh.nih.gov/health/statistics/index.shtml>
- Fry, J. (2012). Suicide awareness and prevention training in a high security setting. *Mental Health Practice*, (15), 25-31.
- Hoover,C. (2013). Parents-care: A suicide prevention program for parents of at-risk youth.
- Muehlenkamp, J. (2005). Self-injurious behavior as a separate clinical syndrome. *American Journal of Orthopsychiatry*, 75 (2), 324-333.
- Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self injury. *Current Directions in Psychological Science*, 18(2), 78-83.

Have a loved one who's Suicidal?

Supporting a loved one with suicidal thinking, self injury, or contemplating suicide is complicated...

KNOW THE FACTS!

suicidal thinking, self injury, or contemplating suicide is complicated...



Don't let your story end

Risk Factors

Demographic: male, widowed, divorced, single, increases with age, white

Psychosocial: Lack of social support, unemployment, drop in socioeconomic status, firearm access, loss

Psychiatric: Carries a psychiatric diagnosis, or has several diagnosis (comorbidity)

Physical Illness: Chronic diseases such as HIV/AIDS, peptic ulcer's, hemodialysis, lupus, pain syndromes, functional impairment, diseases of the nervous system

Psychological dimensions: hopelessness, psychic pain/anxiety, psychological turmoil, decreased self-esteem, perfectionistic qualities

Behavioral dimensions: Impulsivity, aggression, severe anxiety, panic attacks, agitation, intoxication with substances (alcohol/drugs), prior suicide attempts,

*****Insomnia (poor sleep/lack of sleep)*****

Childhood trauma: sexual/physical abuse, neglect, parental loss **Genetic and familial:** family history of suicide, mental illness, or abuse

Protective factors

- ****Stable social support system**** (parents, caregivers, friends, spouses, partners, teachers, mentors, therapist, or any person the individual identifies as supportive)
- Availability and ability to use **coping skills**
- Active participation in one's treatment
- Experiencing a sense of hopefulness
- Spiritual inclinations
- Pregnancy or having children younger than age 18 in the home

Those who provide **nonjudgmental, sensitive communication** leads to an individual experiencing an ability to interpret their feelings without fear or shame or guilt and are more likely to engage in therapy and treatment recommendations.

How best to help and support your loved one:

How to approach and talk to your loved ones: Using listening skills and therapeutic questions that reflect this approach:

Explore the presenting problem: asking him/her to describe how close they came to completing suicide and how the individual feels about being alive. Information and detail about the attempt, method, and planning involved. Inquire about stressors in their life, hopelessness, assess for alcohol or drug use.

Be careful to **NOT** make the individual feel shameful about the event rather offer **hope** in normalizing the situation with statements such as "a lot of people experienced similar experiences and feelings as you have"

Assess for safety: can he/she maintain their safety on their own?

If not consider hospitalization. **Call 911 or # 413-499-0412** and ask for **Crisis**

Are the tools to attempt suicide removed from their location? (guns, weapons, medications, etc.)

Encourage distraction/calming activities such as walking/exercising, listening to a favorite music, going for a drive, etc.

Suggest an agreement for the individual to get in touch with his or her clinician, if there is no assigned clinician consider making the appropriate referral. New intakes for setting up Psychiatrist/Therapist can be made at the : **Brien Center in Pittsfield; 413-499-0412, request TSP**

Local Resources

Berkshire Crisis Team. Operated by The Brien Center: 413-499-0412 is available **24/7**

Peer support group for anyone seeking a space to discuss suicide and mental health issues in a non-judgmental/safe environment: **"Alternatives to Suicide"** Meetings: every Wednesday 3pm-4:30pm 150 North St, Suite 28, Room 1 (2nd floor)

Youth Zero Suicide Program—available for individuals aged 10-24 with support following a suicidal crisis—including short term clinical interventions with youth and families, clinical consultation with providers, assistance with obtaining new providers, and problem-solving with patient teams clinical interventions and peer support groups. Please contact: **Christina Marks 413-358-8752. Office Located at The Warriner Building at 741 North Street, Pittsfield, MA**

Crisis Text Line
Text 24/7: 741-741

The Trevor Project for LGBTQ Youth
Call 24/7: 1-866-488-7386
Or Text Monday-Friday 3p-10pm: 1-202-304-1200

National Institute of Mental Health:
www.nimh.nih.gov

NAMI - National Alliance of Mental Illness www.nami.org

Outpatient Resources

Clinical and Support Options: 413-236-5656

ServiceNet Inc.: 413-442-4003

South Bay Community Services/ Pittsfield Outreach Program Center: 61 Eagle Street, Pittsfield 413-418-2300

Berkshire Psychotherapy Network
www.BerkshirePsychotherapyNetwork.org

For private provider list: berkshiremd.com