Family Intervention for Suicide Prevention (FISP)

The Family Intervention for Suicide Prevention (FISP) is a cognitive behavioral family intervention for youth ages 10-18 who are presenting to an emergency department (ED) with suicidal ideation or after a suicide attempt. The main goal of the FISP is to use the ED visit as an opportunity to decrease the short-term risk of repeated suicidal ideation and behavior by building the coping skills of youth and their families, enhancing motivation for follow-up mental health treatment, and improving linkage to outpatient follow-up treatment services after discharge from the ED or hospital.

Rooted in social learning and family systems theories and based on the Emergency Room Intervention for Adolescent Females (reviewed by NREPP separately), the FISP focuses on the following: (1) reframing the suicide attempt as a problem requiring action, educating families about the importance of outpatient mental health treatment and restriction of access to dangerous attempt methods, and obtaining a commitment from the youth to use a safety plan during any future crises; (2) strengthening family support by encouraging the youth and his or her parents to identify positive attributes of the youth and family; (3) developing a hierarchy of potential suicidality triggers by using an "emotional thermometer" to identify feelings and physical, cognitive, and behavioral reactions to the triggers; (4) developing a safety plan and practicing its use for reducing "emotional temperature" and risk of increasing suicidality; and (5) creating a safety plan card to provide a concrete tool that youth can use during times of acute stress and suicide risk to cue reminders of reasons for living and safe and adaptive coping. Youth participants also can be encouraged to develop a "hope box," which expands on the safety plan card and contains concrete objects (e.g., CDs or playlists of calming music, scented bubble bath, coping cards) to cue the use of the coping strategies listed on the card.

The FISP, which is delivered by mental health providers or health providers with some mental health training, has three core components:

- ED staff training. The training is designed to improve usual ED care and the quality of the ED environment in which the other core components are delivered. A leadership team within the organization determines optimal implementation strategies. ED staff training can be delivered during ED meetings.
- Youth and family crisis therapy session. This session aims to enhance protective processes and skills for reducing the risk of suicidal behavior while providing a positive therapeutic experience to increase motivation for outpatient follow-up treatment in both youth and parent participants. The session is delivered in 30-60 minutes during the ED visit. Although the session is usually conducted with the youth and his or her family, it can be conducted with just the youth if it is not possible or optimal to conduct the session with the entire family together.

- Care linkage telephone contacts. These telephone contacts are structured and focus on reminding the youth and his or her family that a therapist is available to assist them in obtaining follow-up care, motivating the youth and family (through motivational interviewing strategies) to obtain follow-up care for the youth, monitoring the youth's status, and linking the youth and family to appropriate community treatment and services. Telephone contacts begin within the first 48 hours after discharge, with follow-up contacts until the youth is linked to care (usually at 1, 2, and 4 weeks after discharge).

Descriptive Information

Areas of Interest	Mental health treatment
Outcomes	**Review Date: April 2014** 1: Linkage to outpatient mental health treatment services
Outcome Categories	Mental health Treatment/recovery
Ages	6-12 (Childhood) 13-17 (Adolescent)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Outpatient
Geographic Locations	Urban Suburban
Implementation History	The FISP was first implemented in Los Angeles, California, during an evaluation in 2005 with 181 patients. Since then, training in the intervention has been provided for five sites in California.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes

Adaptations	The FISP has been adapted for use in the homes of youth or in non-ED settings (e.g., inpatient, residential, outpatient, school, other community programs) where the youth may present with recent suicide attempts, nonsuicidal and ambiguous self-harm, and/or suicidal ideation. Training in the FISP's ED component has been conducted at a site in Massachusetts. This training also has been integrated into Youth Partners in Care--Depression Treatment Quality Improvement training and incorporated as the first session of the SAFETY Program, a 12-week cognitive behavioral family treatment designed to be incorporated within emergency services following a suicide attempt. The FISP also was adapted for delivery as a home-based intervention for youth with "suicide incidents" in the Celebrating Life Program, developed to address suicide attempts by youth within the White Mountain Apache community.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	IOM prevention categories are not applicable.

Quality of Research

Review Date: April 2014

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Asarnow, J. R., Baraff, L. J., Berk, M., Grob, C. S., Devich-Navarro, M., Suddath, R., et al. (2011). An emergency department intervention for linking pediatric suicidal patients to follow-up mental health treatment. Psychiatric Services, 62(11), 1303-1309.

Supplementary Materials

Asarnow, J. R., Berk, M. S., & Baraff, L. J. (2009). Family intervention for suicide prevention: A specialized emergency department intervention for suicidal youths. Professional Psychology: Research and Practice, 40(2), 118-125.

Asarnow, J. R., Baraff, L. J., Berk, M., Grob, C., Devich-Navarro, M., Suddath, R., et al. (2008). Pediatric emergency department suicidal patients: Two-site evaluation of suicide ideators, single attempters, and repeat attempters. Journal of the American Academy of Child and Adolescent Psychiatry, 47(8), 958-966.

Hoagwood, K., Horwitz, S., Stiffman, A., Weisz, J., Bean, D., Rae, D., et al. (2000). Concordance between parent reports of children's mental health services and services records. Journal of Child and Family Studies, 9(3), 315-331.

Horwitz, S. M., Hoagwood, K., Stiffman, A. R., Summerfeld, T., Weisz, J. R., Costello, E. J., et al. (2001). Reliability of the Services Assessment for Children and Adolescents. Psychiatric Services, 52(8), 1088-1094.

Hughes, J. L., & Asarnow, J. R. (2013). Enhanced mental health interventions in the emergency department: Suicide and suicide attempt prevention. Clinical Pediatric Emergency Medicine, 14(1), 28-34.

Intervention Fidelity Checklist for Family Intervention for Suicide Prevention

Service Assessment for Children and Adolescents, Modified for Outcome Assessments in the FISP Evaluation Trial

Spirito, A., Boergers, J., Donaldson, D., Bishop, D., & Lewander, W. (2002). An intervention trial to improve adherence to community treatment by adolescents after a suicide attempt. Journal of the American Academy of Child and Adolescent Psychiatry, 41(4), 435-442.

Outcomes

Outcome 1: Linkage to outpatient mental health treatment services	
Description of Measures	Linkage to outpatient mental health treatment services was assessed using a modified version of the Service Assessment for Children and Adolescents. Approximately 2 months after discharge from the ED or hospital (i.e., the 2-month follow-up), parents were asked to report their child's use of mental health treatment services after the ED visit, including outpatient services such as a partial day hospital or day treatment program, a mental health specialist, in-home services, therapy visits, and medications visits. In addition, parents were asked to provide information regarding any medications taken by their child since the ED visit. A youth version of the survey was completed by youth participants, and these data were used when data from parents were unavailable.
Key Findings	A study was conducted at two EDs where youth aged 10-18 presented with suicidal ideation or after a suicide attempt. Youth and their families were randomized to receive the FISP or enhanced usual care (control condition). ED staff who provided enhanced usual care completed a training session that was based on practice parameters developed by the American Academy of Child and Adolescent Psychiatry and included information on the importance of linking suicidal patients to outpatient mental health treatment, restricting access to dangerous or lethal suicide attempt methods, and understanding the increased suicide risk associated with substance use; in addition, a handout on practice parameters was provided, and a list of referral resources was made available at each ED site. Findings included the following:

	• At the 2-month follow-up, youth who received the FISP were more likely than those in the control group to be linked to any outpatient mental health treatment services (92% vs. 76%; odds ratio = 6.2; p = .004). • Also at the 2-month follow-up, in comparison with youth in the control group, those who received the FISP had higher rates of use of psychotherapy (76% vs. 49%; odds ratio = 4.0; p = .001) and combined use of psychotherapy and medication (58% vs. 37%; odds ratio = 3.3; p = .003), as well as more outpatient treatment visits (p = .003).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.1 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	6-12 (Childhood) 13-17 (Adolescent)	69.1% Female 30.9% Male	45.3% Hispanic or Latino 33.1% White 12.7% Black or African American 8.8% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity

4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Linkage to outpatient mental health treatment services	3.3	3.5	1.8	3.3	3.3	3.5	**3.1**

Study Strengths

Both reliability and validity of the measure were evaluated by independent investigators and found to have high test-retest and interrater reliability, both for parents and for children ages 11 and older, and good concordance between parent reports of service settings used and objective measures (e.g., medical and administrative service records). Individuals who delivered the intervention were trained, and quality assurance raters completed chart reviews, rating each FISP session for completion of the intervention components. Interrater reliability between the two quality assurance raters was assessed through a comparison of ratings on 20 randomly selected cases and was found to be strong. Sophisticated statistical methods were used to account for missing data resulting from attrition. The use of a randomized controlled design helps rule out a number of potential threats to internal validity. Despite randomization, there were a few variables (e.g., total problem and externalizing scores) that showed baseline differences between groups and were included in regression models, along with other potential confounding variables (e.g., days between baseline and follow-up, ED site, age, gender). The statistical analysis techniques were sophisticated and appropriate for the study outcome and used an intent-to-treat approach.

Study Weaknesses

Although intervention fidelity was measured with retrospective chart reviews, there was no direct observation of the implementation of intervention components. Because receipt of the intervention was defined as the completion or partial completion of each component, it is unclear how many participants completed the full intervention.

Readiness for Dissemination

Review Date: April 2014

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Asarnow, J. R. (n.d.). Emergency care for suicidal youths: Improving ED care & patient outcomes [PowerPoint slides]. Los Angeles: University of California, Los Angeles.

Asarnow, J. R. (n.d.). FISP: An enhanced mental health intervention for emergency care [PowerPoint slides]. Los Angeles: David Geffen School of Medicine, University of California, Los Angeles.

Asarnow, J. R., Armm, J., & McGrath, E. (2013). Care linkage manual: Family Focused Intervention for Suicide Prevention (FISP). Los Angeles: University of California, Los Angeles.

Asarnow, J. R., Rotheram-Borus, M. J., & Piacentini, J. (2013). Family Intervention for Suicide Prevention (FISP): Emergency crisis intervention session. Los Angeles: University of California, Los Angeles.

Family Intervention for Suicide Prevention (FISP): Current training recordings. (2013).

Family Intervention for Suicide Prevention (FISP) therapist adherence care linkage contacts checklist. (2005).

FISP Fidelity Checklist Crisis Intervention

Train-the-Trainer's Protocol

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.5	3.5	4.0	**3.7**

Dissemination Strengths

Materials are well researched and address all aspects of implementation of family and individual sessions. Training materials are concise and standardized for consistent delivery. Several training options are available. The developer assists sites in identifying a leadership team and the providers who should be trained to deliver the intervention. Technical assistance and treatment fidelity checks are available to new sites to support building, maintaining, and monitoring implementation quality and outcomes.

Dissemination Weaknesses

It is unclear how potential implementers learn about the program itself or training and support opportunities.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Collaborative planning (includes working with the implementation site to identify a leadership team, plan an initial organizational training, identify who will be trained, determine how implementation will be incorporated into usual care, and finalize a plan for quality assurance)	About $1,000, but varies depending on organization implementation plan	Yes
On-site or Webinar-based organizational training	Varies depending on style of training and site needs	Yes
1-day, on-site FISP Crisis Session and Care Linkage Contacts Training	$3,000 per site, plus travel expenses	Yes
Telephone consultation (includes case review, follow-up, and emails to implementers summarizing issues related to implementation)	$300 per hour	Yes, 2 hours of telephone consultation hours are required
Family Intervention for Suicide Prevention (FISP): Emergency Crisis Intervention Session (manual)	Included in cost of on-site training	Yes
Care Linkage Manual	Included in cost of on-site training	Yes
Structured clinical assessment of trainee competence and adherence to the FISP (includes feedback)	$300 per trainee	No
Technical assistance and program evaluation consultation	$300 per hour	No

Treatment fidelity checks and feedback to implementers (includes additional check on treatment fidelity and provider competence in the FISP)	$300 per review	No

Replications

No replications were identified by the developer.

Contact Information

To learn more about implementation or research, contact:
Joan Rosenbaum Asarnow, Ph.D.
(310) 825-0408
jasarnow@mednet.ucla.edu