

RAW FILE
ENGAGING & SUPPORTING FAMILIES IN SUICIDE PREVENTION
MARCH 5, 2018
1:40 P.M. ET

Captioning Provided By:
Caption First, Inc.
P.O. Box 3066
Monument, CO 80132
800 825 5234.

This text, document, or file is based on live transcription. Communication Access Realtime Translation (CART), captioning, and/or live transcription are provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings. This text, document, or file is not to be distributed or used in any way that may violate copyright law.

>> MODERATOR: Hi, everyone, thank you for joining this webinar this afternoon or morning, depending upon where you are calling from. We will be getting started at 2:00 p.m. eastern standard. Until then, please feel free to put where you are calling in from on the map located on your screen. Thank you.

>> Good afternoon or good morning, everyone, thank you for joining our presentation. Thank you for joining us today for the engaging and supporting families in suicide prevention webinar. If you have any technical difficulties, please let us know in the Q and A box located on the left hand of your screen or you can dial 781-530-4708. Phone lines will be muted during the entire webinar. If you have any comments or questions, please, again, type them into the question box located on the left-hand side of the screen. You can make the presentation larger by clicking on the four arrows pointing outwards. On the upper right hand of your screen. Closed captioning will be provided under the Power Point.

We will be recording this meeting and the slides and recording will be available after the webinar. And we will get started in just one second.

>> Thank you, everyone, for being patient as we experience some technical difficulty. I will pass this over to Dr. Richard

McKeon, thank you so much, Dr. Mckeon. Really pleased to be able to support this webinar around engaging and supporting families in suicide prevention. As documented in systems like SAMHSA's national survey on drug use and health and CDC's risk behavior survey. It shows the extent to which we need to do better in our suicide prevention effort. And I really want to thank Perry Hoffman who will be speaking to you immediately after me for being such a strong and articulate advocate for the needs of families and for us to pay more attention to this vitally important issue. Now, SAMHSA has many suicide prevention programs, which we are certainly very grateful for, and although they do not specifically focus on the needs of families, most of them can be vehicles for assisting families. These include our Garrett Leigh Smith youth suicide prevention grants that go to states and tribes, ages 10-24, our adult suicide prevention efforts, the national strategy grants and our zero suicide grant program, as well as through the suicide prevention resource center and the national suicide prevention life line.

The Suicide Prevention Resource Centers work diligently to help get this webinar structured and prepared so that this information could be shared with all of you. Let me just mention two other things. If you are not familiar with them. One -- and basically these are the way that two very critical documents call attention to the importance of work with families.

So the national strategy for suicide prevention which was released by the office of the surgeon general and the national action alliance for suicide prevention has objective 9.4, and that objective is to adopt and implement guidelines to effectively engage families and concerned others throughout entire episodes of care for persons with suicide risk. And then secondly, some of you may be aware that SAMHSA's major strategic direction over the next number of years has been set by the cures Act and the establishment of an interdepartmental serious coordinating committee. And one of the key recommendations of that report is recommendation 2.9 to support family members and caregivers. Now, having language like that in reports is important, but reports by themselves don't lead to change. What leads to change is the active efforts of committed advocates, of researchers, of policy makers, of prevention specialists, of clinicians and, of course, of family members. So we are looking forward to not only sharing information with you, but to be hearing from you around about your needs. Because from SAMHSA's perspective, this is not something where we want to have a single webinar and then feel like we are done. We are hoping that this will be an ongoing commitment to working with families

and the organizations that represent them to help better support them and help better reduce suicide in our nation. So with that I'm going to hand it over to Perry Hoffman.

>> PERRY HOFFMAN: Thank you to SAMHSA and the Suicide Prevention Resource Center for hosting this webinar and supporting an initiative to engage and support families in suicide prevention efforts as someone who has worked for 30 years with families where a suicidal loved one I can attest to how crucial this focus is a supportive and skilled family environment may be perhaps one of the best resources for prevention, intervention and recovery for those at risk.

Let's first look at families of caregivers in general, where the role of families in a loved one's illness has been key for centuries. Groups exist providing education, support, a network for families living the same experiences such as cancer, autism, schizophrenia. They meet in person, online, formally, informally, these groups are life lines for the caregivers. When we look at the suicide prevention community over the past ten years, police, school personnel, health professionals are recognized as key in prevention, and specific trainings have become standardized for each of these groups. Families often are also first responders or serve as safety nets. They too are key in prevention and recovery.

However, there has not been a specialized program that exists for families of suicide attempters. This is the missing link and needs to be considered part of best practice for suicide prevention. Families are devastated and compromised as they have experienced their own trauma from the event and often paralyzed with fear, depression, burden, grief, helplessness, anger, shame and stigma.

We see this in the borderline personality disorder community where suicide and self-injury are hallmark symptoms. Up to 75% of self-injured and 10% of people with BPD die by suicide, not surprising, more than 50% of their family members meet criteria for post-traumatic stress disorder from their relative's suicidal behavior. You will hear about one program that's been helping those families, so although family members can be a valued resource for their suicidal loved ones, they too need skills, training and support. Our hope and goal is to make it standard practice to include families in suicide prevention programs.

Thank you again to SAMHSA, the stew side prevention resource center and also to our presenters for making this the very first step in a larger effort. It is now my pleasure to introduce you to our first speaker. Ken Norton is the Executive Director of the New Hampshire chapter of the National Alliance on Mental Illness. Ken led the development of NAMI New

Hampshire connects suicide prevention program which is designated as the national best practice program in suicide prevention, intervention and postvention. He is also a family member. Ken?

>> KEN NORTON: Thank you all, and thank you, Richard, for SAMHSA hosting this and for PDC's participation and Perry Hoffman for your advocacy relative to families. I would like to start by taking a look at informed consent in a broad category. There are a couple of quotes I will use. I will read them because I think it's important to give voice to those voices that have informed me and my practice, and this is a quote I heard at, from a loss, suicide loss survivor at the American Association of Suicidology conference in 2006. When my father was diagnosed with cancer, the doctors told us he had a 40% chance of living one year. When my son was diagnosed with bipolar disorder, no one told us about the high correlation between the illness and suicide and suicide attempts. If we had known what to look for, he might still be alive today.

I think every family dealing with mental illness should be informed of these risks and I think that this gives a nice perspective on what our role of as treatment providers has been relative to families which has essentially been to hold families kind of at arm's length, and do we engage them relative to the assessment process? Do we engage them in terms of crisis planning? And do we engage them relative to informed consent and what their role in informed consent process might be? And obviously that would be important with minors under the age of 18, but I think it goes well beyond that as well.

And if we look at the folks from the suicide prevention field, we have also had a fairly limited view of what families' roles are, and that view has been relative to kind of focus on families as gate keepers. And I know I myself and I have heard many of my peers say things like if everyone knows the warning signs of suicide, we can save lives and prevent suicide deaths, but is that really enough?

And I think that we really need to move beyond recognition as this quote indicates. I knew my daughter was at risk, I called the school guidance counselor who met with her. I called to get an appointment with her therapist. They all said she was okay, but I knew she wasn't. She took her life three days later.

I think that that speaks to that we need to be able to do more. We often talk about primary care providers and their lack of willing also to ask somebody if they are suicidal because what if they say yes, they don't know what to do or they don't have the time to do that. And I wonder if that same piece applies to us in the suicide prevention community? Do we not

engage families because we really don't know what to say to them or how to engage them or how to better prepare them for dealing where with risk? And what education can we have for them? How do we view them as partners and potential helpers?

And I think barrier number one or enemy number one, if you will, is HIPAA and confidentiality. And ironically, it's the Health Information Portability and Accountability Act, and it was never intended to be the wall that it has become misinterpreted to mean. And in fact, the Department of Health and Human Services clarified HIPAA in a letter to the nation following the Newtown shootings in which they said essentially that a healthcare provider in good faith can provide necessary information to prevent or lessen a serious and imminent threat to the health or safety of the patient or others. And then it goes on to define that in more detail, but there is really, there is really a need for educating folks relative to that, and even the support staff and administrative staff, I can give a personal example with my family member where when, you know, there was a call left on our answering machine that there were appointments available at 2:00, 3:00, and 4:00, and I called back to say, we will take the 4:00 one, they were like, no, you can't confirm that appointment. Your family member has to call.

And at that the time my family member was in a rural area without access to a phone, and I also think that had I called their primary care provider's office, it would have been no question. Oh, okay, fine. I mean, I'm the transportation, you know, how is that working? So I think that kind of leads me to the question, and it's a rhetorical question about does HIPAA protect people's privacy or does it contribute to stigma and the perception that mental illness is something to be ashamed of.

And in New Hampshire we have taken some steps to, which actually existed before HIPAA, to try to -- I'm sorry, I don't know what's going on with my computer here. To try and have some laws relative to -- excuse me. To provide laws that allow for or clarify when families can be disclosed for information. We had a law that NAMI was involved in in passing that allows for specific information to be given to families of caregivers of people with serious mental illness in certain circumstances and that circumstance involves when they have been hospitalized and are being released from the, and particularly our state hospital, and when they are involved with the community mental health center.

That information is really limited to key pieces relative to medications and side effects or other warning signs. And New Hampshire is not alone in that. Oregon has passed similar provisions that even go a step further. They have a bill that requires hospitals to develop a protocol for connecting patients

leaving a psychiatric inpatient admission with a friend or a family member. And that, you know, it doesn't mean that it has to happen, but they have, but they need to have a protocol in place for how and when that will happen. And they also have a bill that clarifies for emergency department personnel the HIPAA allows for sharing information with families. Is so when we are thinking about engaging families and natural supports it's important to think about how can we, with that individual, assess what the level of their natural supports are have she shared their thoughts about suicide or suicide attempts with anybody? Who would they call in the middle of the night to get help? Are they estranged from their family are and is the estrangement a healthy situation or not a healthy situation?

And certainly looking at the fact that withdrawal and isolation can be key risk factors and warning signs for suicide and for suicide risk. If we look at Tom Joiner's theory about suicide prevention that he has identified perceived burdensomeness as a risk factor for suicide. The focus is on the perception. While there may not be burdensomeness it's that perception that they may have become a burden to their family. Is there a way to assess and clarify and have the opportunity to address and reduce those perceptions with that individual?

So the next key thing is about safety planning, and this is really the place where families should be engaged. Safety planning should be person centered and it needs to engage that individual in coming up with the development of their plan, and a plan that is specific to them. What are their personal warning signs for when they are at risk? What would somebody else see or what would give them pause? What is there quote, unquote, personal medicine that they might use? Is it walking the dog? Is it taking a bath? Is it listening to a favorite song? Is it watching a movie? What are those things that they do that helps them relax when they are in crisis, and how to get that together into a plan?

And then coming up with that specific plan for them that also identifies local resources and certainly should also include the National Suicide Prevention Lifeline number as well as part of the plan, and hopefully include engaging families as a part of that too. Then what's the role that lethal means restriction plays with that, and how can we include lethal means restriction in that process of safety planning.

I want to be clear that safety plans are not, quote, unquote, no harm safety contracts. There is no research that supports that the use of no harm contracts are helpful in preventing suicide. I guess in the reverse, the only thing where they might be helpful is if knowing if somebody would refuse to sign that, but signing one doesn't in any way ensure

somebody's safety nor does it protect the clinician or the providers from liability. And I would also add that, you know, that while these were quite popular at a point in time, that they failed to engage the families or the natural resources in any way in the involvement about safety planning.

So when we talk about lethal means restriction, it is part of the national strategy for suicide prevention, and we are looking at removal of the means that somebody might use to take their life. That could be a temporary removal. It could be a permanent removal. Obviously, firearms, given their lethality are very important to move from the home, but also unused prescription medications, car keys, maybe knives or other things specific to that individual. And that, that lethal means restriction should include under what circumstances those things might be returned or who is going to hold them in trying to be as specific as possible about it. One of the beauties of lethal means restriction is that anyone can do it. It doesn't just a clinician or provider, and certainly families are key to often following through with that actual process of removing the lethal means.

And there is a great training that's available for free on the Suicide Prevention Resource Center, FPRC.org website, it's called CALM, Counseling on Access to Lethal Means training. When we are engaging families, what should we be thinking about, and what, you know, how can we engage them in this process? And I think the first thing is to be careful not to pressure anyone family members into a situation that's not manageable, E.G., that they may be asked to provide 24/7 supervision for somebody at high risk.

And I think one of the key things, and this gets back to my first slide about informed consent, is to work with the patient or the client to get a signed release of information. The emphasis there is on work. It isn't just presenting them with this form and saying, you know, are you interested in signing this form, so we can release information to your family. It's talking with them about under what circumstances. If they say no, exploring that further. What does that mean? Here is the information that we would provide. It's limited to this. Would you be comfortable with that? It's only under these circumstances, and I think when we really work to explain that to the person and find out what some of the parameters are, that there is a way to get to yes, which is a critical piece to this in terms of having some type of signed release.

And, you know, I think it's also important as Perry Hoffman talked about for many families that have been through suicide attempts or serious mental illness with their loved ones, they are traumatized, they are stressed. I can certainly say that

from personal experience, and helping them get connected with support can be really key or with education. So, you know, a couple of other things relative to families is that they needn't suffer or worry alone, that they should get connected with other families that might be in similar situations, that they should educate themselves about suicide and mental illness and related challenges for their loved ones. NAMI has great family educational programs around that, although I think it has been mentioned as a field we have done very little relative to specific programs for families who have a loved one who is at high risk or who has already made a suicide attempt.

And certainly to be gentle with yourself and your loved one. I think probably the most important advice that we can give is to just be with that person, and to listen, and to don't feel like, you know, you have to have the right answer or to fix it. And certainly we always want to use the life line 1-800-273-8255 as a resource. There is an after an attempt brochure that is available, and that was done by NAMI together with the FPRC and SAMHSA. It is a part of a series. There are three, and the other two are one or after an attempt for emergency department staff, and after an attempt for that individual who made an attempt. And it's a great guide for how to interact with families following an attempt, and some of the questions for providers, I think, there is questions for providers and questions for families to ask providers. And I think that that can be, those questions can be very informative relative to the types of things that providers should be talking with families about, like why did you make the decision that you did about my family member and their treatment? If they are going to be released, what was that based on or why, if they are going to be admitted? Is there a follow-up appointment scheduled? What's my role as a family member in after care or safety plans?

So some of those questions are really important. Questions, you know, also that the family might ask of their loved one or for provider as well, like what has changed since your suicidal feelings or actions began. How can we know that things are different? So those brochures are a great resource for folks. And then, you know, how can we incorporate this into our practice, and in Oregon, the circles of support has built in a checklist that can be included in a medical record, in, and sort of how do we go through some of these pieces about communicating with family. What are their resources? Have they been informed about what some of the risks are? Have they been informed of the safety plan and what their role in the safety plan is? And then coordinating provision of care. Do they know when the appointment is? Are they going to follow up with that

appointment?

And then the last thing, we in the connect program do a lot of postvention work, and while responding to a suicide is never a pleasant incident, it can be a real learning experience, and sadly a learning experience, but what can, for those of you that have experienced a suicide of a client, I think you know in looking at the retro scope, it's always 2020, but how can we be informed by a suicide death about what we might have done differently, how we could have engaged the family or the natural support system, how we could have gotten a release of information or worked to understand the circumstances about what information might be exchanged.

And then lastly, on a personal note, I would just say having had a family member who has spent a lot of time in crisis and at high risk for suicide that it is extremely stressful as Perry Hoffman had indicated before. And I don't have a lot of words of wisdom except to say that I oftentimes found myself going to bed saying the serenity prayer and waking up in the middle of the night and saying the serenity prayer and saying it first thing in the morning. What is it that I can control? And what is it that I can't control? What is it that I can do?

And then on a more personal note, I kind of stopped saying that I loved you to my family member. I didn't stop entirely, but my message changed to I believe in you, because I knew that they knew that I loved them, but it was clear that they didn't believe in themselves and that was just one of the strategies that I used during that period of time. So thank you, and these are some resources that are available. Support and educational programs through NAMI, the NAMI connect website, lethal means restriction, the after an attempt brochure and the National Suicide Prevention Lifeline.

>> MODERATOR: Thank you, Ken, it's my pleasure to introduce Rajeev Ramchand who is the senior behavioral scientist with the RAND corporation, he is an epidemiologist who studies the prevalence, prevention and treatment of mental health and substance abuse disorders in at-risk populations and communities with a specific focus on suicide and suicide prevention.

>> RAJEEV RAMCHAND: Thanks so much, Perry and I want to echo Perry's thanks to SAMHSA. I have been studying suicide and suicide prevention for around a decade now, and I too have noticed a lack of kind of discussion about integrating families into caring for people who are at suicide risk and who may have had chronic suicidality. My talk today, I will lose my time a little differently than Ken and a little bit worried that I'm preaching to the choir, but I have been thinking about this a lot, and I hope what I can do is articulate why I believe that engaging family members for people at risk of suicide has been a

neglected suicide prevention strategy, and why I'm going to end with a hypothesis as opposed to beginning with a hypothesis and then providing the research evidence behind what we found, I'm going to end with a hypothesis and show you the map of how I got there.

So my main points for those who want to space off or who don't have the capacity to handle right now, I want to talk about the evidence we know that mental health problems do increase the risk for few side, that they are a risk factor for suicide. Then I want to show data to really hone in on the point that has been made already that caring for someone with a mental health problem can be stressful for the caregiver. We have some data, and I will show you data that supports that claim.

But then I'm going to turn it around a bit and say some of our suicide prevention strategies and Ken really kind of prefaced this a little bit, that some of our suicide prevention strategies may actually lack relevance for persons with chronic suicide risk. And then my hypothesis that supporting families of persons with mental health problems can save lives.

So one thing that we do know is that suicide increases, or mental health problems increase risk for suicide. I have shown some of the strongest evidence to date based on a review of the literature. And you don't need to understand really what this SMR means necessarily, but that anything above zero indicates that an increased mortality risk essentially for people with a condition. So you will see that among people who die by suicide, you see increased rates of suicide among people with schizophrenia, depression, borderline personality disorder, bipolar, and then in women, you see evidence for both eating disorders, anorexia and bulimia. So we know that this also exists. We also know there are other risk factors, of course.

We know that mental health contributes in sick ways to suicide risk. We also hear that relationship list cord is a risk factor for suicide risk. And sometimes in our research and in, when we run things like regression models, we compete the two against each other, we treat them as independent constructs between each other, relationship discord and mental health symptoms. So, and I show here significant relationship. This is from one of my own studies where we interviewed family members of people who recently died by suicide, and you will see that I even do the same thing. I ask relationship status as completely independent under a section on mental health status.

I have done the same thing, but in analyzing that data, it really made me reconsider this approach. So what we, in contrary, in contrast, rather, to thinking about them as independent things, I really think that it obscures this dynamic

relationship. What I mean there is that mental health symptoms exhibited by a person can actually increase or be a causal factor of relationship discord which can then reemphasize or worsen the original person's mental health symptoms to start with. Unless we intervene in that cyclical process, you can see it just spiraling downward and continuously getting worse, both the discord between the two partners or the pair, it could be a parent and a child, it could be friends, it could be a spouse relationship. We see that that worsens, and we then see that that could also influence the person's mental health symptoms. So we see this potential spiraling out of control.

So to move on to the fact that there is some evidence to support this that caring for somebody with mental health symptoms is a problem. I will draw from a study we did in 2014 on observational survey of caregivers. So this study was focused on military caregivers, and so we identified people who were caring for somebody informally, so not in a paid way, and we were really focused on the military caregiver population. So that could be of interest and I will show data for military and Veteran caregivers for those engaged with working with those communities, but really if you are not, we also interviewed as many caregivers as we could, so non-military caregivers as well, and the results really hold true.

So it should be of relevance to everyone. We conducted the survey. This tells you where we spoke to people. It was all across the country. What we find is that 9% of the U.S. of U.S. adults report being caregivers at some point in their lives. That equates to around 20 million individuals at some point in the past year. So that equates to around 20 million individuals. These are the types of conditions that we heard people are caring for. So a lot of it has focused on that third bar chart down, chronic conditions like cancer. So you see 77% of pre 9/11 caregivers and 63% of civilian caregivers report that they are caring for people for things like cancer or other chronic conditions.

But what you will also notice is that around a third of caregivers to pre 9/11 military Veterans as well as caregivers to non-veterans are caring for somebody who they report having a behavioral health problem, so a mental health condition. Again, this has been a neglected population in the past, and so it just kind of says that there is a group of people who are out there caring for people with behavioral health conditions and it's around a third, a little bit higher, but you can just estimate it's around a third of the 9% of caregivers who are currently in the United States.

So traditionally how we have measured caregiver burden and the activities of caregivers we ask about things like help with

activities of daily living, so things like bathing or walking or, you know, standing up, sitting down, or then we kind of will go a little bit further and talk about instrumental activities of daily living, getting to appointments, things of that nature. We were cognizant of the fact that those might not capture the actual tasks that people are performing who are caring for individuals with behavioral health conditions, so we asked an additional question. We asked a very broad question, are you helping your care recipient, the person you are caring for cope with stressful situations?

And you will see that between 50%, around 50% to three quarters of the caregivers we spoke to reported that they were helping their loved one, the person they were caring for, help with these stressful situations. So they were performing activities that have been previously really not considered as part of the care giving literature when talking about the roles of responsibilities that caregivers assume. But we also found that this care giving has a toll. So what we found is that of those that we interviewed compared to non-caregivers, all caregivers regardless of whether they were serving military personnel, Veterans or non-veterans faced an increased criteria for probable depression themselves.

So around 40% of our post 9/11 and around one in five caregivers who are not caring for somebody in the military met criteria for depression themselves which was elevated from non-caregivers. And when we looked at why, what were some of the factors that increased risk for depression, we looked at a whole host of factors. All of those things that you see on the right-hand side, things like demographics, education level, household income, relationship to the care recipient, the ones that emerged were we saw some demographic differences which we were prepared for. We saw income characteristics which we were prepared for. We know that that's consistent with trends. We also spent time care giving so the more individuals spent time caring for someone the more risk for depression themselves.

But also those caregivers who reported that they were helping the care recipient cope with stressful situations that that was a task that they were doing as part of their care giving duties, that increased their risk for depression themselves. So it's just providing evidence of the spiraling condition that I was talking about before that you are caring for somebody with behavioral health conditions, it's causing depression in yourself, and that depression that you are experiencing as a caregiver can cause further strain on your relationship with the person that you are supposed to be supporting.

I want to turn now to talk about now that I have kind of

provided the evidence that caring for somebody with a behavioral health condition can have real ramifications, real mental health ramifications to the individual themselves, I want to talk about some of what we know about how we should prevent suicide, especially from a universal approach. One of the popular things that I have seen is activities or brochures or posters that promote the warning signs for suicide, and you will see one example from right here. And the question I want to ask is for these individuals who are in these dynamic relationships with somebody with a behavioral health condition who may, actually they may know that the person is at risk for suicide is promoting the warning signs an effective strategy for families of these individuals? And for two reasons I'm going to say it's not, and I will show evidence of the two. The first is what you do with warning signs? Generally what the advice is that's given in these awareness campaigns is that we find somebody with a warning sign, we intervene, and we usher them into care. What I will show and hopefully tell you is that a lot of people who die by suicide actually are already in care, and I will show you evidence.

So it may not be that they need to initiate care at that time. But secondly, and perhaps more importantly I will show you preliminary pilot data that suggests that these warning signs may not be valid for some of the people who die by suicide. So this is data from 2014 and it was from a large cohort study that looked at healthcare visits in the four weeks prior to suicide deaths among individuals who later died by suicide. What you will see is that 50% of those who die by suicide had actually seen somebody in the healthcare setting within a month before dying.

You will see that a quarter of those were actually saw somebody in a mental healthcare capacity. So around a fourth of the people who died by suicide had seen a mental healthcare provider within the four months prior to their death. This is from a large study, but it's consistent with data that we have seen from a number of other studies that are much smaller in scope. So there is a significant portion of people who are at risk for suicide who die by suicide who are already engaged in mental healthcare. But further, and this is the point I want to make is this issue about the warning signs.

So these are the warning signs that many of you know about, things like ideation, substance use, purposelessness, and we conducted interviews with family members of 17 suicide in the New Orleans over the course of a year. We asked them about warning signs and when they occurred. Specifically, does you witness these signs before a week before the person died by suicide and did you witness these symptoms or these signs when

30 days before the death.

And what you will see in this chart is that many of the warning signs were observed, but they didn't indicate immanent risk because not only were they observed in the seven days before death, but they were also observed in the 30 days before death. So it wasn't that the substance use increased or that the person with hopelessness suddenly expressed a feeling of hopelessness in the acute days before suicide, but that for the past month, they will really, to the individual telling us, for the past month they had been exhibiting signs of hopelessness. They had been exhibiting mood changes. They were being reckless. All of these things that we think of as warning signs for the immediate time before death actually weren't predictive of the suicide death.

I would like to posit that we don't know to tell family members what they should be looking out for to indicate that somebody is suicidal right now. Or in an acute stage, and that's something that I think we need to do a lot more research on. As I said before, I will end with a hypothesis, and my hypothesis is I hope from the data that I have provided that we could say that supporting caregivers of those with mental health problems are recurrent or chronic suicidality can prevent suicide, but that's a hypothesis that I can't prove right now, but I think that we need to prove it, and I think that that's where research is needed.

What that means, and I think that I'm setting up the next speaker, we need to develop, and test interventions specifically directed for caregivers. But also ones that include caregivers in the treatment that the person is receiving. And these are very distinct, so ones that both include family members so a tradition 58 family therapy you might think of, but then treatments that are directed towards those individuals who are caregivers themselves, exclusive of their relationship with the person.

The second is that we need to disseminate the programs that work. So often in research we find good programs, they are great programs, but they remain kind of, the scope of the programs remains small, and we need to really pursue an aggressive strategy for when we know something works, when it's evidence-based when we have research findings behind it that we get it out into the community, that we make sure that people across the United States and abroad are aware of these programs and that they have access to them.

And then finally, I think that it goes without saying that we really need to include engaged survivors with lived experience in our suicide prevention efforts. My interviews with the 17 family members of those people who lost their lives

in New Orleans, were extremely insightful, but we need to ensure that family members ask tell us what they needed during times of distress, what they need during times of distress so that we can respond and tailor our interventions to meet those needs. So that's what I had to share with you today. Thanks so much. I look forward to the questions and I really hope that as was said earlier that this is the beginning of a dialogue about how we can support families to really prevent suicide, the continuous increase that we are currently experiencing, so thanks so much.

>> MODERATOR: Thank you, Rajeev Ramchand, it's now my pleasure to introduce Alan Fruzzetti who is the director of the DBT boys program and director of family and training services for three east programs at MacLean hospital and with an appointment pending, associate professor at Harvard medical school. He is director of research for the National Educational Alliance for Borderline Personality Disorder.

>> ALAN FRUZZETTI: Thanks so much, Perry for the introduction, and thing thanks to the people at SAMHSA for putting this I think very important step toward suicide prevention into a webinar to get us started. Indeed I want to pick up, thanks so much Rajeev Ramchand for that set up, because I want to talk about a program that we have been running that for now 16 years called family connections. It's a program for parents. I'm going to talk about particularly a program for parents, but it's been a program for airports and partners and others, people with borderline personality disorder and more recently also now a program for people who are suicidal or at risk for suicide.

I think the rationale for this has already been well covered, so I just want to review a little bit about the relationship not only between family functioning and, say, individual psychopathology and distress and disorder which I think has been well covered, but specifically look at suicidality. So we looked at a study which actually was a randomized trial looking at two different treatments for suicidality in teens and young adults, and we tracked their family functioning over time, before treatment, during treatment, and then following treatment for both treatments.

And this was a treatment study that provided no particular family interventions. People, this was not a family intervention study. It was an individual treatment study. What we found was for those people in the study, regardless of which treatment they were in, that family functioning mediated their outcomes. What that means is that for people for whom family functioning improved as they went through individual treatment, their outcomes were considerably better than if their family functioning didn't get much better over the course of their

individual treatment. So this is just further evidence that indeed this idea of individual well-being and family well-being are not independent. They are closely linked. And that's a, on the one hand, makes research on this more complicated than likely has been evident for many years. On the other hand, it means that we have wonderful opportunities to intervene in efficient and very effective ways.

So even though the suffering of families and their role in treatment has largely been ignored, when you -- we have lots of evidence now that it's folly to ignore it and efficient and effective instead to include families. I want to talk about some ways that we might do that. So one is our program we call family connections. Family connections is a program that my dear friend and colleague Perry Hoffman and I started a long time ago. We noticed that there were access programs in the system for people with borderline personality disorder, people who are highly suicidal and self-harming, didn't have good access to care. Their families, their partners and their parents didn't have good access to care. And it was our belief from the beginning that their well-being mattered independently and likely rolled around and had an impact on the person identified as the patient.

We constructed family connections really with three important and somewhat separate goals. The first was to provide state of the art psycho education and family psycho education. So information about disorders, information about treatments, information about family functioning, diagrams and models and data in particular. Like what kinds of things would be helpful? What kinds of things might not be so helpful? As you can imagine, psycho education varies over time as we learn more. The part of the program that we call psycho education has changed quite a bit. We know quite a bit more now in 2018 than we did in 2001 or 2002 when we started this program.

The second goal of family connections has to do with teaching family members skills. We see problems in families not as something that families should be blamed for or patients should be blamed for, but rather as problems that require skills. Somebody needs something to be able to do something in a different way, and the person doesn't have the skills to do it. So they may be individual skills, things like how to manage emotion, how to figure out actually what you want and communicate that clearly, being able to pay attention without getting, becoming too reactive to what you hear.

Those are all individual skills. And, of course, family skills start to become what we do with information that we get from our loved ones, how to pay attention to other people, how to actually incorporate that into our own emotion and manage our

emotion as we listen, to be able to respond in a much more validating, understanding way, even when we are scared or up set or don't like something, and when it comes to in particular to parents and children, how to be effective at helping kids do things that are safer, more effective without destroying the relationship.

And then because this is a group program, family connections has always been something that's been done in groups, there is an element of social support. Being able to come together with other parents and other partners who have loved ones with the same kinds of problems. One of the most common things we hear early on in our family connections program is how surprised people are how many months or years they felt like they must have been the only person in the world with these kinds of difficulties, and to be able to join a group with people who have similar kinds of issues and similar kinds of struggles, to be able to help and support each other is very important.

And so this increased social support helps them create a network of social support that often endures well after family connections formally ends. Now, let's bring our attention back briefly to suicidality. Suicidality is the large umbrella term for suicidal thinking, suicidal urges, suicidal attempts. As you saw in the last presentation, or maybe it was the first one, suicide unfortunately shows up in a lot of different diagnostic groups. It's not just one diagnosis. And so for so long we thought about treating suicide only inside the diagnosis itself, but that may be a very 20th century idea. And so the idea of thinking about suicidality as a transdiagnostic program or a transdiagnostic phenomenon, meaning transdiagnostic means it's across different diagnoses. The problem actually might be very similar even though different people may meet criteria for different diagnoses.

Or, in fact, sometimes may not meet criteria for any diagnosis. And given that as many as three quarters of the people who have died by suicide haven't had contact with a mental health professional in the last month, it may be that many, many people are not diagnosed and maybe don't even meet the criteria for a diagnosis. However, that doesn't mean that suicidality isn't a very severe problem. Of course, it is.

So thinking about a transdiagnostically might get us out of the handcuffs that thinking diagnostically might put us in. When we do that, we recognize that, therefore, we are not limited to think about the psychological or the biological concomitants, the things that show up with a specific diagnosis. So someone could be suicidal with, and be depressed or have an eating disorder or substance use disorder, borderline

personality disorder, or many other problems or many of these problems all put together at the same time.

Now all notice in our little triangle of psychological, biological and social that most treatments are geared to the psychological or the biological. The biological, of course, are medicines and other biological interventions and, of course, there isn't really any biological intervention for suicidality, per se. At least not directly. Of course, helping people be less depressed or get off substances helps reduce suicidality. Psychologically we can say the same thing, that there are many diagnoses here and there are interventions, psychological ones specifically for suicidality.

Yet here we are in 2018 and most of our interventions don't include the social, in particular the family component, and I would adhere culture and other relationships are important as well. But families are often readily available, not always, sometimes their absence is part of the problem, but when they are available as was just noted by, I think, both Ken and Rajeev Ramchand, that they are not included. They are not included in treatment most of the time.

That could be because of things like misunderstandings about HIPAA, or it could simply be that people, that therapists, social workers, psychologists, psychiatrists don't know how to incorporate families into treatment, don't know enough about that. Even though there is a fair amount of information available.

We get so focused on learning how to treat a specific diagnosis that it's only recently that people have begun to think transdiagnostically. So by bringing the social in, the social, of course, affects the biological, the social affects the psychological and vice versa. And we are really limiting our ability to be effective when we cut off a full third of these three factors because they actually influence each other in such an enormous way.

So family connections is a program that typically when we started out was a 12-week weekly program for about two hours. More recently in order to try to increase access, we have also turned it into an intensive weekend where people can get a lot of the skills and education and some of the social support by coming all day on, say, a Saturday and Sunday, or two Saturdays in a row split into two weekends, that kind of thing. Family connections a grass roots program. It's led by trained family members and or professionals in the United States for reasons having to do with the way that our healthcare system is structured, it's most often family members.

And we train them up, we train them up for free, within the National Education Alliance for Borderline Personality Disorder,

and then the idea is that they go out and they offer family connections programs to family members who need them for free. So there is no cost to participate, which removes almost all significant barriers other than geographic ones to having access, and, of course, with telephones and Internet connections, really the barriers to participate come down and access just goes way up. So at this point we have lost count at how many people in the U.S. have taken it. Thousands and thousands of people have participated, and family connections is now widely available not only in the United States, but we think at least 21 other countries offer family connections.

Now, this is significant because by treating family members separately, and this was, of course, a point that Rajeev Ramchand was making at the end of his presentation, that that's in addition to including family members in treatment, this is a program for family members to come to on their own. And, of course, the idea is, and I will talk about this in a few minutes, that that is a win/win. It's good for the family members who participate, but it's also good for their loved ones. I will come back to that, but first I want to talk just for a minute about what some of the research data looks like from family connections.

At the moment, there are five published studies, and several more studies in the pipeline to being published. Two of those were published by our group, Perry Hoffman led by Perry Hoffman and me but other have been published by other people who have nothing to do with the development and certainly aren't biased in any way. They all show significant improvements across all of the important areas that we hypothesized for family members who participated.

I want to give you one example. The first study we did which was in the beginning when we hardly knew what we were doing was the most conservative in terms of outcome. We have better and better outcomes as time goes on and we have learned how to do a better job, improved our materials, improved our teaching. So study one is a pretty good example of conservative outcomes. This was published in 2005. Now, one of the variables that we are interested in measuring was grief. And that might seem like an odd thing because the vast majority of participants have ones who are still alive although they have made suicide attempts.

But the grief here is the idea that their life and the life of their loved ones is not what they planned. It's not what they set out hoping for. And so there is an enormous loss around expectations and hope and trajectories, and being able to acknowledge those losses, even though the person is very much still alive, and we hope is going to have a fantastic life, as

time goes on, things will get better and better, there is still a lot of grieving involved.

As you can see from the graph, grieving starts, the orange, you will see several slides here that have the same color coding, the orange is taking before family connections, the yellow is after, and then the green is six months later after the program as stopped. And what you see here is this pattern of things getting considerably better from before to after taking financially connections, and then improvements continuing into the future, which suggests that some of the reasons that things are getting better is because people are learning how to adapt their skills and their ways of managing the situation with loved ones.

It's not just a function of social support because the social support ends at the end of the group, but the gains generally continue well after family connection ends suggesting that people are learning a lot and moving forward and using their new skills into the future. We looked at changes in general psychological distress and depression and you see the same pattern, significant improvements after family connections with continued improvements into the future.

We are also interested in this concept of burden that was mentioned I think by Ken earlier, that being perceived as a burden is one of the risk factors for suicidality. We want to work on people not feeling like their loved one is a burden to them and alleviating their burden even though they may still be in some kind of a caregiver role, we want to manage that role to reduce its burden significantly, and as you can see, these are all significant improvements from pre to post, so now there is an even bigger reduction in the follow-up period.

Again, really good improvements over time. The flip side of this, of course, in terms of not just reducing problem areas, but also trying to improve a sense of mastery or empowerment is very important for caregivers. People who have suicidal loved ones not only is that tragic to just have the suffering of someone you love be so close, but it also, people experience this burden, they experience distress, they experience grief and they feel disempowered like my life is not my own. I have got to be on call to my loved one, I have got to watch and be vigilant, I have got to do this, that, and I just don't have power in my own life.

Of course, we are trying with family connections to help people be re-empowered without in any way doing anything that's unhelpful to their love the one who is suicidal or otherwise struggling. As you can see from this graph, empowerment and mastery goes up quite a bit from before to after family connections and continues in the upward direction even in the

follow-up period. So this is really good news that we have a program that's had tens of thousands of participants worldwide now with half a dozen studies or more that show that there are really big improvements and it's free.

So, of course, we have been trying to disseminate this program for quite a few years, reasonably successfully. Our goal is to make it even more available to families and family members who need it. Now, let's think further about suicidality. Now, one of the things about suicidality as a transdiagnostic concept is to say something, I want to say something that I think is kind of obvious. People don't kill themselves when their experience is that their life is good or going to get better. People think about killing themselves or try to kill themselves when they reach the end of their rope and they are very miserable and don't perceive that it's going to change.

Now, that's an emotional state that we often refer to as emotion dysregulation. The idea of emotion dysregulation is that when we are dysregulated, the only things that really on our mind is getting rid of the pain. And it doesn't really matter to us at that moment what the medium or long-term consequences are for that. So a person might use drugs or be aggressive or self-harm or attempt suicide not really caring about the negative consequences of those acts. They may all be designed to simply find a way to get temporary relief, and, of course, in the case of suicide, it's not temporary, but at that moment people don't really care. It feels so awful.

So we have got to think about this idea of emotion dysregulation and how social interaction, what the social context for emotion dysregulation is. Now, this is a pretty controversial in some ways idea, because we live in times that see emotion as being inside the person, but we know from hundreds and hundreds of studies that there are all kinds of social events and social processes that have a big impact on other people's emotions and are in turn affected by the expression of emotion of other people. So that's just another way of picking up the earlier slide that before it was that the relationship between family distress and individual distress, and I want to make that even more specific, that individuals can be dysregulated and vulnerable to getting dysregulated, that has an impact socially on other people.

When people are dysregulated, they are not calm. They are not able to express their experience in easy to understand ways. They could be very off-putting, they can be demanding, they can be overwhelmingly sad and depressing and difficult to manage. And it's easy for people to misunderstand their experience and blame them or just misunderstand and tell them it's easier than

it really is, or they ought to do X, Y, Z, when they have tried X, Y, Z, 500 times. That invalidating response, of course, results in increased negative emotion. Everybody knows that, and I will come back to a slide about that in a minute. So we call this a transaction, because what one person does, person A has a big impact on person B, and what person B does have an impact on person A, and it kind of goes around and around.

It's not really rocket science. That part is not controversial, but when we try to put it in terms of emotion dysregulation and suicidality, now it sounds complicated. Now, of course, we are not blaming anybody. There is no blame here. People are doing the best they can in this model, it's just that it's hard and people get stuck in these transactions. So a healthy transaction, so the person on the top here would have some self-awareness, and some situation awareness, like I'm feeling this, I'm wanting that, and this is the situation, and manage and be aware of his or her emotions, and they would be what we call primary emotions.

They make sense in that context, so it's kind of a dangerous situation, you feel scared. If it's a situation where you are not getting what you want, and you keep working at it, you feel frustrated. If you are working hard and you get something you have been working toward, you feel joy, so forth, so on. And, of course, because you are regulated, that's this top part, the expression of your emotion and the expression of what you are wanting and thinking and feeling and doing is all connected. It makes sense. It's easy to understand and so the other person, so now we will go down that left arrow to the bottom person, that person is aware, and it's easy to understand.

Oh, I get it, that happened, you know, you were driving along, somebody cut you off, and that was really scary. See, that makes sense, it's not hard to understand. But if you come home and you are yelling about the boss who just gave you a raise, it's hard to understand. And in fact, it may be this left over fear from somebody just cutting you off on the road. So this awareness and understanding of the other keeps the second person barely regulated him or herself, it's easy to understand and say things that are quite naturally validating like that makes sense, oh, gee, should I feel that way too? Of course, you would want to do that. Those kinds of validating statements that actually everybody loves, and actually have a profound impact on our well-being.

Now, unfortunately the problematic transactions go differently. The person is not so self-aware, but instead is judgmental, which distorts thinking, emotions get higher and higher and what comes out isn't accurate. It doesn't make

sense. There is a sensible thing that could come out, it just doesn't. Then the other person maybe feels attacked, gets judgmental back, gets angry, and invalidates which, of course, jacks the other person's emotion up some more, and this continues. This is just a graph that shows that even for very ordinary people, the green line is one, when we stress people out, if we also validate their stress, like it makes sense that you feel uncomfortable. It makes sense that you are stressed out, that even while we continue to stress them out, they feel better.

But the red line shows that if they are stressed out and you invalidate them, you don't tell them that their experience makes sense, they can't get used to the stress. The stress continues on unabated. And, of course, that's part of what we are, that's -- there is no better evidence for the social influence of emotion than this. Everybody is the same here, the people on the red line and the green line. The only difference is that the person in the experiment is validating in the case of the people on the green line, and invalidating the people on the red line. So just to summarize results from our study with parents of teens, I want you to see that the parent skill group, the family connections group, that's the green that the kids showed significantly better improvements on a wait list. This is randomly assigned from pre to post, from time one to time two. Similarly, in terms of ratings of parent invalidation, they rated their parents as being much less invalidating by time two after the parents went through the skill and support group, and they felt much more like their parents were much more available if their parents went through the parent skill group, the family connections.

And the kids in turn showed fewer problems, that's the green, with regulating their emotion over time. So this validating, invalidating piece is a very important mediator that actually has a direct impact on teenagers' emotions. And, parent improvement more validating, less invalidating showed their kids showed more improvements in their emotion regulation, and more improvements in terms of being less depressed. So there are lots of things connected to, and I'm not going to run through them all, emotion dysregulation, but I want to emphasize that the social context for emotion dysregulation is something that families can have an enormous impact on. So conclusions, if we think transaction alley, we recognize that we can help parents and partners. What's good for them is good for their loved ones. If we think transdiagnostically, we could think about emotion regulation and validation as a key stool socially to help regular -- tool to help regulate people. Of course, there are other factors, but these are very potent ones. And

regardless, including parents and other loved ones in treatment and other programs is really essential. It's important to make access easy as well.

So thanks very much for listening. I hope this has been helpful, and I will turn the program back over to Perry, I think.

>> PERRY HOFFMAN: Great --

>> KERRI NICKERSON: Thank you Alan, this is Kerri Nickerson from the Suicide Prevention Center. Thanks to all speakers for their wonderful presentations. So we will start the question and answer period of our webinar, if you have questions, feel free to type those into that Q and A section on your screen. And So the Alan, just a quick clarifying question, someone has a question about whether there are family connections programs available to residents of New Hampshire or similar programs in New Hampshire?

>> There are. Short answer.

>> KERRI NICKERSON: How can people find out about those.

>> If they go to the NEABPD website, and I'm sure that's here somewhere, and you click on the family connections website, there is a way they can send a direct message to the coordinator saying where they live and is that they are looking for family connections and we will do our best to get them connected.

>> KERRI NICKERSON: Great. Thank you. And just a clarifying, just so there is no confusion, Ken, if you wanted to say anything more about this, feel free, but there is also through NAMI a family, a national connections program for peer support groups, and that isn't to be confused with the family connections program that we have been talking about here.

>> KEN NORTON: Family to family, that's right, different.

>> There is also a national NAMI program called connections that's a support group for peer to peer.

>> Right, of course.

>> So a little confusing with the names.

>> KERRI NICKERSON: And, Ken, is there anything else that you would like to share, certainly we have heard great examples of some programs for supporting families, but is there anything else you would want to share about resources both nationally and through local chapters, your chapter of NAMI?

>> KEN NORTON: Well, you know, NAMI is a national organization and has chapters around the country, and the program differs from chapter to chapter, but typically what is available are some types of educational programs and support groups, and I think that, you know, the program, the family connections program that Alan has detailed is fabulous. And I would just say that, you know, that in my experience both personally as a family member and professionally that there is a

lot of wisdom from other people with lived experience, whether that's people who have lived with suicidal thoughts or attempted suicide or other family members who have had a person in that situation or loved one or those caregivers. And connecting with that peer to peer wisdom and support and knowing that you are not alone is really important, and encourages people to seek that out wherever they are and whatever way they can find that.

>> KERRI NICKERSON: Thank you. Rajeev, there is a couple of questions for you. In your findings that you listed, there seemed to be kind of a major jump in some findings about changes post 9/11, some of the caregiver statistics seem to jump way up. Would you be able to say a little bit more about that?

>> RAJEEV RAMCHAND: Sure. This is a great question. I wasn't planning on going into the military versus civilian caregiver distinction, but since there was that evidence there, I will speak to it. Generally in our study what we found is that post, people who are caring for someone post 9/11 are very different than people who are caring for Veterans from the pre-9/11 era, or from, or non-caregivers. So generally the care giving literature and research on caregivers and overwhelming majority of caregivers in the United States are generally speaking adults who are caring for their elderly parents who are having things like as I said before, chronic conditions like cancer, things like dementia. They don't necessarily live with their parents. They, you know, take turns doing that.

Now, this is really different from this group of, we estimate 5.5 million post 9/11 or 1.1 million post 9/11 caregivers and this 1.1 post 9/11 caregivers are generally spouses. They are living with the person they are staying w the post 9/11 caregiver, care recipient are more likely to have behavioral conditions like post-traumatic stress disorder. So it's just, it's hard to group them together even though I did it, but they are very distinct groups that have very unique challenges. They spend more time because they are living with the person doing caregiving, assuming care giving duties so we assume it's the combination of things like they are younger, they are married, so they have a different relationship, they are spending a lot of time with these care giving duties, and they are caring for somebody with post-traumatic stress disorder or other behavioral conditions that really collectively elevate their risk for things like depression themselves and things of that nature.

>> KERRI NICKERSON: Great. Thank you. And for all of our presenters, is there any, any evidence-based ways that families can be engaged while their loved ones are actually in the ED? Are there lessons learned there that you may want to share?

>> RAJEEV RAMCHAND: I don't have any lessons learned. I

can respond to that a little bit in that I think the question is actually a really astute one. I think that emergency departments are increasingly been recognized as places where we can really identify people who we may not know are at risk of suicide, and we can -- so there is definitely a way to identify them. I think that now our challenge as a community is thinking of once we have identified somebody in the emergency department, what are, what is the standard of care? Whatever our operating procedures? How do we best care for the person that we have now identified as being at risk for suicide who may have come in for a broken ankle or something like that. I think we are figuring out what to do with the patient him or herself, and I think that rather than, I would actually really advocate that rather than figuring out what to do with them and then as an afterthought think about what to do with their families and how to integrate their families, I think this discussion really propels us to think about the two concurrently. How do we treat the person and their family at the same time and how do we integrate that care within the ED setting? I think this is an opportune time to look at the question and develop standard policies, practices and procedures to do that.

>> RICHARD McKEON: This is Richard McKeon from SAMHSA. I will make a comment on that. Based from my experience having run a psychiatric emergency service in years past, because I think clearly in terms of evaluating and intervening for people at risk for suicide in the emergency room, families have a critical role to play on a number of different dimensions. One is as part of the assess. Is risk. Family members often times will have vital information that has to be part of doing an informed suicide risk assessment.

Also I think one of the things that we need to move towards is that my experience was that most people in the emergency room who we are seeing because of something related to suicide were willing to have their families contacted. And I think the larger problem were providers not asking for that. Granted they will be a smaller number of people who will refuse consent, but I think if we routinely ask for consent, I think in the majority of instances, it's going to be there. And any kind of safety plan or treatment plan, whether the person gets admitted to the hospital or not, that has the active engagement of the family, I think my hypothesis would be are longer term chances of success are going to be greater.

So I think it's a really important question, and while we certainly need better data on it, I think there is a vital role for families to play. I'm going to be needing to leave the call, but James Wright will be closing for SAMHSA and I'm so glad that so many people were on the call listening to these

great presentations. The last time I looked we had well over 400 people listening to the call.

>> KEN NORTON: This is Ken, I can't to echo what Rajeev and Richard said. One to Rajeev's point we are sighing this data shows that a number of people who are dying by suicide who have had recent visits to the emergency room aren't necessarily presenting with mental health issues, so there really is a need to screen beyond that, and then secondly from my own personal experience relative to temporary removal of firearms, you know, you will have families say, oh, the kids don't know where the guns are, and I say, well, right, they probably, you don't think you know where you hide the Christmas presents either.

And or there is a gender piece where the woman might not know that there are firearms in the home and that's broad brush, but I think that engaging families and having these conversations is really key. I think this has been a great presentation to be able to highlight some of the different strategies.

>> KERRI NICKERSON: Thank you so much to all of our presenters. I know there are several other questions but unfortunately, we are running very short on time. I did just want to remind folks there are several family members who have asked some questions about how to handle situations within their own families and I just want to put a plug out there to please remember to reach out with any of the questions when you are concerned about a loved one to your, to the National Suicide Prevention Lifeline. That's 1-800-273-8255 here in the U.S. I know with have a couple of international participants as well. So, again, I just want to thank all of our participants. There has also been several questions about whether the slides will be posted after the event, and they will. They will be posted on the Suicide Prevention Resource Center's website. That is SPRC.org. And with that, I will turn it over to James Wright from SAMHSA to close us out.

>> JAMES WRIGHT: I want to thank all of the presenters and we are really looking forward to continuing this conversation. We do realize how important family voices are to those in suicidal crisis and the support they provide. So we look forward to that conversation, and if you do have other examples and are willing to share with us and the Suicide Prevention Resource Center, please reach out, and also let us know if there are areas that you think would be beneficial to focus on in the future. Thank you, everyone, for participating in today's webinar.

(Concluded at 3:26).

This text, document, or file is based on live transcription. Communication Access Realtime Translation (CART), captioning, and/or live transcription are provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings. This text, document, or file is not to be distributed or used in any way that may violate copyright law.
