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Engaging and Supporting Families in Suicide Prevention: What Work and Research Are Showing

Substance Abuse and Mental Health Services Administration, the Suicide Prevention Resource Center, and the National Education Alliance for Borderline Personality Disorder

Monday, March 5, 2018 2:00:00 PM EST - 3:30:00 PM EST
Dr. Richard McKeon
Chief, Suicide Prevention Branch
SAMHSA, CMHS

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).
Thank you.

SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD)
Engaging and Supporting Families in Suicide Prevention

SAMHSA Webinar March 5, 2018

Perry D. Hoffman, Ph.D.
President
National Education Alliance for Borderline Personality Disorder (NEABPD)
www.borderlinepersonalitydisorder.com
Families as caregivers

The role of families as caregivers in a loved one’s illness has been key for centuries.

Groups exist providing education, support, a network for family members living the same experiences (cancer, autism, schizophrenia).

These groups are lifelines for the caregivers.
In the Suicide Prevention Community

Police, school personnel, health professionals are recognized as key in prevention and specific trainings have become standard along with their own support systems.

Families often are also first responders or serve as safety nets.
They too are key in prevention and recovery.
Families and suicide prevention

However, there has not been a specialized program that exists for families of suicide attempters.

This is a 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 events and often paralyzed with fear, depression, burden, grief, helplessness, anger, shame, and stigma.
Overlapping communities

- We see this in the Borderline Personality Disorder (BPD) community where suicide and self-injury are hallmark symptoms. Up to 75% have self injured and 10% of people with BPD die by suicide.

- More than 50% of their family members meet criteria for PTSD from their relative’s suicidal behavior.
You will hear about one program that has been helping those families.

So...although family members can be a valued resource for their suicidal loved one, they too needs skills training and support.

Our hope and goal is to make it standard practice to include families in Suicide Prevention Programs.
Thank you for making this the first step in a larger effort

- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Suicide Prevention Resource Center (SPRC)

Presenters:
Ken Norton, Rajeev Ramchand, Alan Fruzzetti
Engaging and Supporting Families in Suicide Prevention

What Work and Research Are Showing

March 5, 2018
Informing Family of Risk

“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/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...”

A survivor of suicide loss – April 2006
American Association of Suicidology Conference
Beyond Recognition

• “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 Ok, but I knew she wasn’t – she took her life 3 days later…..”

– A survivor of suicide loss in NH.
The Tragedy of Mental-Health Law
Patient protections have become rigid rules excluding families from patient care and exceeding common sense.
By LLOYD I. SEDERER

After Newtown, there is widespread concern that laws regarding mental-health services need reform. Two places to start are the laws governing involuntary hospitalization, and the restrictions placed on communication with a patient’s family.

Across the U.S. today, federal and state laws give people with mental illness the right to decide when, where, how, and if they will receive care. Yet some serious mental illnesses (such as schizophrenia or mania) can make it difficult for those affected to assess the reality of their own experiences or their need for treatment.

An individual with a mental illness that begins with his hands outstretched aggressively with the officers who arrived on the scene. The young man had never been to this particular ER, so there was no record of any previous treatment he may have received or any medical or mental conditions he may have had. In the presence of the police and hospital security, he appeared quiet and cooperative, even saying he regretted losing his temper.

But his disheveled and fearful look prompted a nurse to call for a psychiatric consult. The consultation revealed that while he lived with his parents, he didn’t want the hospital to contact them. He said he’d never had any such outbursts before.

Today’s laws were mostly written decades ago, in response to an era when doctors and hospitals had almost unbridled control over patients and their treatments.

What began as patient protections have in many instances become rigid rules and procedures that seem to exceed patient needs and even common sense. Good intentions spawned these laws, but in practice, they can interfere with or delay the delivery of necessary care and crucial communication between caregivers and families—as families of people with serious mental illnesses can attest in often heartbreaking detail.
• DHHS “Message to Our Nations Health Care Providers” January 13, 2013 from Leon Rodriguez Director of DHHS Office of Civil Rights

• “When a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with the applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat.”
DOES HIPAA PROTECT PEOPLE'S PRIVACY OR DOES IT CONTRIBUTE TO STIGMA AND THE PERCEPTION THAT MENTAL ILLNESS IS SOMETHING TO BE ASHAMED OF
NH RSA 135c:19

• Allows for disclosure of specific info to families of caregivers of people with serious MI
• Specific process for disclosure
• Specific circumstances and info that can be disclosed.

Oregon has similar provisions

• House Bill 2023 (Chapter 466) Requires hospitals to develop a protocol for connecting patients leaving a psych admission with a friend of family member

• House Bill 2948 (Chapter 473) Clarifies for Emergency Department personnel that HIPAA allows for sharing info with families.
Engage Family/Natural Supports

- Assessing levels of support is essential for assessing and managing suicide risk
- Have they shared their thoughts/attempts of suicide with anyone?
- Who could they call in the middle of the night for help?
- If estranged from family would it be health or unhealthy to re-engage?
- Withdrawal & Isolation key warning signs
Burdensomeness?

- Thomas Joiner has identified *perceived burdensomeness* as an important risk factor for suicide.
- Appropriate engagement of families may offer an opportunity to address and reduce those perceptions.
Safety Planning

- Person centered – engage the individual in development of the plan
- Identify key warning signs specific to that individual
- Identify “personal medicine” what has helped the individual get through previous crisis
- List local resources including the Lifeline #
- Have a specific crisis plan
- Engage family and natural support systems
- Reduce access to lethal means
No Harm/Safety Contracts

- Existing research does not support the use of no harm contracts in preventing suicide
- No harm contracts do not provide any civil liability protection in the event of a malpractice suit
- No harm contracts should only be used by a qualified health care professional as one part of a full risk assessment
Lethal Means Restriction

- Temporary removal of or access to firearms
  - Be clear on circumstances for their return
- Removal of unused prescription medications
- Depending on particular circumstances – car keys/knives etc.
- You can access or refer families to free on line CALM (Counseling on Access to Lethal Means) training:  Free training [www.sprc.org](http://www.sprc.org)
Engaging Families

• Don’t pressure anyone into a situation that is not manageable (eg. around the clock supervision).
• If needed, work with the patient to get a signed release
• Be aware of the tremendous stress and pain families may be in
• Help get them connected with support
What Can You Advise Families?

• Don’t suffer or worry alone – seek support for yourself
• Educate yourself about suicide and related challenges your loved one faces
• Be gentle with yourself and your loved one
• Listen and be present (don’t try to “fix” it)
• Use the National Suicide Prevention Lifeline as a resource 1-800-273-8255
### After an Attempt:

#### Questions for Providers

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you believe professionally that my family member is ready to leave the hospital?</td>
<td></td>
</tr>
<tr>
<td>Why did you make the decision(s) that you did about my family member’s care or treatment?</td>
<td></td>
</tr>
<tr>
<td>Is there a follow-up appointment scheduled? Can it be moved to an earlier date?</td>
<td></td>
</tr>
<tr>
<td>What is my role as a family member in the safety plan?</td>
<td></td>
</tr>
<tr>
<td>What should we look for and when should we seek more help, such as returning to the emergency department or contacting other local resources and providers?</td>
<td></td>
</tr>
</tbody>
</table>

#### Questions for Families to ask their loved one

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel safe to leave the hospital, and are you comfortable with the discharge plan?</td>
<td></td>
</tr>
<tr>
<td>How is your relationship with your doctor, and when is your next appointment?</td>
<td></td>
</tr>
<tr>
<td>What has changed since your suicidal feelings or actions began?</td>
<td></td>
</tr>
<tr>
<td>What else can I/we do to help you after you leave the emergency department?</td>
<td></td>
</tr>
<tr>
<td>Will you agree to talk with me/us if your suicidal feelings return? If not, is there someone else you can talk to?</td>
<td></td>
</tr>
</tbody>
</table>
Sample Check List

Circles of Support: Communication Checklist

Where an elevated risk of suicide is identified in adult patients (or when patient is a minor), take the following steps regardless of whether or not one has a signed authorization:

- Following the initial evaluation, communicate with the patient and the family/parents regarding diagnoses, treatment recommendations and safety issues. Do **not** assume they know anything about the nature of mental illness, treatment, risk factors, or community resources.

- Explicitly inform the family in the presence of the patient of all safety issues, including risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.

- Discuss available community resources to help the family and patient, including resources for case management, support groups, improving mental health at home, and other relevant factors.

- Coordinate provision of care when a patient transitions from one level of care to another, or one provider to another:
  - Involve patient and family in planning process including discussion of interim safety plan.
  - Assure follow up is in place with a specific timely appointment.
  - Assure accepting provider has full knowledge of history and risk issues/records.
  - Confirm that patient has attended the follow up appointment.

Additional Notes:
What Can Postvention Teach Us About Engaging Families of Those at Risk?
I believe in you.
Resources

• NAMI Support Groups/Educational Programs [www.nami.org](http://www.nami.org)
• NAMI NH Connect Suicide Prevention program [www.theconnectprogram.org](http://www.theconnectprogram.org)
• Lethal Means Restriction: Suicide Prevention Resource Center: [https://www.sprc.org/comprehensive-approach/reduce-means](https://www.sprc.org/comprehensive-approach/reduce-means)
• National Suicide Prevention Lifeline 1-800-273-8255 [https://suicidepreventionlifeline.org/](https://suicidepreventionlifeline.org/)
Ken Norton
NAMI NH
603.225.5359
knorton@naminh.org
Caring for persons at risk of suicide

Rajeev Ramchand
Mental health problems increase risk for suicide

Caring for someone with mental health problems can be stressful

Some suicide prevention strategies may lack relevance for families of persons with chronic risk

Supporting families of persons with mental health problems may save lives
Elevated suicide risk among persons with mental disorders

<table>
<thead>
<tr>
<th>Mental Health Condition</th>
<th>SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>12.9 (0.7-174.3)</td>
</tr>
<tr>
<td>Depression</td>
<td>19.7 (12.2-32.0)</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>45.1 (29.0-61.3)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>17.1 (9.8-29.5)</td>
</tr>
<tr>
<td>Anorexia nervosa (women)</td>
<td>31.0 (21.0-44.0)</td>
</tr>
<tr>
<td>Bulimia nervosa (women)</td>
<td>7.5 (1.6-11.6)</td>
</tr>
</tbody>
</table>

Treating mental health and family relationships as "independent" obscures a dynamic relationship.

### XIII. Significant Relationship

<table>
<thead>
<tr>
<th>Source of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Was s/he in a significant relationship at the time of death?</strong></td>
</tr>
</tbody>
</table>
| ○ No | ○ Yes  
| **If s/he was in a significant relationship** |  
| **Was this relationship on the verge of breaking up or threatened with breaking up?** |  
| ○ No | ○ Yes  
| **Was anyone in the relationship pregnant or had had a recent abortion?** |  
| ○ No | ○ Yes  
| **If s/he was not in a significant relationship** |  
| **Had s/he been in a relationship that had recently undergone a break-up or separation** |  
| ○ No | ○ Yes  
| *IF YES:*
  How long ago: __________  
| **When was the last significant relationship s/he was in?** |  
| Year it ended: __________  
| How long did it last: __________  

**Relationship Stress/ Discord**

**Mental Health Symptoms**
National survey of caregivers

Sample

1,129 military caregivers
1,828 civilian caregivers
1,163 non-caregivers

9% of U.S. adults are caregivers

Neurological
Chronic (e.g., cancer)
Traumatic brain injury
Behavioral health

Help with at least 1 activity of daily living

Help with at least 1 instrumental activity of daily living

Help care recipient cope with stressful situations

% meeting criteria for probable depression

- Post-9/11: 38%
- Pre-9/11: 19%
- Civilian: 20%
- Non-caregiver: 10%

Consistent with general population

Helping care recipient cope with stressful situations
Time spent caregiving
Relationship to care recipient
Household income characteristics
Type of disability
Education level
Marital status
Demographics (race/ethnicity, sex, age)

Tested predictors of major depression

Confirmed predictors of major depression among post-9/11 caregivers

Demographics (race/ethnicity, sex, age, marital status)

Education level

Type of disability

Household income/characteristics

Relationship to care recipient

Time spent caregiving

Helping care recipient cope with stressful situations

Promoting the suicide warning signs is a popular suicide prevention strategy.
Is promoting the warning signs an effective strategy for families of persons with recurrent suicide risk?
Many suicide decedents have a history of recent mental health contact.

Warning signs may not indicate acute risk.
Many suicide decedents have a history of recent mental health contact

<table>
<thead>
<tr>
<th>Healthcare visit in 4 weeks prior to suicide death</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any</td>
<td>49.9</td>
</tr>
<tr>
<td>Any mental health (MH)</td>
<td>23.8</td>
</tr>
<tr>
<td>Inpatient MH</td>
<td>4.7</td>
</tr>
<tr>
<td>Inpatient chemical dependency (CD)</td>
<td>0.5</td>
</tr>
<tr>
<td>Emergency Dept. MH</td>
<td>7.5</td>
</tr>
<tr>
<td>Emergency Dept. CD</td>
<td>1.4</td>
</tr>
<tr>
<td>Outpatient MH</td>
<td>14.6</td>
</tr>
<tr>
<td>Outpatient CD</td>
<td>0.6</td>
</tr>
<tr>
<td>Primary Care MH</td>
<td>8.0</td>
</tr>
<tr>
<td>Primary Care CD</td>
<td>0.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>7 days before death</th>
<th>30 days before death</th>
<th>New Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation</td>
<td>10</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Substance use</td>
<td>11</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Purposelessness</td>
<td>10</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Anxiety, etc.</td>
<td>11</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Feeling Trapped</td>
<td>10</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>10</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>11</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Anger, etc.</td>
<td>8</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Recklessness</td>
<td>7</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Mood changes</td>
<td>11</td>
<td>14</td>
<td>3</td>
</tr>
</tbody>
</table>

Warning signs may not indicate acute risk

Among 17 suicides in New Orleans in 2016

Hypothesis: Supporting caregivers of those with mental health problems or recurrent/chronic suicidality can prevent suicide

- Develop and test interventions that include caregivers AND those specifically for caregivers
- Disseminate those programs for caregivers that work (e.g., Family-to-Family)
- Include and engage survivors with lived experience in suicide prevention efforts

Rajeev Ramchand
Ramchand@rand.org
Family Connections: A Program for Parents of Suicidal Teens and Young Adults

Alan E. Fruzzetti, Ph.D.
Director, Boys Residential DBT Program
Director, Training in Family Services, 3East Programs
Family Functioning & Suicidality

• **Improvements in family functioning:**
  – Mediate patient suicidality outcomes
  – Mediate self-harm outcomes
    • Independent of treatment effects
      (Fruzzetti et al., in review)

• Despite the suffering of families, and their role in effective treatment and outcomes, families have largely been ignored by the mental health system.
Family Connection Goals

1. Psychoeducation/family psychoeducation

2. Skills
   - Individual skills
   - Family skills

3. Increase social support and create a network of social support
Suicidality

• Transdiagnostic
  – Self-harm/suicide attempts/suicide risk found across multiple diagnoses
  – Individual may meet criteria for many diagnoses…or none

• Can think about causes, and consequences, at multiple levels, and intervene where most practical (impact)
Family Connections Overview

1. 12 weekly sessions, about 2 hours each
2. Intensive weekend
3. Split/two weekends

Led by trained family members and/or professionals, in the community, typically outside the mental health system

Free/no cost to participate: improves access

Widely available in U.S. & other countries
Research Support

5 published studies on Family Connections, with more on the way, all with similar results:

*Significant improvements for family members*
Example of FC Outcomes

Study 1: Hoffman, Fruzzetti, Buteau et al., 2005
Changes in Grief

Texas Grief Instrument

Pre
Post
Followup
Changes in Distress/Depression

![Bar chart showing changes in BDI scores across Pre, Post, and Follow up](chart.png)
Changes in Burden Experienced
Changes in Mastery/Empowerment

Pre
Post
Follow up

(C) Alan E. Fruzzetti 2018
Focus: the social context of emotion dysregulation
Transactional Model: Factors Influence Each Other (Reciprocal)

Individual Emotion
Vulnerability & Dysregulation

Invalidating Responses
Healthy Transactions

Awareness (self, situation)
Primary emotional responses
Lowered emotional arousal
Accurate expression

Awareness, understanding (other)
Lowered emotional arousal
Validating responses
Problematic Transactions

- Judgments, distorted thinking
- Secondary emotional responses
- Emotion dysregulation
- Inaccurate expression

- Defensiveness, judgments
- Anger & emotion dysregulation
- Invalidating responses
Validating vs. Invalidating Responses

Shenk & Fruzzetti, 2011

Stress

Negative Emotional Arousal

Time Periods

Shenk & Fruzzetti, 2011

(C) Alan E. Fruzzetti 2018
Randomized Trial

Helping parents helps their teens.
Teen Rating of Parent Validation

![Graph showing the Teen Rating of Parent Validation over two time points (Time 1 and Time 2). The graph compares PSG and Waitlist groups with a significant difference indicated by *p<.05. N=38, *p<.05.

Payne & Fruzzetti, in review

(C) Alan E. Fruzzetti 2018
Teen Rating of Parent Invalidation

![Graph showing the change in teen rating of parent invalidation from Time 1 to Time 2 for two groups: PSG and Waitlist. The graph indicates a decrease in rating for both groups over time.]

- Time 1: PSG (green) and Waitlist (yellow) ratings are higher compared to Time 2.
- Time 2: Both groups show a decrease in rating, with the Waitlist group having a slightly lower rating compared to the PSG group.

N=38

Payne & Fruzzetti, in review

(C) Alan E. Fruzzetti 2018
Teen: Parent Emotional Availability

Payne & Fruzzetti, in review

N=49, *p<.05

(C) Alan E. Fruzzetti 2018
Difficulties with Emotion Regulation

Payne & Fruzzetti, in review

N=78, *p<.05

(c) Alan E. Fruzzetti 2018
And…

- Parent improvements – increasing validating & decreasing invalidating responses – had a big impact on their adolescents:
  - Improvements in teen emotion regulation
  - Improvements in teen depression
Emotion Dysregulation

- Low Self-Esteem
- Problems in Relationships
- Anxiety About Emotion & Dysregulation
- Fears of Abandonment
- Attempts to Avoid or Numb
- Self-Judgments
- Problems Thinking & Problem-Solving
- Impulsive Behaviors
Conclusions

• Think transactionally:
  – Parents need help, and what is good for parents is typically helpful to their teens

• Transdiagnostic factors to consider:
  – Emotion regulation vs. dysregulation
  – Validating vs. invalidating responses

• Likely to be other important factors

• Regardless...include parents, and other loved ones, in treatment, or other programs

• Make access easy
References


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