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SAMHSA
Substance Abuse and Mental Health
Services Administration

Dr. Richard McKeon

Chief, Suicide Prevention Branch

SAMHSA, CMHS
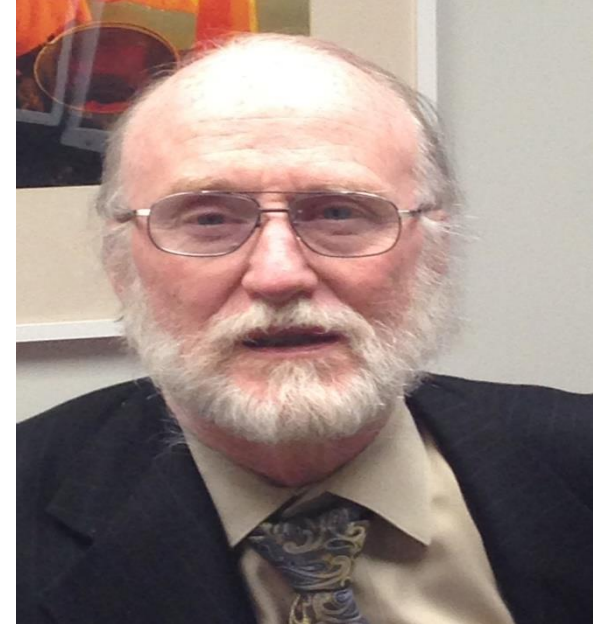
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Thank you.

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)

SAMHSA
Substance Abuse and Mental Health
Services Administration

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.

Overlapping communities

- 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

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- "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.

HIPAA: Excluding Families

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 interferes with his judgment, self-interest

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.

HIPAA CLARIFIED

- 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."

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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 Disclosure of Info to Families

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.

http://www.gencourt.state.nh.us/rsa/html/X/135-C/135-C-19-a.htm

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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.

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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.

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Safety Planning

- Person centered – engage the individual in evelopment 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

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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://training.sprc.org/index.php

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

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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

Questions for Providers

Do you believe professionally that my family member is ready to leave the hospital?

Why did you make the decision(s) that you did about my family member's care or treatment?

Is there a follow-up appointment scheduled? Can it be moved to an earlier date?

What is my role as a family member in the safety plan?

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?

National Suicide Prevention Lifeline:
After an Attempt

A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Questions for Families to ask their loved one

Do you feel safe to leave the hospital, and are you comfortable with the discharge plan?

How is your relationship with your doctor, and when is your next appointment?

What has changed since your suicidal feelings or actions began?

What else can I/we do to help you after you leave the emergency department?

Will you agree to talk with me/us if your suicidal feelings return? If not, is there someone else you can talk to?

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Sample Check List

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:

Circles of Support: Communication Checklist

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What Can Postvention Teach Us About Engaging Families of Those at Risk?

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I believe in you.

Resources

- NAMI Support Groups/Educational Programs www.nami.org
- NAMI NH Connect Suicide Prevention program www.theconnectprogram.org
- Lethal Means Restriction: Suicide Prevention Resource Center: https://www.sprc.org/comprehensive-approach/reduce-means
- After An Attempt: https://www.sprc.org/resources-programs/after-attempt-emotional-impact-suicide-attempt-families
- National Suicide Prevention Lifeline 1-800-273-8255 https://suicidepreventionlifeline.org/

Ken Norton

NAMI NH

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Caring for persons at risk of suicide

Rajeev Ramchand

Main Points
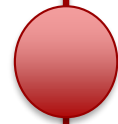
- Mental health problems increase risk for suicide
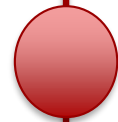
- Caring for someone with mental health problems can be stressful
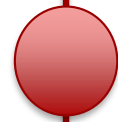
- Some suicide prevention strategies may lack relevance for families of persons with chronic risk
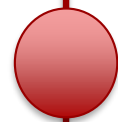
- Supporting families of persons with mental health problems may save lives

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Elevated suicide risk among persons with mental disorders

Mental Health Condition	SMR
Schizophrenia	12.9 (0.7-174.3)
Depression	19.7 (12.2-32.0)
Borderline personality disorder	45.1 (29.0-61.3)
Bipolar disorder	17.1 (9.8-29.5)
Anorexia nervosa (women)	31.0 (21.0-44.0)
Bulimia nervosa (women)	7.5 (1.6-11.6)

Reference: Chesney, Goodwin, Fazel.2014. Risk of all-cause and suicide mortality in mental disorders: a meta-review. World Psychiatry, 13(2), 153-160.

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

XIII. Significant Relationship

		Source of Information*
Was s/he in a significant relationship at the time of death?	o No o Yes	
*If s/he **was** in a significant relationship*		
Was this relationship **on the verge of breaking up or threatened with breaking up?**	o No o Yes	
Was anyone in the relationship **pregnant or had had a recent abortion?**	o No o 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	o No o 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
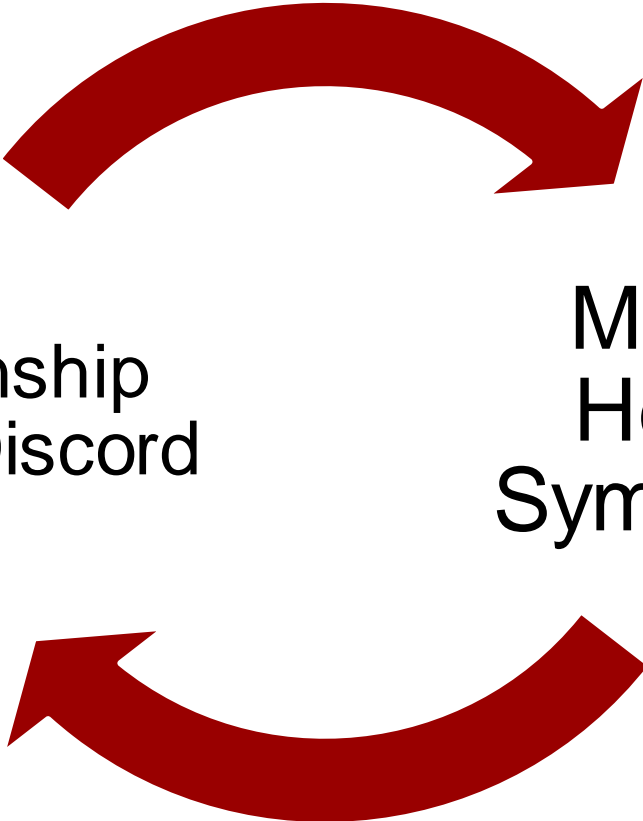
National survey of caregivers
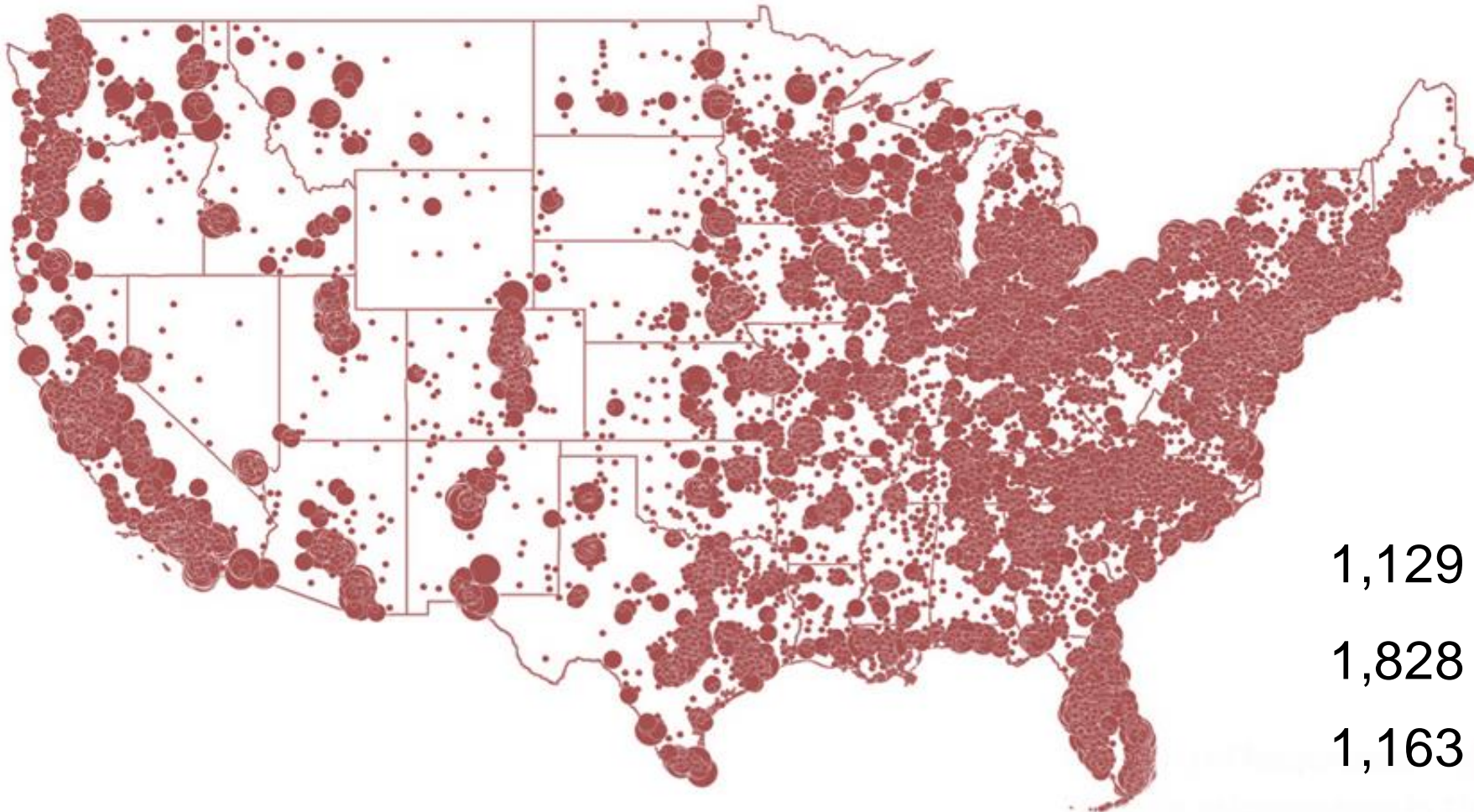
Sample
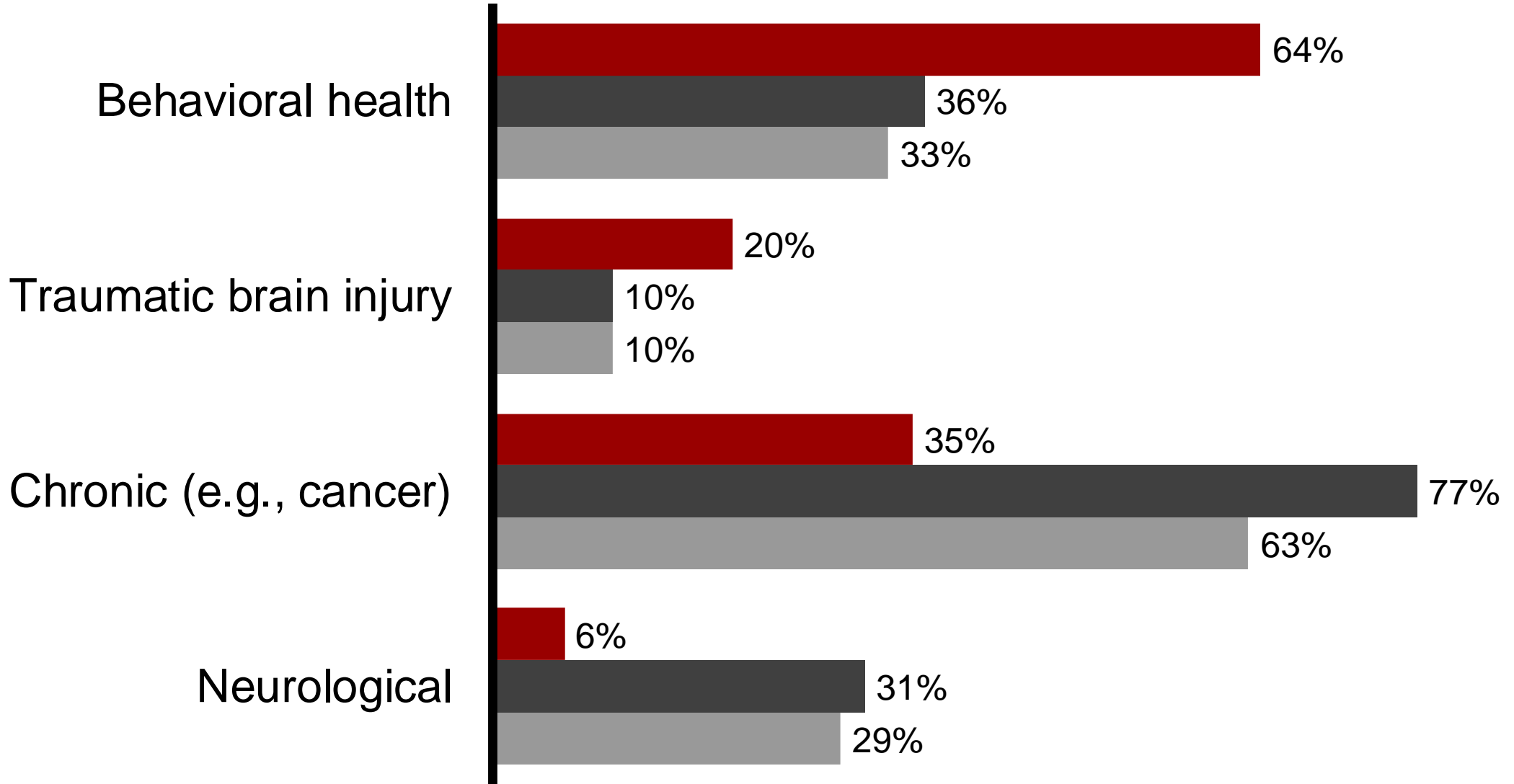
1,129 military caregivers
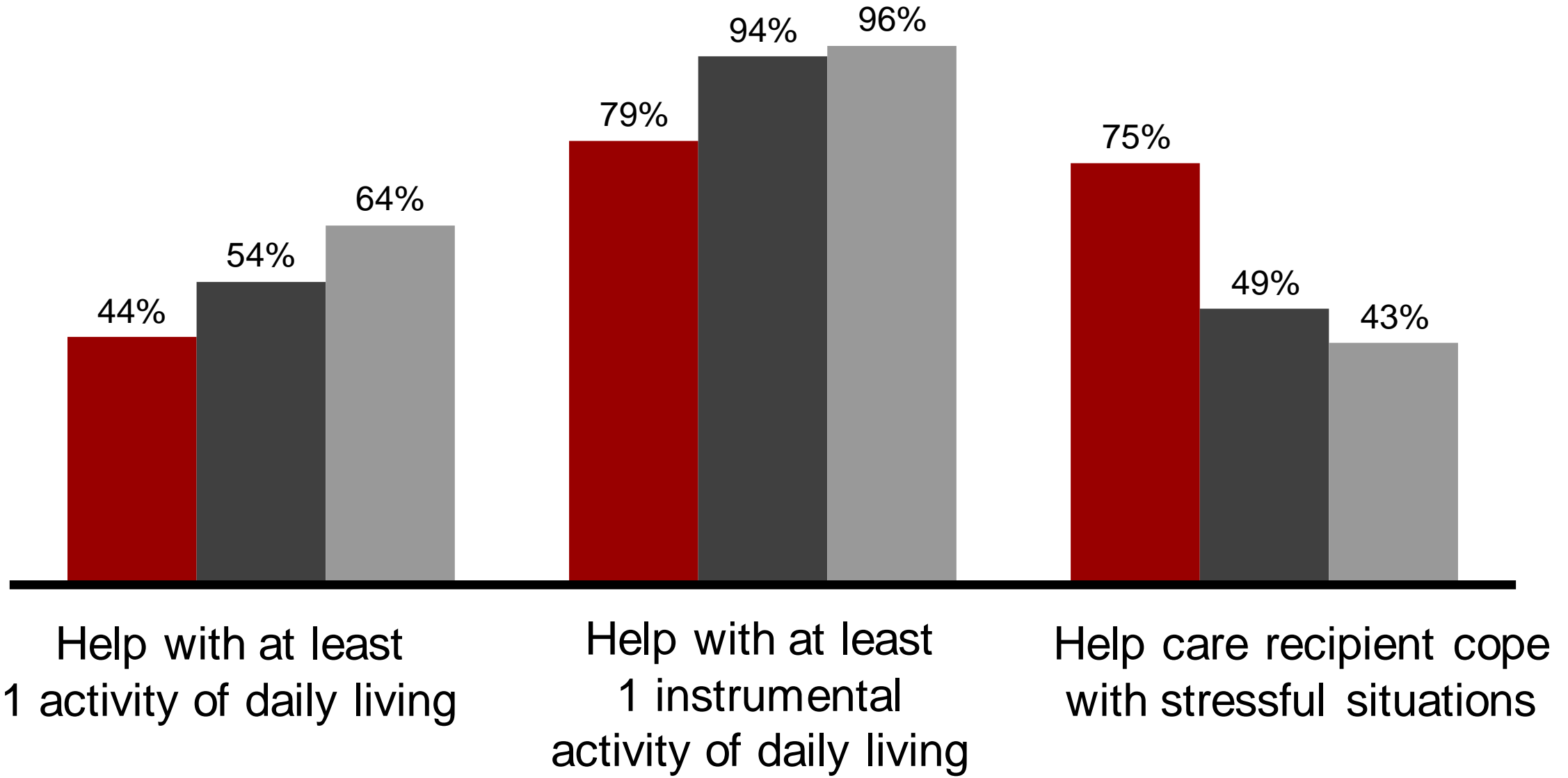
1,828 civilian caregivers

1,163 non-caregivers

Reference: Ramchand, Tanielian, et al., 2014. Hidden Heroes: America's Military Caregivers. Santa Monica, CA: RAND Corporation.
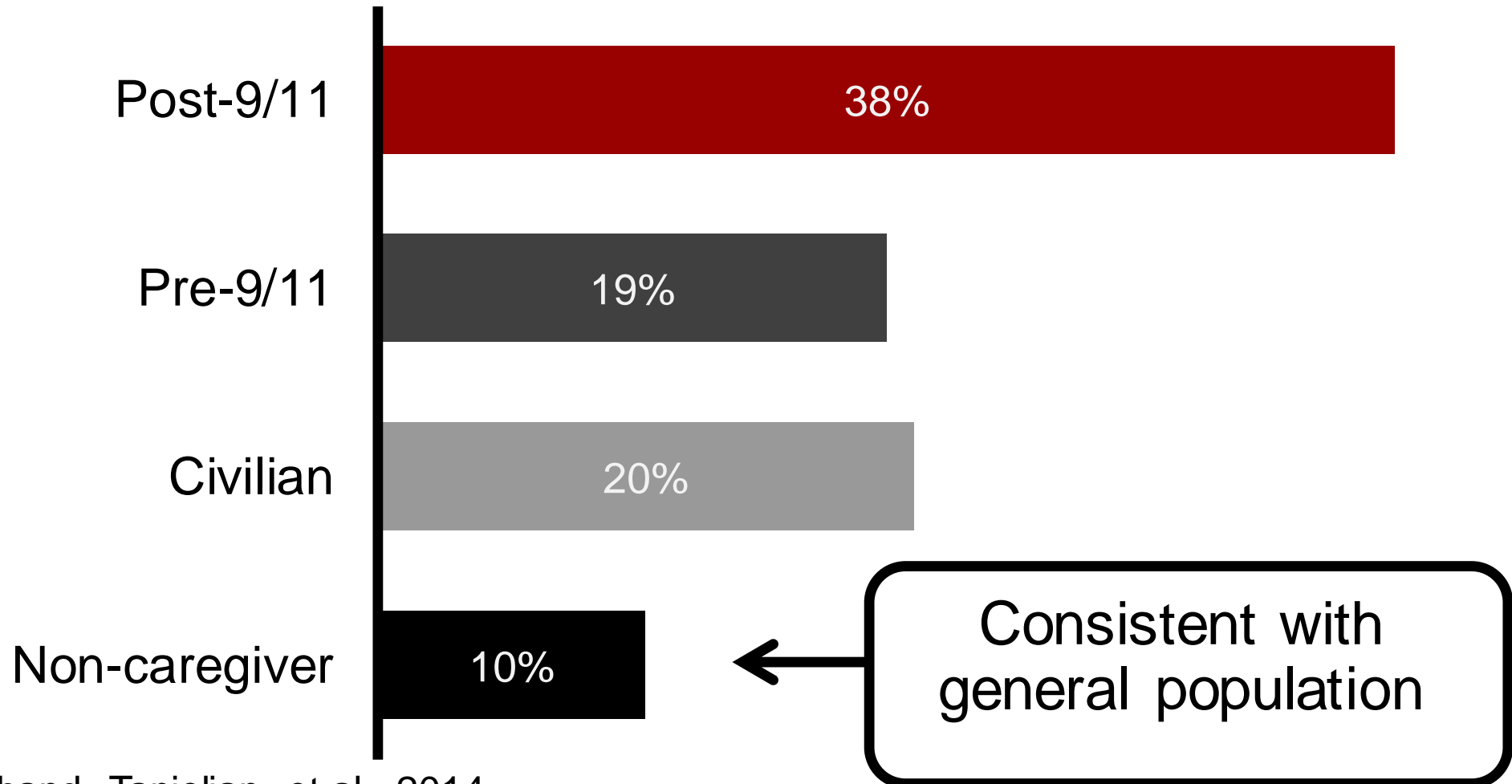
9% of U.S. adults are caregivers

Reference: Ramchand, Tanielian, et al., 2014.

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Reference: Ramchand, Tanielian, et al., 2014.

Post-9/11 **Pre-9/11** **Civilian**

Help with at least
1 activity of daily living — Post-9/11: 44%, Pre-9/11: 54%, Civilian: 64%

Help with at least
1 instrumental
activity of daily living — Post-9/11: 79%, Pre-9/11: 94%, Civilian: 96%

Help care recipient cope
with stressful situations — Post-9/11: 75%, Pre-9/11: 49%, Civilian: 43%

Reference: Ramchand, Tanielian, et al., 2014.

% meeting criteria for probable depression

Post-9/11 — 38%

Pre-9/11 — 19%

Civilian — 20%

Non-caregiver — 10%

Consistent with general population

Reference: Ramchand, Tanielian, et al., 2014.

Tested predictors of major depression

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

Reference: Ramchand, Tanielian, et al., 2014.

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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

Reference: Ramchand, Tanielian, et al., 2014.

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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
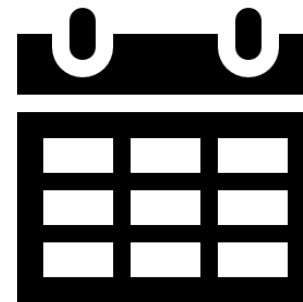
Warning signs may not indicate acute risk

Many suicide decedents have a history of recent mental health contact

| Healthcare visit in 4 weeks prior to suicide death	%
Any	49.9
Any mental health (MH)	23.8
Inpatient MH	4.7
Inpatient chemical dependency (CD)	0.5
Emergency Dept. MH	7.5
Emergency Dept. CD	1.4
Outpatient MH	14.6
Outpatient CD	0.6
Primary Care MH	8.0
Primary Care CD	0.7

Reference: Ahmedani et al., 2014. Health care contacts in the year before suicide death. J Gen Intern Med, 29(6), 870-877.

	7 days before death	30 days before death	New Onset
Ideation	10	11	3
Substance use	11	12	1
Purposelessness	10	14	4
Anxiety, etc.	11	15	4
Feeling Trapped	10	12	4
Hopelessness	10	13	4
Withdrawal	11	12	2
Anger, etc.	8	9	2
Recklessness	7	10	3
Mood changes	11	14	3
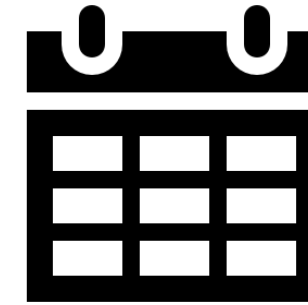
Warning signs may not indicate acute risk

Among 17 suicides in New Orleans in 2016

Reference: Ramchand et al., 2017. Opportunities to intervene? "Warning signs" for suicide in the days before dying. Death Stud, 41(6), 368-375.

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

Reference: Dixon et al., 2011. Outcomes of a randomized study of a peer-taught Family-to-Family Education Program for mental illness. Psychiatric Services, 62(6): 591-597.

Rajeev Ramchand

Ramchand@rand.org

RAND
CORPORATION

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

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE
1811

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):

Psychological
Cognition, emotion, attention

Social
Family, culture, relationships

Biological
Neurobiological, other biological systems
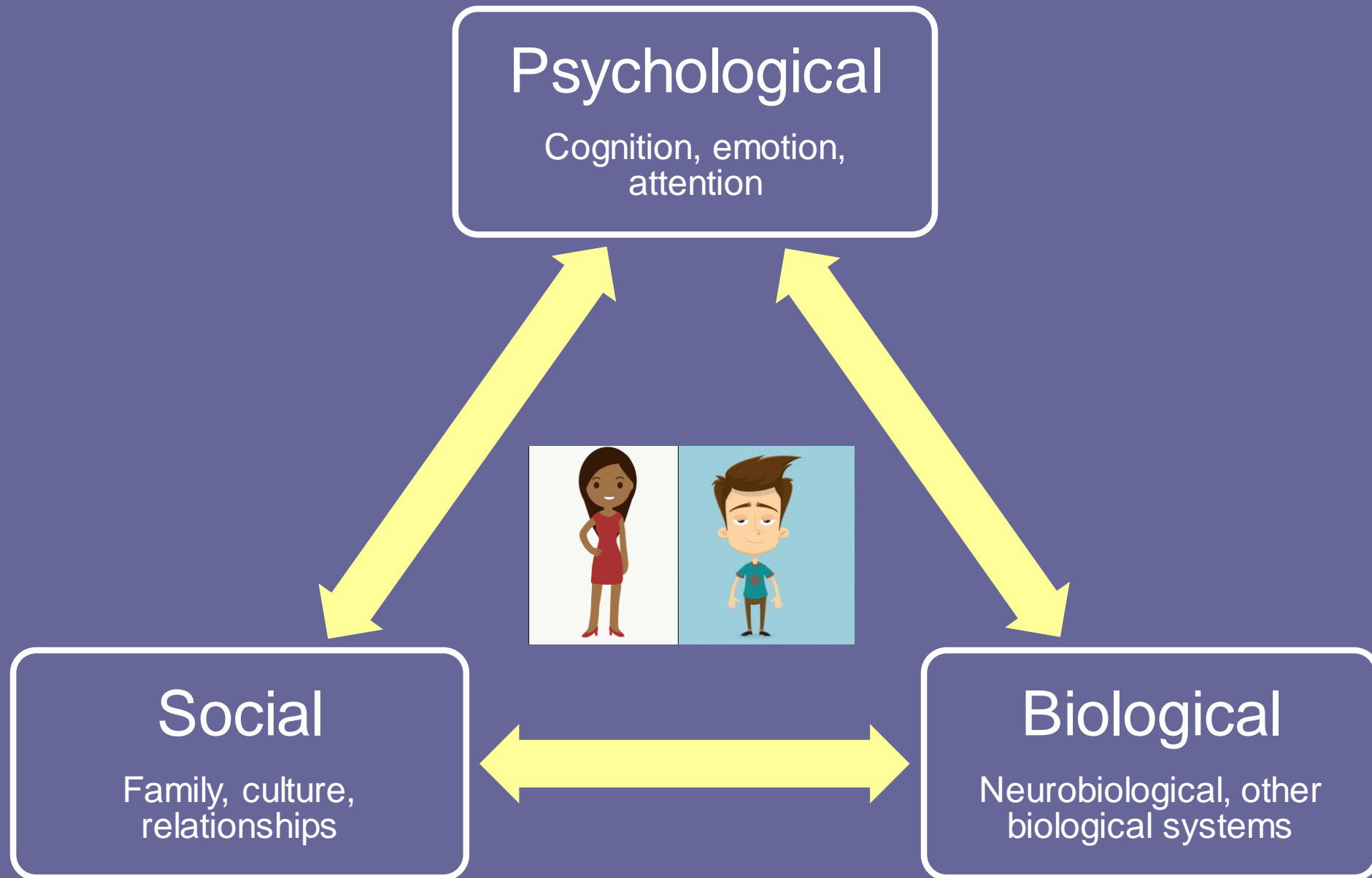
Family Connections Overview

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
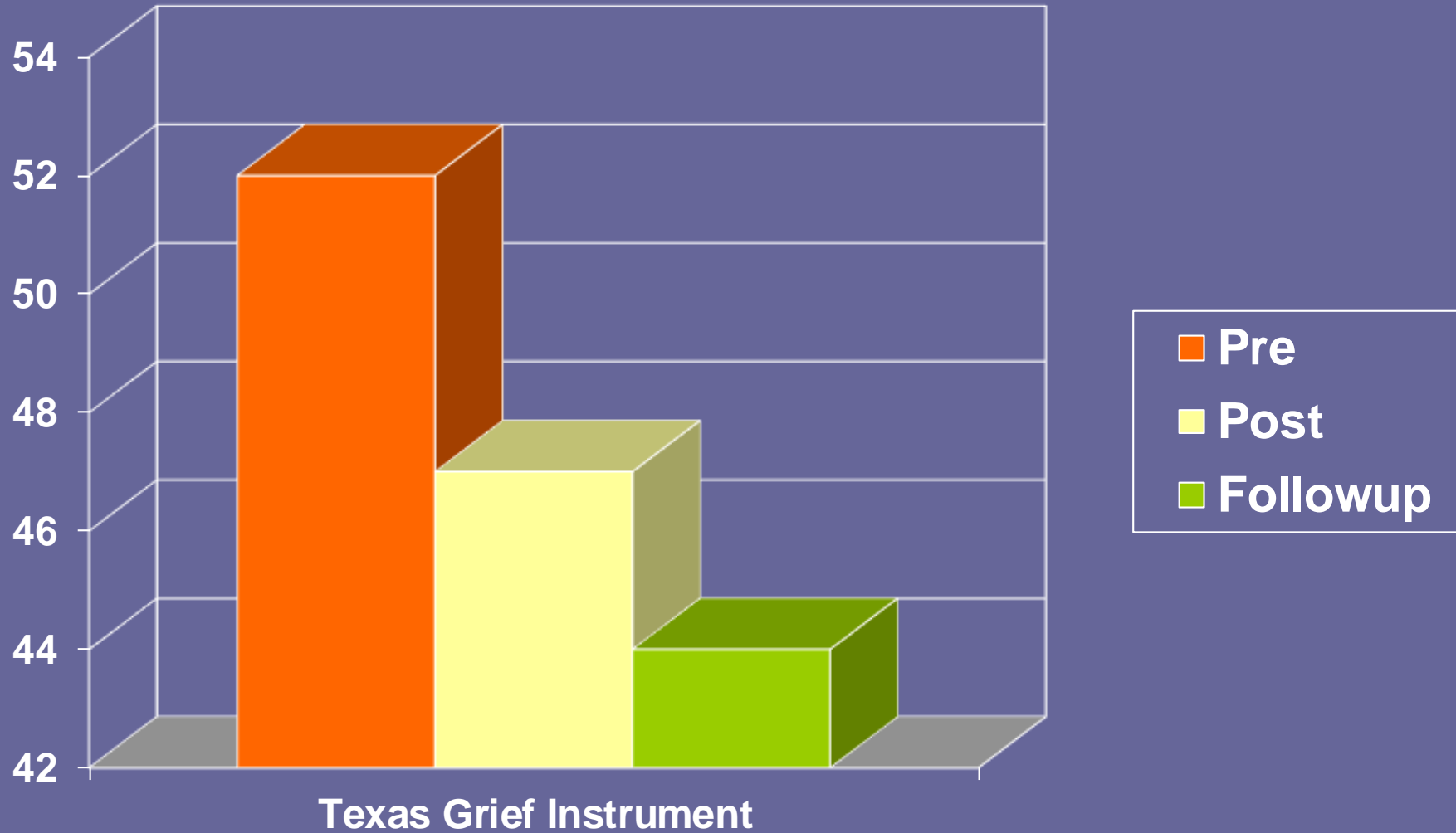
Changes in Distress/Depression

BDI

Legend: Pre, Post, Follow up

61
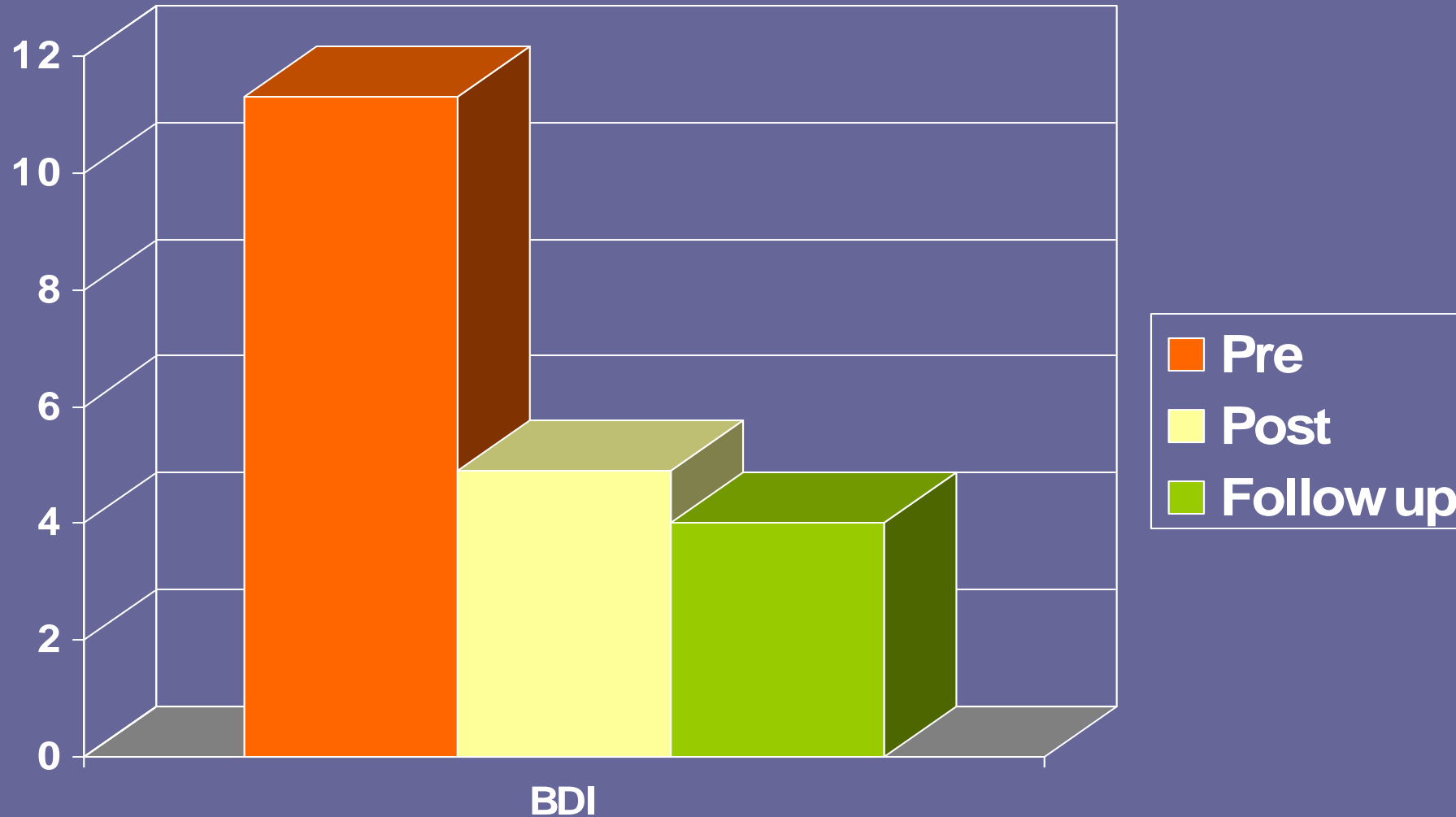
Changes in Burden Experienced

62
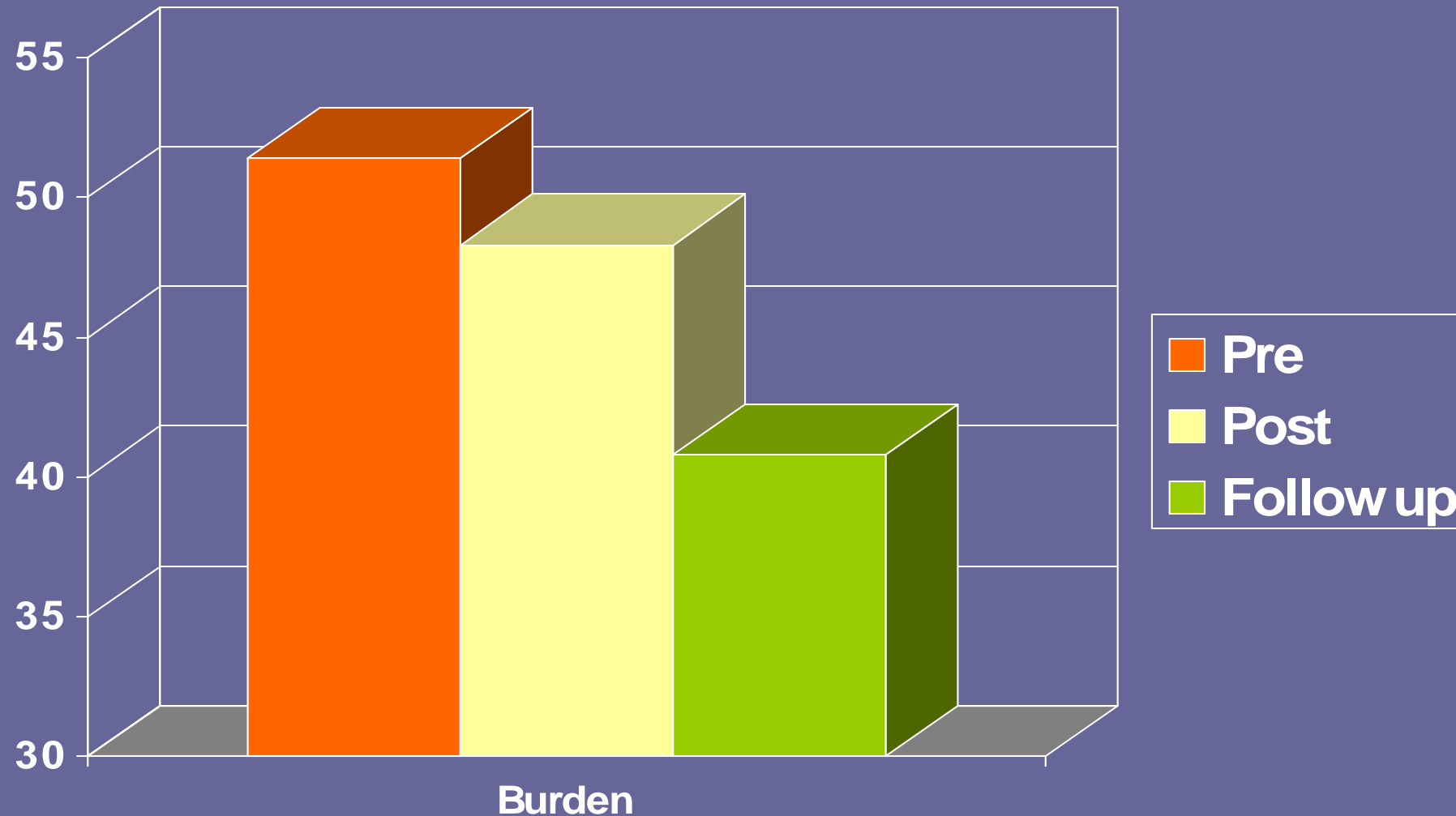
Changes in Mastery/Empowerment

63
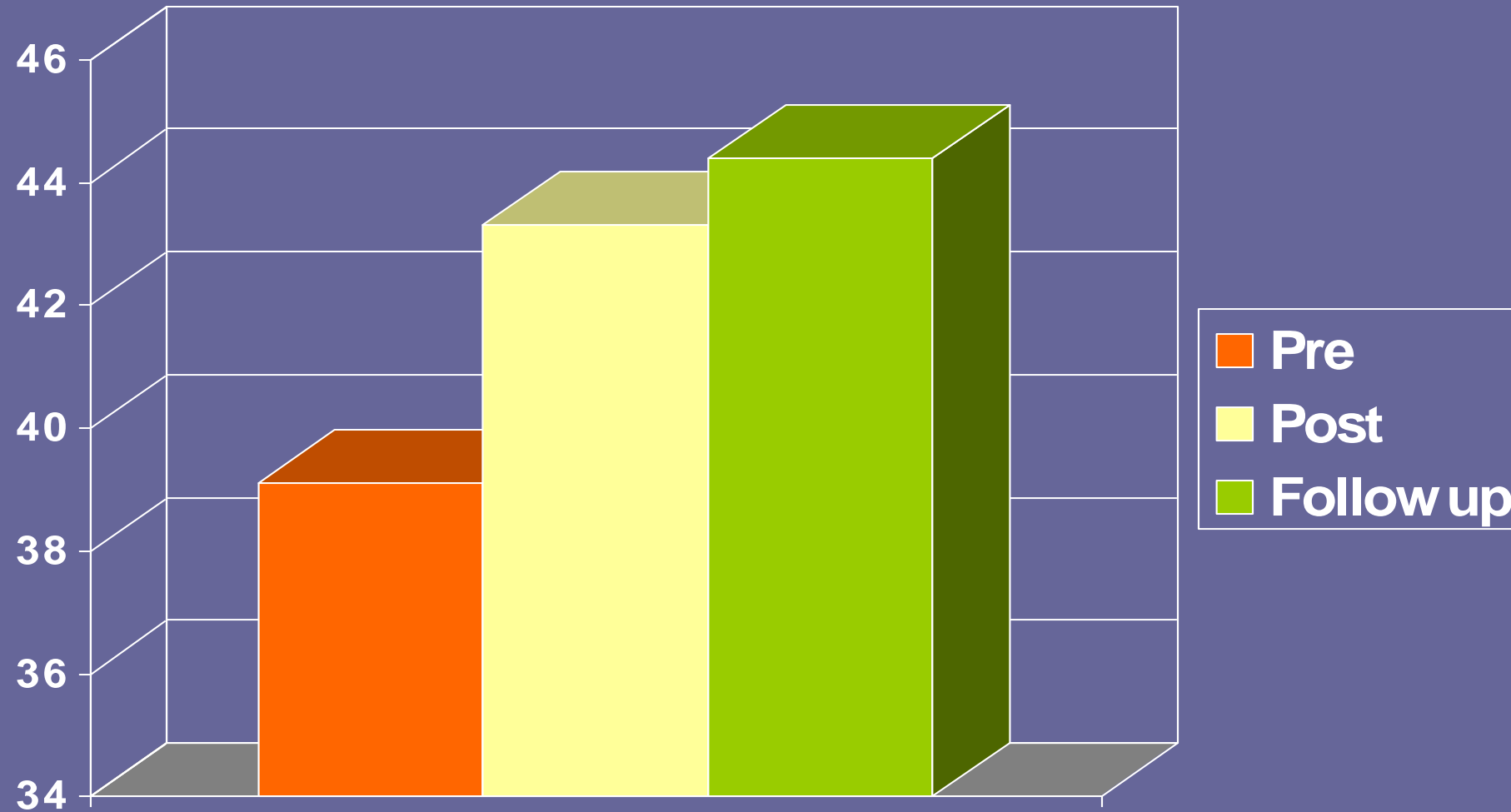
Focus: the social context of emotion dysregulation

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**
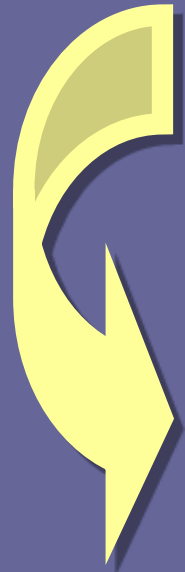
Problematic Transactions

Judgments, distorted thinking
Secondary emotional responses
Emotion dysregulation
Inaccurate expression

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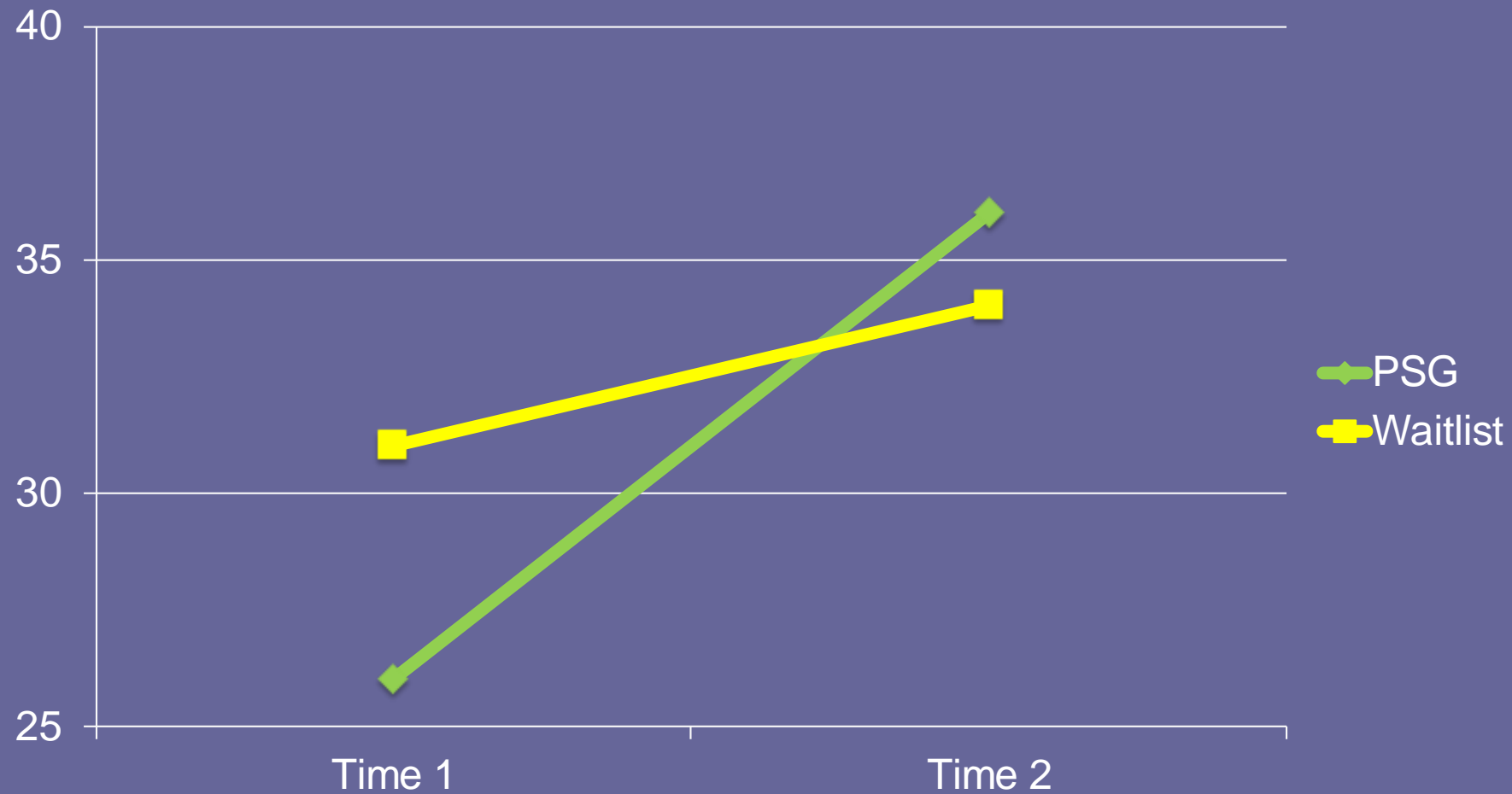
Validating vs. Invalidating Responses

Stress

Negative Emotional Arousal

Time Periods
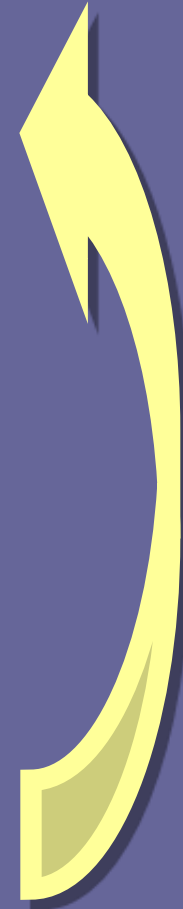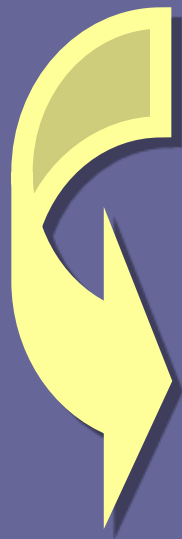
Validation
Invalidation
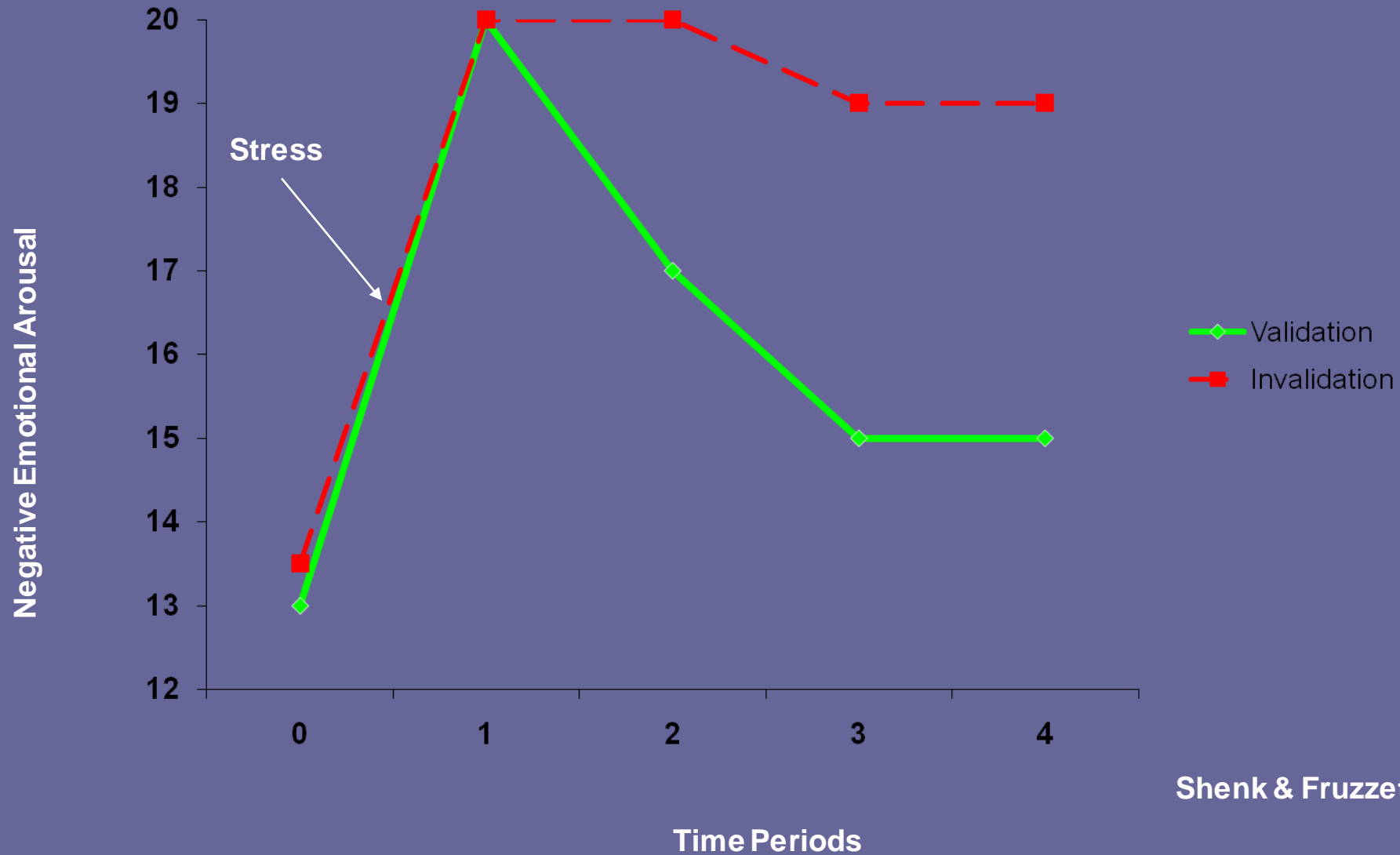
Shenk & Fruzzetti, 2011

Randomized Trial

Helping parents helps their teens.

Teen Rating of Parent Validation
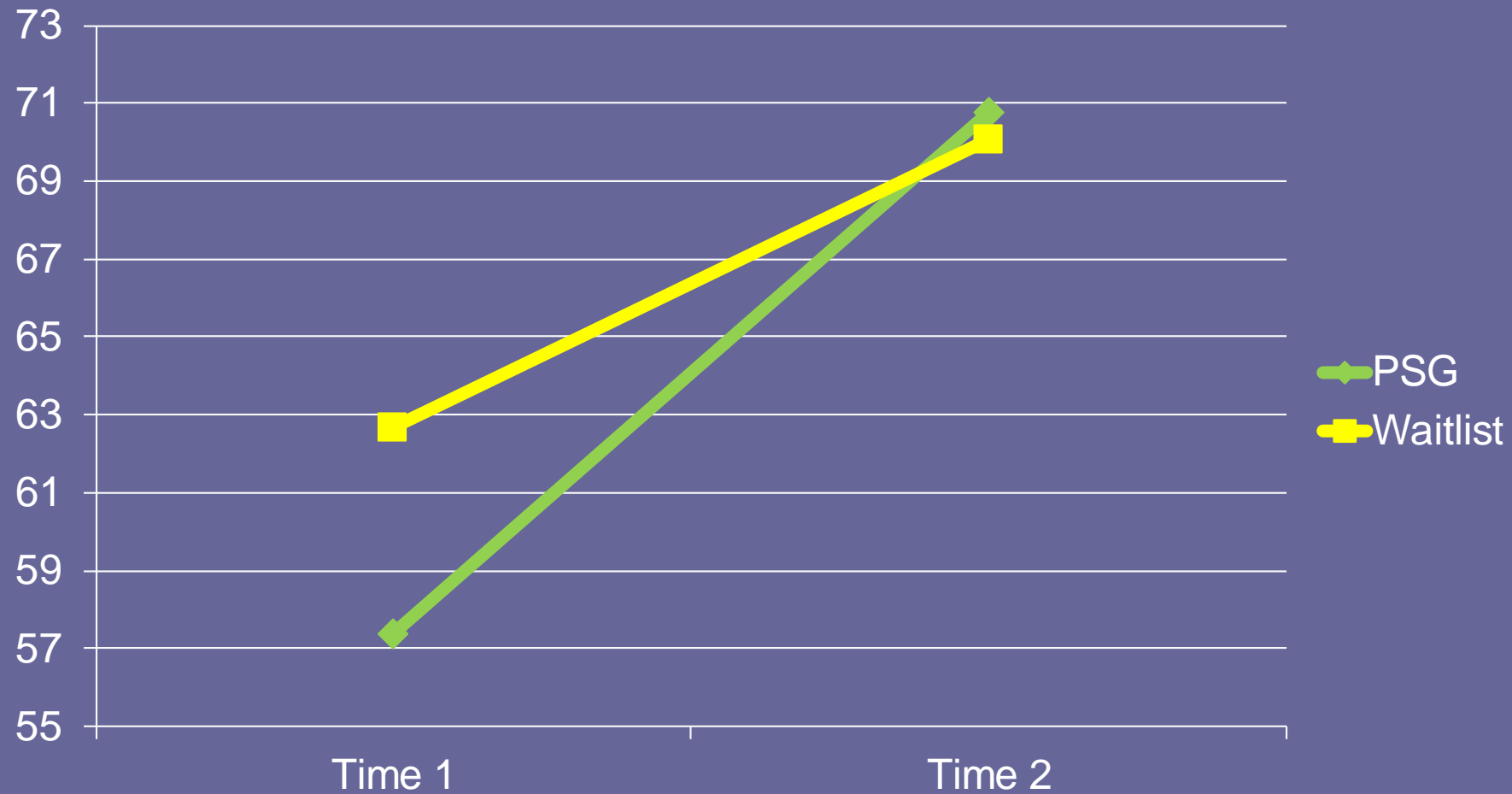
PSG
Waitlist

N=38, *p<.05

Payne & Fruzzetti, in review

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Teen Rating of Parent Invalidation

PSG
Waitlist
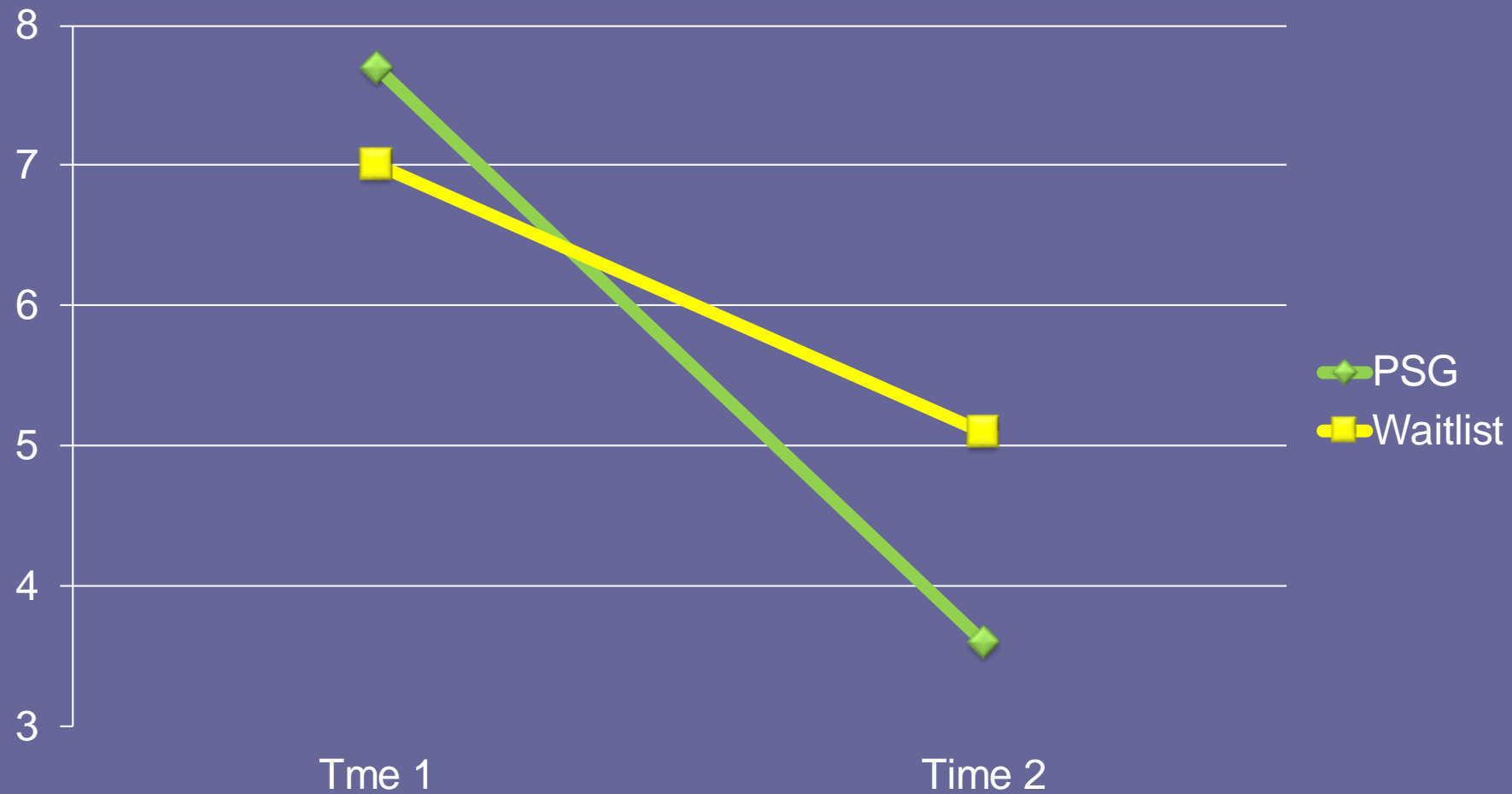
N=38

Payne & Fruzzetti, in review

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Teen: Parent Emotional Availability

N=49,*p<.05

Payne & Fruzzetti, in review

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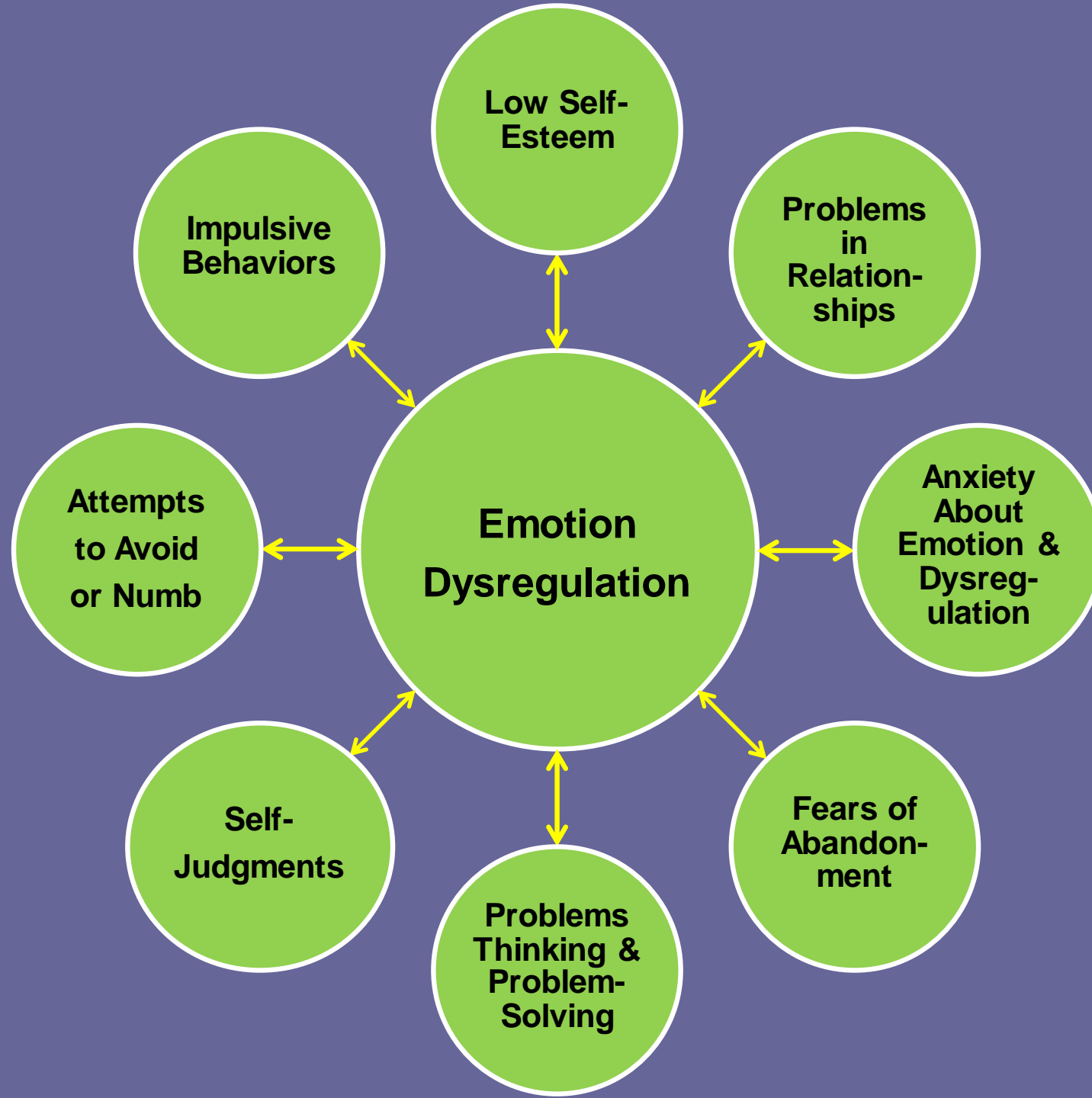# Difficulties with Emotion Regulation
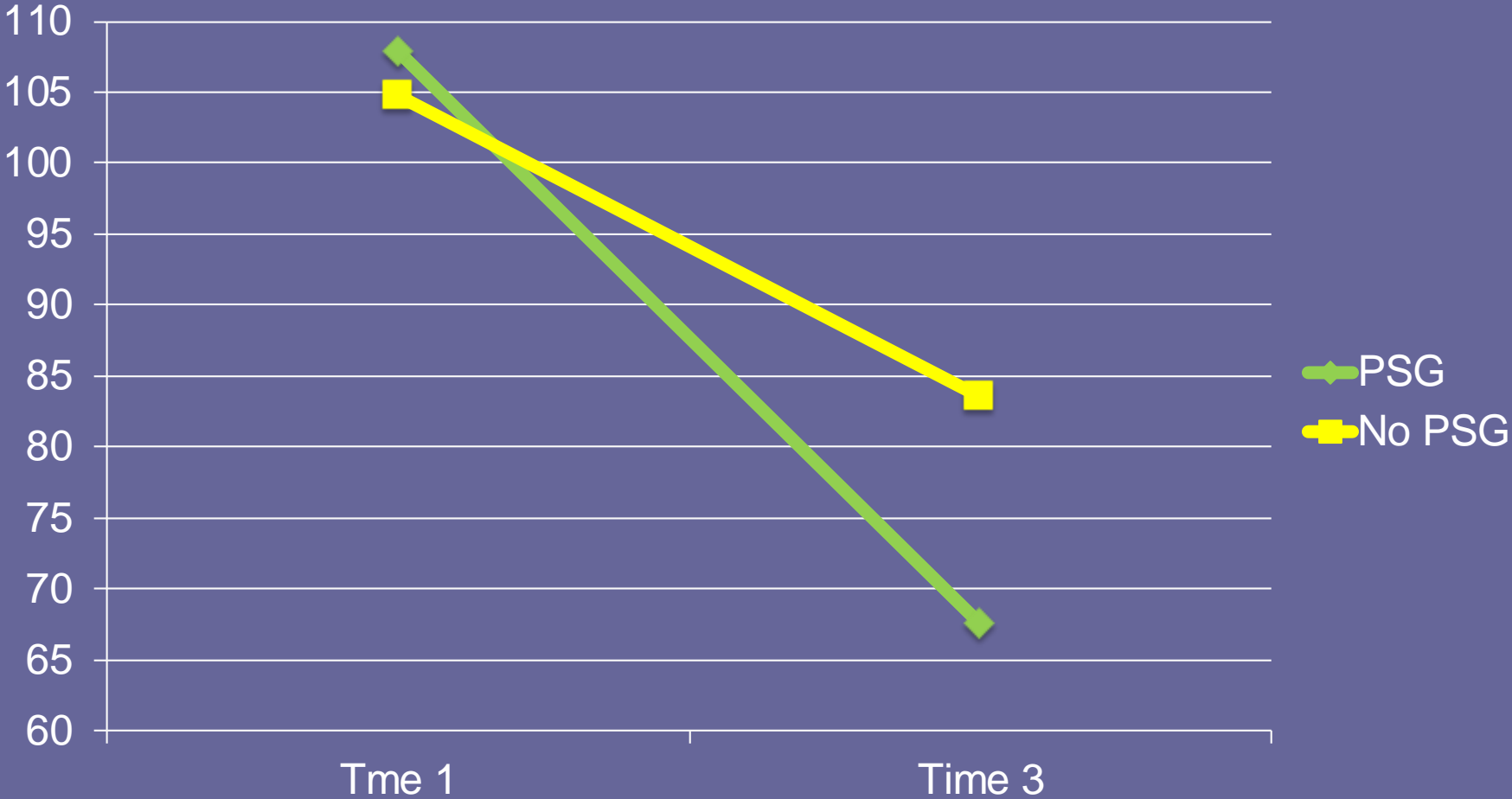
N=78,*p<.05

Payne & Fruzzetti, in review

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And…

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

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**

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