Engaging Family and Supportive Others in Working with Suicidal Individuals

Beth S. Brodsky, Ph.D.
Thomas Jewell, Ph.D.

NYS Suicide Prevention Conference
September 18, 2019 Albany NY
Clinical Learning Collaborative Series II, Session 1
NYASSC Zero Suicide Project

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Beth Brodsky, Ph.D

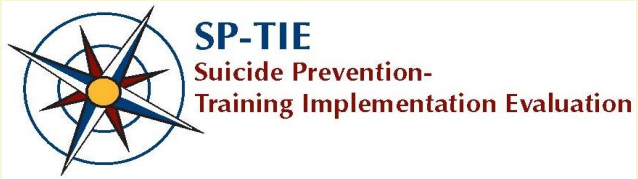
Associate Director, Suicide Prevention, Training Implementation and Evaluation Program, NYSPI

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Tom Jewell, Ph.D

Implementation Specialist and Program Manager, Center for Practice Innovations, NYSPI



Welcome & Introductions

- Welcome and Introductions

Agenda

- Overview of the role of Family engagement in the NYASSC Zero Suicide Assess, Intervene and Monitor Protocols in the various treatment settings: Inpatient, Outpatient, CPEP and SUD
- Engaging individuals and family members regarding family involvement
- Providing psychoeducation about suicide and risk for families
- Additional levels of family involvement
- Break-out groups
- Discussion

Learning Objectives

Participants will learn:

- How to approach people to involve family members and determine the appropriateness of doing so; obtain consent
- How to approach family members to invite them to become involved
- Key aspects of psychoeducation regarding suicidal risk and prevention
- Various ways in which families can play a role in supporting the treatment of a suicidal family member

Rationale for family engagement

- Treating individuals at risk for suicide is stressful and requires a comprehensive approach
- When appropriate, family and friends can provide a safety net for times when high risk individuals are not within the treatment setting
- Family members are also affected
- Family members can be a source of support - we can work together
- Explicit guidelines for working with and engaging families are not a usual feature of clinical training

Role of family engagement in NYASSC protocols

Patient and Family Engagement

(Throughout episode of care)

ASSESS

UNIVERSAL SUICIDE SCREENING
All patients screened with the C-SSRS SCREEN version

COMPREHENSIVE SUICIDE RISK ASSESSMENT including Risk & Protective Factors and Access to Lethal Means

INTERVENE

MONITOR

Suicide Care Management Plan

UNIVERSAL PRECAUTIONS
Psychoeducation regarding suicide warning signs, Lifeline and GOT5 Crisis Text Line numbers

TREATMENT PLAN
with goals and objectives that specifically target suicide, including a plan for

the identified foreseeable change**S**

Stanley-Brown Safety Plan
(with lethal means reduction counseling)

STRUCTURED FOLLOW-UP PHONE CALL
Within 48-72 Hours of discharge

OUTPATIENT APPOINTMENT
Scheduled within 5 days of discharge

WARM HAND-OFF OF RECORDS
Forward records prior to first visit, including discharge summary including 2 foreseeable changes and safety plan

CARING CONTACTS
Send within 2 weeks and 3 months of inpatient discharge

Note: Items in BLUE represent procedures for all patients, and items in PINK for those assessed to be at higher risk

Common practitioners' concerns

Clinicians concerns about working with families

- Clinicians don't feel trained
- Preconception that family is the cause of the problem
- Working with families increases uncertainty
- Involving families might make things worse

Reassurance – you don't have to be a trained family expert to incorporate some of these strategies

Conversations and consent

"BIG PICTURE" - People can and should be engaged to explore whether they wish to give permission to family/friend involvement.

The process:

- Identify supports in the person's network
- Explore involvement of others in matter-of-fact manner
- Discuss the pros and cons
- Explore concerns
- Ask "the question" (Is it okay to…?)
- If the person refuses, explore the reasons why. Possibly re-visit at a later time.

Why is Shared Decision Making important?

- In many situations, there is no single “right” health care decision. This is especially true for choices about treatment, for example, when:
  - More than one reasonable option
  - No one option has a clear advantage
  - The possible benefits and harms of each option affect patients differently

Steps to Shared Decision Making

Choice Talk

- Make clear there's a choice to be made
- "Let's work as a team to make a decision that best suits you and your goals and preferences."

Option Talk

- Explain the options / alternatives
- Explore the pros and cons; what's the evidence say?

Decision Talk

- Discuss values; encourage a preference-based decision
- Support the person's and family's decision

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Use Open-ended Questions

What?: What are your concerns?
When?: When could you meet?
How?: How do you feel about this approach?
Why?: Why do you feel this way?

Then use closed ended questions to verify and clarify:

- Are you okay with this approach?
- Do you have any other concerns?
- Is it okay to reach out to the family member you chose?

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Consent not “all or nothing”

Consent can be specific – consent to discuss safety planning but not other information.

Client Consent	
Permission Granted	Permission Denied
“We can discuss suicidality and safety plans with my family members.”	“We cannot discuss the negative things I’ve said about my family to you, the practitioner.”

The specific stigma and shame surrounding suicide can exacerbate lack of willingness to disclose to or involve family members/support systems

Tangible + Concrete Plan – families can often be a part of the plan

SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service _____
   Emergency Services Address_____
   Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

From Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice. 19*, 256–264

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Overview of Safety Planning: 6 Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help to resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means

Families can help remind their loved ones to use the plan, can help recognize warning signs, and be part of steps 3-6

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Challenges and opportunities

Family involvement can make a unique and meaningful contribution – particularly to safety planning and means reduction

It can be challenging to balance the wants/needs of clients and family members

Families may sometimes not feel equipped to become more involved. They may be hesitant to take on too much for safety and safety planning.

Approaching family members

Approaching family members:

- Nonjudgment and empathy
- Understand any limitations re: involvement
- Be aware of fear of possible suicide
- You may see family members at their “worst”

Try to put people at ease. Be calm and clear when speaking. Try not to take anything personally.

Begin assessing (briefly) and partnering with families

Assessing the capacity/willingness of family members to play a role

- Recognize/praise family for being there
- Acknowledge the situation and stress
- Suggest possibilities using Shared Decision (includes the possibility of being a part of the safety plan)
- Discuss each option

Impact of family involvement

Talk with family about any concerns they may have. Listen and explore.

Consider the impact of family involvement on everyone

- Can family make decisions right now?
- Should the initial interaction be limited to basic psychoeducation?
- Does family have the time? Transportation?
- Does everyone wish to partner together toward a common goal? Or not?

Various ways to be involved

Explain the various levels of family involvement that are possible regarding suicide prevention

- Basic psychoeducation and information
- Developing and being part of person's safety plan
- Monitoring warning signs
- Encouraging treatment engagement
- Attending treatment meetings
- Reaching out (in specific ways) during times of increased risk
- Assisting with means reduction

No one-size shoe fits all!

Psychoeducation: Suicide risk is fluctuating

It comes and it goes

It spikes, then subsides

It can range in severity from mild to severe

Implication: Families can learn to know the warning signs of increasing risk

Common warning signs

Feelings (sadness, depression, hopelessness)

Actions (isolating, withdrawing, impulsiveness)

Changes (eating, sleeping and work behaviors)

Talking (talking about suicide or about not being around anymore)

Situations (relationship problems, job loss, medical diagnosis)

Debunking common myths about suicide

There is nothing we can do to stop a suicidal person

People who talk about suicide just want attention

Only trained professionals can help someone who is suicidal

It doesn't help to restrict access to lethal means

Implication: Families - and family involvement - can make a difference!

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Universal precautions and resources

Recognize the fluctuating nature of suicide

Understand the warning signs

Know the resources to call and when to call

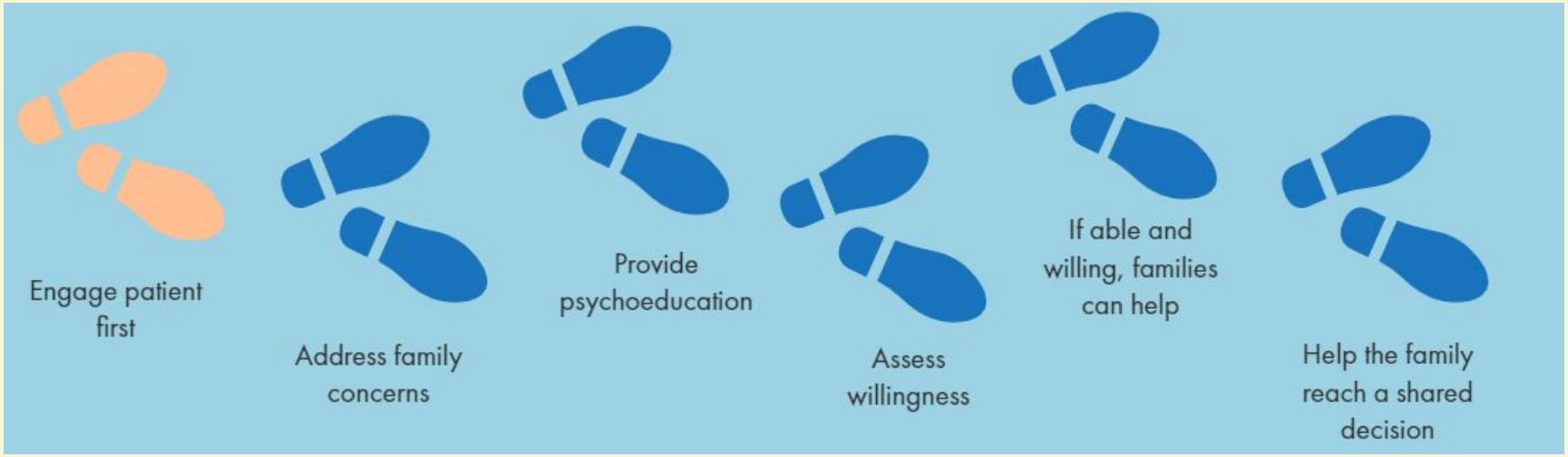
National Suicide Prevention Hotline (800-273-8255)

Local crisis hotline

Further levels of involvement

- After starting with basic psychoeducation, the person and family may consider a higher level of involvement such as:
  - monitoring risk
  - noticing warning signs
  - being a part of the patient's safety plan including means reduction
  - encourage engagement
  - contact with mental health professionals, make contact with professionals at times of increased risk – clinician provides support
  - encourage family to get their own source of support (therapy, NAMI, support groups)
- Talk about how to guide families in playing a "gatekeeper" role – to know when to bring to ED vs. handling things at home, engaging with outpatient providers
- This is not a family therapy situation
- Take care of self in order to take care of loved ones

Summary of steps to engage families



Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Summary

- Families can be a potential source of support in the treatment, and can feel supported by contact with treaters
- Families are pain just like the suicidal individual. Families need guidance and support, empathy and understanding
- People are often reluctant to include family – sometimes for good reason, other times need encouragement to seek help
- Clinicians are often reluctant to include family – don't feel equipped, feel it is an extra burden, sees family as a source of stress rather than support
- When families are not in the position to be involved, it is important to identify others in the patient's environment (friends) if possible.
- Clinicians should be prepared to engage families when appropriate, and to the degree appropriate to the individual situation, in various mental heal

Break Out Groups for Role Play

CPEP: Doug and his friend Danny

Inpatient: Alan and his wife Andrea

Outpatient: Lisa and her parents

Guidelines for Role Play

Inpatient: Address Alan's ambivalence regarding involving his wife Andrea in his discharge plan. Address Andrea's concerns about Alan coming home and explore possibilities for her involvement, such as being part of his safety plan, helping reduce access to means, helping him engage in outpatient treatment

Outpatient: Imagine a family meeting in which therapist explores willingness of Lisa's parents to be involved in her treatment, and Lisa's willingness to have them involved. Explore pros and cons of them either coming to treatment sessions at times, monitoring her warning signs, helping her get to sessions. How to balance validating Lisa as well as her parents' experience

CPEP: Two scenarios - Doug is hospitalized or Doug is discharged. How does a CPEP social worker engage Doug's friend Danny during a short, one-time interaction. Perhaps being a part of his safety plan, visiting him in the hospital, making sure he gets to his outpatient appt?

Other areas to discuss/role play: Psychoeducation regarding fluctuating nature of suicidal risk, warning signs, myths

Possible role play/discussion themes

Consent process using shared decision making, open ended questions, collaborative

Addressing ambivalence about involving family

Addressing family concerns and balancing them with patient's concerns

Psychoeducation

Assessing willingness for higher levels of involvement

Explore possible levels of involvement

safety plan, means reduction, monitoring warning signs, attending sessions, calling treatment provider, facilitating treatment attendance and adherence

Questions?

Let’s talk more

Contact Information

Beth Brodsky, PhD

Beth.Brodsky@nyspi.columbia.edu

Thomas Jewell, PhD

Thomas.Jewell@nyspi.Columbia.edu

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation