Innovations in Clinical Assessment and Treatment of Suicide Risk

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Texas Suicide Prevention Symposium:
Coming Together to Care 2015
Houston, Texas
August 19, 2015

State of the art early on…

- Psychological autopsy studies of completed suicides
- Establishing the key role of psychopathology and suicide
- The epidemiology of suicide and suicidal behaviors
- Youth suicide focus (Secretary's Task Force)
- The birth of the suicide survivor movement
- Routine use of lengthy inpatient hospitalization
- Routine use of "no-suicide" contracts—"commitment to safety"

Today the field is exploding…

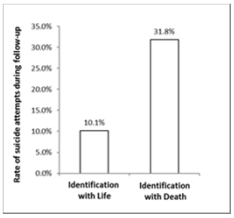
- Suicide research is increasing exponentially
- VA and DOD are spending multi-millions on suicide prevention
- State legislation *requiring* suicide-specific training for mental health professionals continuing education (e.g., Washington)
- The potential impact of the lived-experience and attempt survivor movement
- National Action Alliance (Clinical Care Task Force → "Zero Suicide" movement to raise the standard of clinical care)
- An increasing emphasis on evidence-based treatments, but…

Innovation in Suicide Assessments

- "Traditional" clinical approaches
  - Clinical interviewing
  - Risk assessment tools
- Stratification of suicidal risk—typologies of suicidal states
  - Quantitative approaches
  - Qualitative approaches
- Indirect assessments ("occult" suicidal risk)
  - Risk assessment tools
  - Objective assessment
- Indirect assessments of risk through measures of CNS arousal
  - Eye-blink startle response
  - Autonomic nervous system activation

Suicide IAT

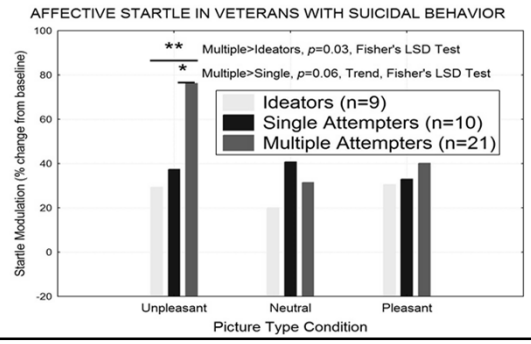
Does S-IAT add incrementally to prediction of future suicide attempts?



*Those with death ID were more likely to make an attempt after discharge

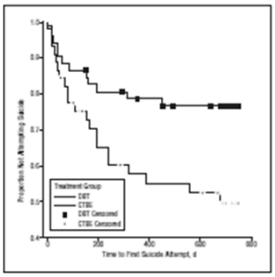
*IAT added incrementally to prediction of SA beyond diagnosis, clinician, patient, and SSI (OR=5.9, $p<.05$)

Affective Startle and Suicide Risk (PI: Goodman/Hazlett)



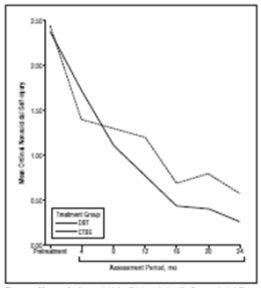
Innovation in Suicide Treatments

- Suicide-specific treatments
- Brief Interventions
- Alternative interventions and modalities
- The increasing role of technology
- Non-demand caring contact
- Matching different suicide-specific interventions and doses of care to different suicidal states across different settings
- ACA: Least restrictive, evidence-based, and cost-effective



DBT's Impact on Suicide Attempt Behavior

DBT's impact on Non-Suicidal Self-Injury Behavior

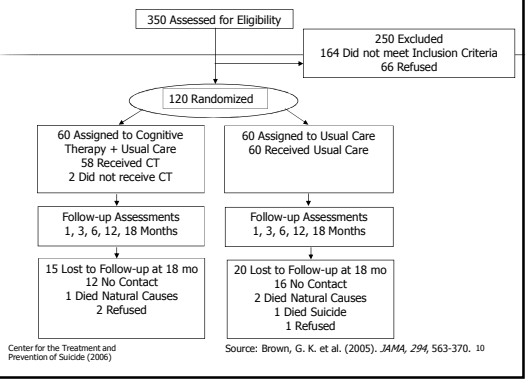


Resources for Dialectical Behavior Therapy

Source Texts:
http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/linehan.htm&dir=pp/pd

Training Website: http://behavioraltech.org/index.cfm

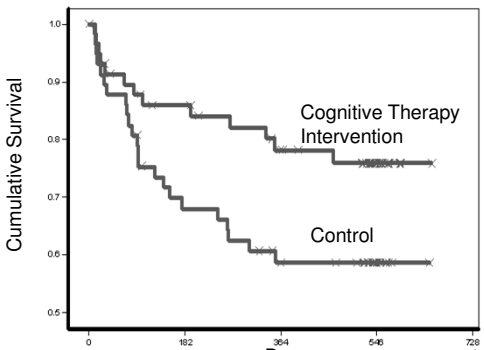
Participant Flow



Center for the Treatment and Prevention of Suicide (2006)

Source: Brown, G. K. et al. (2005). *JAMA, 294,* 563-370. 10

Survival Functions for Repeat Suicide Attempt by Study Condition



Source: Brown, G. K. et al. (2005). *JAMA, 294,* 563-370.

*$p < .05$

Post Admission Cognitive Therapy (PACT)

Individual Therapy – 6 TOTAL Sessions: 90 Minutes Each

Treatment Phase	Therapeutic Goals
Phase I Sessions 1 and 2	❑ Build Therapeutic Alliance ❑ Provide Psychoeducation ❑ Develop Collaborative Safety Plan ❑ Construct Suicide Attempt Story
Phase II Sessions 3 and 4	❑ Instill Hope – Increase Reasons for Living ❑ Teach Adaptive Coping Strategies ❑ Target Deficits in Problem Solving
Phase III Sessions 5 and 6	❑ Promote Linkage to Outpatient Aftercare ❑ Teach Relapse Prevention Strategies ❑ Refine Safety Plan before Discharge

Safety Planning Intervention

(Stanley & Brown, 2008; 2012)

- Similar to other emergency plans (e.g., do x, y and z in a certain order in case of low cabin pressure on a plane)
- Compilation of evidenced-based strategies (e.g., means restriction, social support)
- A ***collaboratively*** developed ***prioritized written*** plan that can be used during or preceding a suicidal crisis
  - Helps individuals identify ***personal*** warning signs for suicidal crises
  - Lists internal & external coping strategies
  - Identifies sources of support-peer, family, superiors, professionals
  - Provides guidance on making one's environment safe
- Conveys that suicidal feelings and urges can be "survived" and controlled
- Adopted nationwide across VAMCs for high suicide risk Veterans
- Recognized by Best Practice Registry for Suicide Prevention
- Requires minimum of training; Can be used by a wide range of helping services professionals with varying degrees of education

Phone app site: https://itunes.apple.com/us/app/safety-plan/id695122998?ls=1&mt=8

Resources for Cognitive Behavioral Therapy

Source Text:

Cognitive Therapy Training:

http://www.beckinstitute.org/cbt-workshop-registration/

Other Key Websites:

http://veterans.utah.edu/home

http://www.usuhs.mil/faculty/holloway/index.html

http://www.suicidesafetyplan.com/Home_Page.html

Empirical research from USAF 10th Medical Group (n=55) has shown that CAMS patients reach complete resolution of suicidality about 4-6 weeks more quickly than treatment as usual patients (Jobes et al., 2005; Wong, 2003)

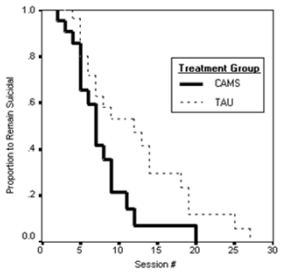
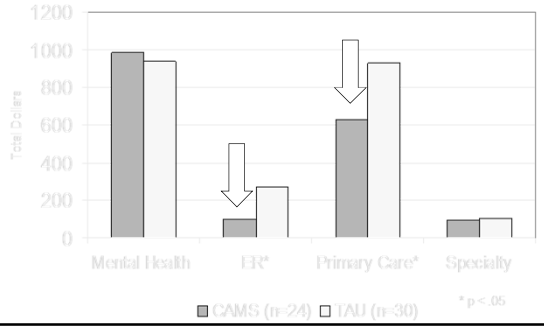


Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.

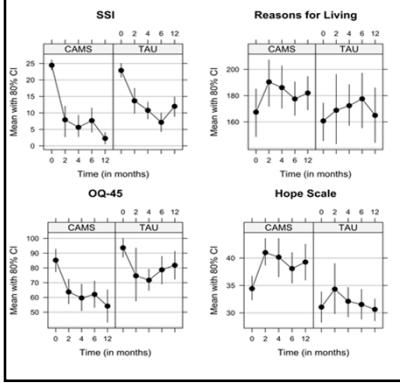
10th Medical Group Research: Six Month Period After the Start of Mental Health Care—Mean Health Care Costs



Strong Correlational and Open Trial Support for SSF/CAMS

Authors	Sample/Setting	n =	Significant Results
Jobes et al., 1997	College Students Univ. Counseling Ctr.	106	Pre/Post Distress Pre/Post Core SSF
Jobes et al., 2005	Air Force Personnel Outpatient Clinic	56	Between Group Suicide Ideation, ED/PC Appts.
Arkov et al., 2008	Danish Outpatients CMH Clinic	27	Pre/Post Core SSF Qualitative findings
Jobes et al., 2009	College Students Univ. Counseling Ctr.	55	Linear reductions Distress/Ideation
Nielsen et al., 2011	Danish Outpatients CMH Clinic	42	Pre/Post Core SSF
Ellis et al., 2012	Psychiatric Inpatients	20	Pre/Post Core SSF Suicidal Ideation, depression, hopelessness
Ellis et al., 2015	Psychiatric Inpatients	52	Suicide ideation/cognitions

CAMS RCT (Comtois et al., 2011)



Significantly higher patient satisfaction ratings and better clinical retention…


Research Article
COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY (CAMS): FEASIBILITY TRIAL FOR NEXT-DAY APPOINTMENT SERVICES

Operation Worth Living: DOD-Funded CAMS RCT at Ft. Stewart, GA

Consenting Suicidal Soldiers (n=148)

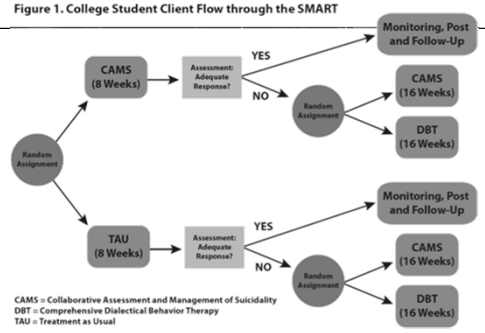
Control Group	Experimental Group
E-CAU	CAMS
3 months of outpatient care (n=75)	3 months of outpatient care (n=73)

Dependent Variables: Suicidal Ideation/Attempts, Symptom Distress, Resiliency, Primary Care visits, Emergency Department Visits, and Hospitalizations.

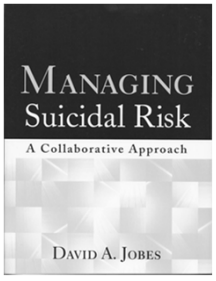
Measures: SSI, OQ-45, SHBQ, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 months)

NIMH-Funded R-34; PI: Jacque Pistorello, Ph.D.; Co-I: David Jobes, Ph.D.

Figure 1. College Student Client Flow through the SMART



(Two additional well-powered RCTs of CAMS are underway in Denmark and Norway)

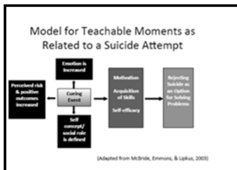


Resources for CAMS

CUA Suicide Prevention Lab: https://sites.google.com/site/cuajsplab/home

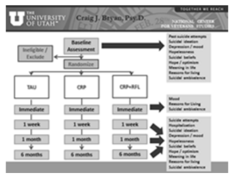
CAMS e-learning: www.empathosresources.com

Guilford Press book:
http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/jobes.htm&dir=pp/law



Stephen O'Connor, Ph.D.
Use of a one-time psychological intervention on medical-surgical units with inpatient suicide attempters…

Craig Bryan, Psy.D.
Brief intervention using Crisis Response Plan + Reasons for Living with suicidal Soldiers…



An Open Trial of Motivational Interviewing to Address Suicidal Ideation With Hospitalized Veterans

Peter C. Britton,[1] Kenneth R. Conner,[1] and Stephen A. Maisto[2]

[1] VA Center of Excellence for Suicide Prevention
[2] Syracuse University

Objective: The purpose of this open trial was to test the acceptability of motivational interviewing to address suicidal ideation (MI-SI) for psychiatrically hospitalized veterans with suicidal ideation, estimate its pre-post effect size on the severity of suicidal ideation, and examine the rate of treatment engagement after discharge. **Methods:** Participants received a screening assessment, baseline assessment, one or two MI-SI sessions, posttreatment assessment, and 60-day follow-up assessment. Thirteen veterans were enrolled, 9 (70%) completed both MI-SI sessions and the posttreatment assessment, and 11 (85%) completed the follow-up assessment. **Results:** Participants found MI-SI to be acceptable. They experienced large reductions in the severity of suicidal ideation at posttreatment and follow-up. In the 2 months following discharge, 73% of participants completed two or more mental health or substance abuse treatment sessions each month. **Conclusions:** These preliminary findings suggest that MI-SI has potential to reduce risk for suicide in psychiatrically hospitalized veterans and that a more rigorous trial is needed. © 2012 Wiley Periodicals, Inc. J. Clin. Psychol. 68:961–971, 2012.

BRIEF INTERVENTIONS…

Peter Britton, Ph.D.
1-2 sessions of Motivational Interviewing
With veterans following a suicide attempt…

ASSIP – Attempted Suicide Short Intervention Program
Anja Gysin-Maillart, Konrad Michel

u[b] UNIVERSITÄT BERN

4 Sessions, followed by regular letters over 2 years

Session No.	Therapeutic elements	ASSIP Modules
1	Establish a therapeutic relationship	**-> Narrative interview, video recorded; SSF-II**
2	Emotional activation, restructuring	**-> Video playback; confrontation**
3	Develop a shared understanding	**-> Handout (homework; psychoeducation)**
		-> Written summary of vulnerability and triggers
	Safety planning	**-> Individual safety card ("Leporello")**
4	Protocol rehearsal	**-> Re-exposure to trigger event (video)**
(5)	Continuous therapeutic relationship Reinforcing safety strategies	**-> Semi-standardized letters over 2 years**

Manual, ASSIP – Kurzintervention nach Suizidversuch, A. Gysin-Maillart, K. Michel, Huber Bern 2013

ASSIP 2-Year Results

Table 2. Repeat suicide attempts during 24-months follow-up

Follow-up	Group	N	Attempts	Persons	P
All diagnoses, ITT					
6 months	ASSIP	59	1	1	$t_{(52.5)} = -2.34$, $p = .023$
	CG	52	18	7	
6-12 months	ASSIP	59	1	1	$t_{(58.5)} = -1.81$, $p = .076$
	CG	50	6	5	
1-12 months	ASSIP	59	2	2	$t_{(54.6)} = -2.78$, $p = .007$
	CG	43	24	10	*Cohen's d=.54*
12-18 months	ASSIP	55	1	1	$t_{(44.2)} = -1.84$, $p = .072$
	CG	42	8	5	
18-24 months	ASSIP	56	2	2	$t_{(45.2)} = -1.58$, $p = .122$
	CG	42	9	5	
1-24 months	ASSIP	55	5	5	$t_{(43.3)} = -2.79$, $p = .008$
	CG	43	41	16	*Cohen's d=.83*

Abbreviations. ASSIP: Therapy plus TAU; CG: Assessment plus TAU; ITT: Intention-to treat analysis. T-test for independent samples.

Caring-Contact Research: Motto's Classic Caring Letter Study

3,005 Depressive or Suicidal Persons Identified at 9 psychiatric inpatient hospitals

1,939 Received Treatment | **843 Refused or No Treatment** | **223 Treatment Undetermined**

Randomization

389 Contact | **454 No Contact**

Source: Motto & Bostrom, 2001

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Contact Letter sent every 1-4 months over 5 year period

Dear *Patient's Name:*

"It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note, we would be glad to hear from you."

Source: Motto & Bostrom, 2001

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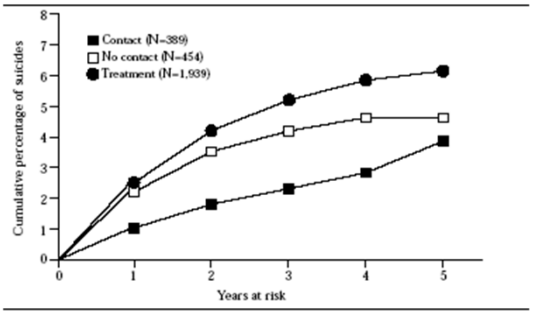
Cumulative Percentage of Suicides



Source: Motto & Bostrom, 2001

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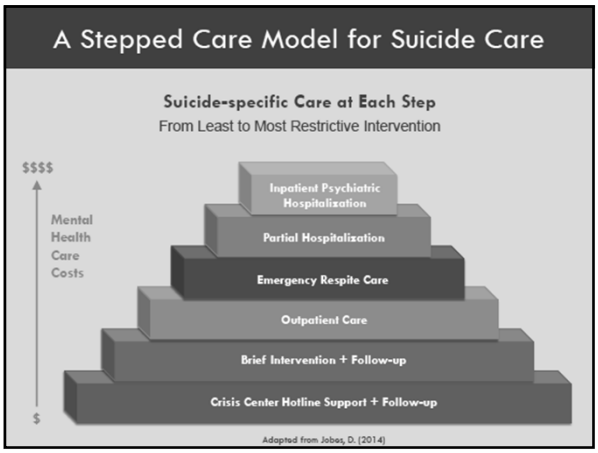
A Stepped Care Model for Suicide Care
Suicide-specific Care at Each Step
From Least to Most Restrictive Intervention
$$$$
Mental Health Care Costs
$
Inpatient Psychiatric Hospitalization
Partial Hospitalization
Emergency Respite Care
Outpatient Care
Brief Intervention + Follow-up
Crisis Center Hotline Support + Follow-up
Adapted from Jobes, D. (2014)