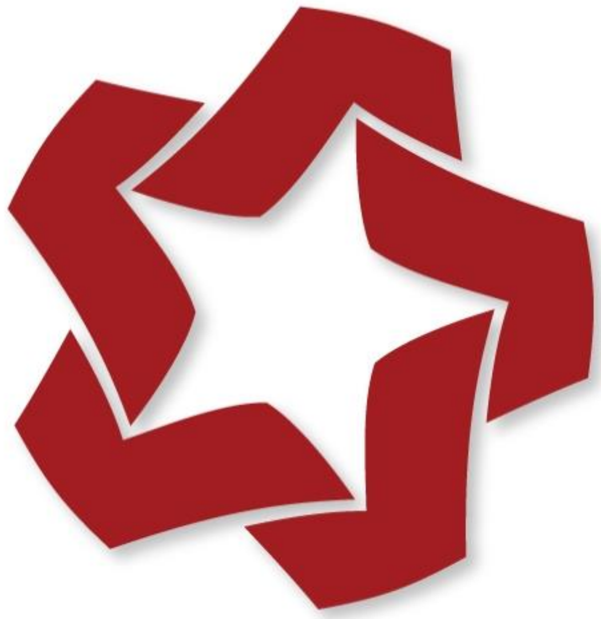

Principles of Effective Suicide Care: Evidence-Based Treatments

David A. Jobes, PhD, ABPP
Marsha Linehan, PhD, ABPP
Diana Cortez Yanez

February 10, 2015

Moderator

Julie Goldstein Grumet, PhD
Director of Prevention and Practice
Suicide Prevention Resource Center

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Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

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Zero Suicide

WHAT IS ZERO SUICIDE?

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Zero Suicide is…

- Embedded in the National Strategy for Suicide Prevention.
- A priority of the National Action Alliance for Suicide Prevention.
- A focus on error reduction and safety in healthcare.
- A framework for systematic, clinical suicide prevention in behavioral health and healthcare systems.
- A set of best practices and tools including www.zerosuicide.com.

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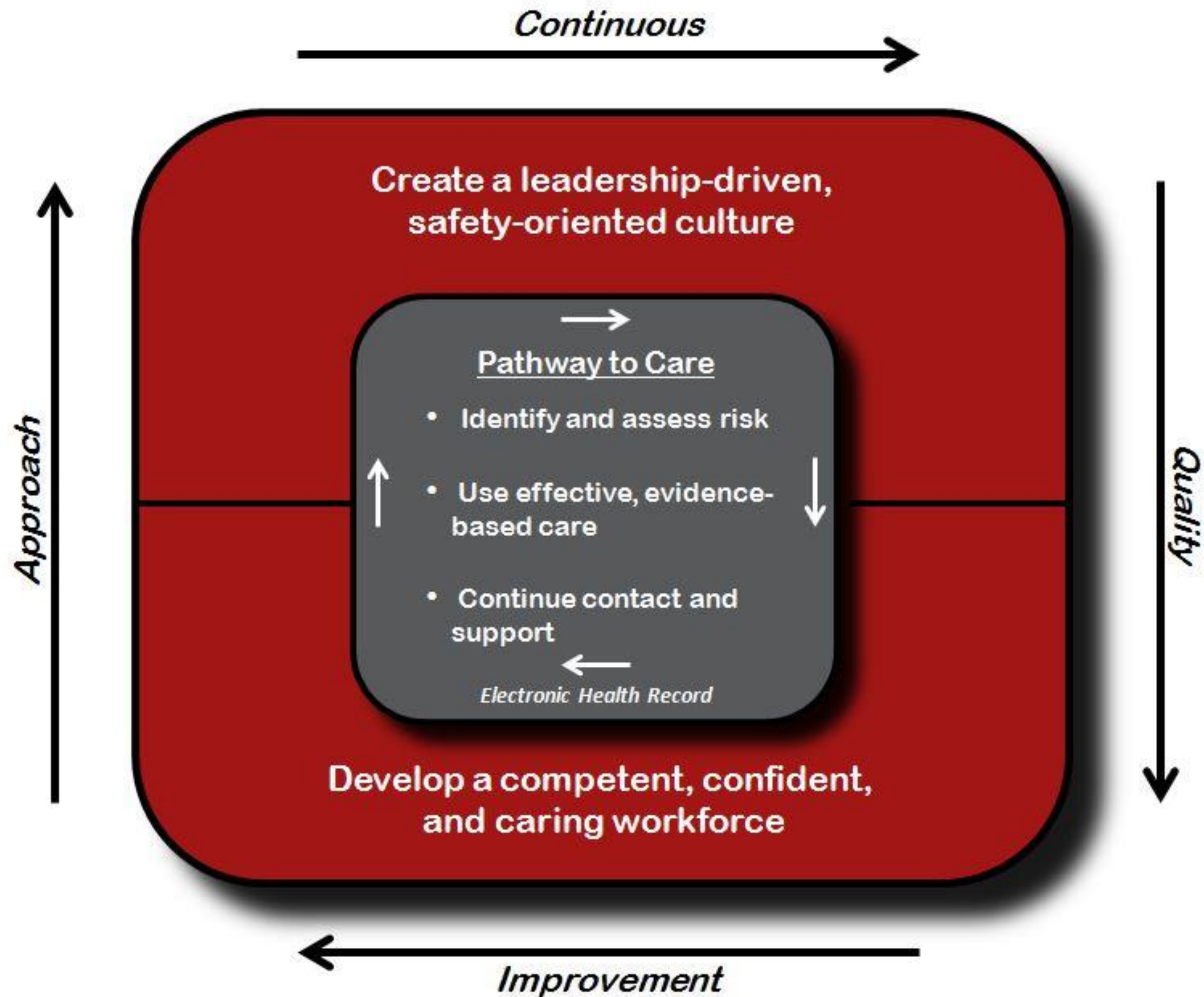
The Dimensions of Zero Suicide



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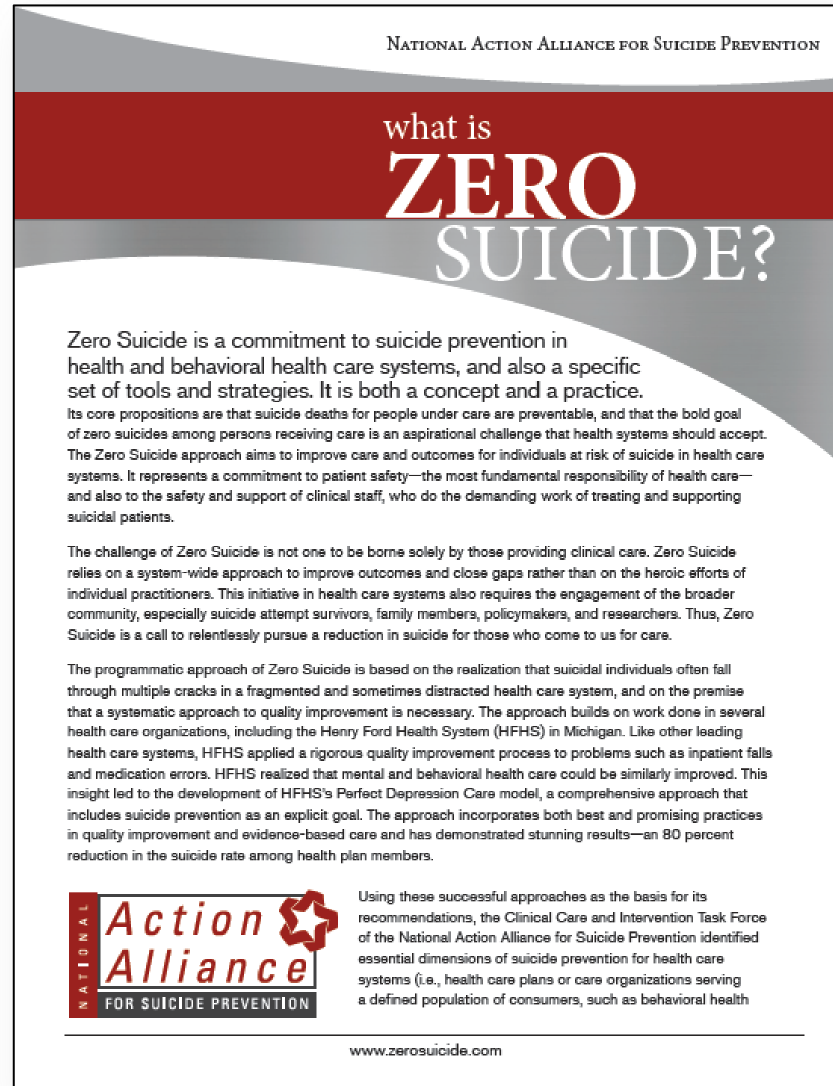
Resource: Explaining Zero Suicide


National Action Alliance for Suicide Prevention

what is ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

National Action Alliance for Suicide Prevention

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential dimensions of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health

www.zerosuicide.com

Access at: http://www.zerosuicide.com

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#zerosuicide

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National Council for Behavioral Health Annual Conference

The Zero Suicide Approach:

Providing Suicide Safer Care in Health Care Settings

Sunday, April 19, 2015, 9:00 am to 5:00 pm

Orlando, Florida

This hands-on pre-conference workshop will help launch organizations interested in adopting a Zero Suicide approach. Participants will learn to describe the Zero Suicide core dimensions, complete an organizational self-assessment, identify key next steps, and describe the tools available to health care organizations that seek to adopt a Zero Suicide approach. While individuals are welcome, we encourage teams to attend together.

Register now: http://www.thenationalcouncil.org/events-and-training/conference/conference-sessions/preconference-universities/

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Presenters

David A. Jobes, PhD

Marsha Linehan, PhD

Diana Cortez Yanez

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Learning Objectives

By the end of this webinar, participants will be able to:

1. Explain how using evidence-based approaches to treatment improves outcomes for those at risk for suicide;
2. Recognize the importance of treating suicide symptoms directly;
3. Describe two evidence-based models of suicide care; and
4. Understand the perspective of people with lived experience and how it is impacted by receiving evidence-based care.

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Presenter

David A. Jobes, PhD, ABPP

Professor of Psychology and Associate Director of Clinical Training

Catholic University of America

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State of the art in the early 1980's…

- Psychological autopsy studies of completed suicides
- Establishing the key role of psychopathology and suicide
- The epidemiology of suicide and suicidal behaviors
- Youth suicide focus (HEW 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…

There is still a professional crisis…

FOCUS ON ETHICS
Jeffrey E. Barnett, Editor

Ethical and Competent Care of Suicidal Patients: Contemporary Challenges, New Developments, and Considerations for Clinical Practice

David A. Jobes
The Catholic University of America

M. David Rudd
Texas Tech University

James C. Overholser
Case Western Reserve University

Thomas E. Joiner Jr.
Florida State University

Clinical work with suicidal patients has become increasingly challenging in recent years. It is argued that contemporary issues related to working with suicidal patients have come to pose a number of considerable professional and even ethical hazards for psychologists. Among various concerns, these challenges include providing sufficient informed consent, performing competent assessments of suicidal risk, using empirically supported treatments/interventions, and using suitable risk management techniques. In summary, there are many complicated clinical issues related to suicide (e.g., improvements in the standard of care, resistance to changing practices, alterations to models of health care delivery, the role of research, and issues of diversity). Three experts comment on these considerations, emphasizing acute versus chronic suicide risk, the integration of empirical findings, effective documentation, graduate training, maintaining professional competence, perceptions of medical versus mental health care, fears of dealing with suicide risk, suicide myths, and stigma/blame related to suicide. The authors' intention is to raise awareness about various suicide-related ethical concerns. By increasing this awareness, they hope to compel psychologists to improve their clinical practices with suicidal patients, thereby helping to save lives.

Keywords: suicide, informed consent, risk assessment, treatment, risk management

Clinical Work With Suicidal Patients: Emerging Ethical Issues and Professional Challenges

David A. Jobes

Clinical work with suicidal patients is fraught with professional challenges. Some of these challenges include psychologists' inability to predict behaviors with low base rates (such as suicide attempts and completions), the decision to commit a person to an inpatient setting, intense countertransference issues, and the potential life-or-death implications of treatment (Jobes & Berman, 1993; Jobes & Maltsberger, 1995; Maltsberger & Buie, 1974). Although these concerns continue, additional challenges have recently emerged, which make providing this care even thornier. In this article, I examine various present-day issues that clinicians face with suicidal patients, with an eye to ultimately enhancing the ethical and effective clinical care of suicidal patients. The following fictitious cases capture a sampling of current concerns.

David A. Jobes received his PhD in clinical psychology at American University, and he completed his clinical internship at the Washington, DC, Veterans Affairs Medical Center. He is a professor of psychology and a codirector of clinical training at The Catholic University of America. He maintains a private clinical and forensic practice at the Washington Psychological Center (Washington, DC). His areas of professional interest include clinical suicidology, ethics, and risk management.
M. David Rudd received his PhD in psychology from the University of Texas–Austin and completed his internship in clinical psychology at Silas B. Hays Army Community Hospital, Fort Ord, California. He completed 2 years of postdoctoral training at the Beck Institute in Philadelphia. He is a professor and chair of the Department of Psychology at Texas Tech University and also maintains a part-time private practice and risk management consulting business.
James C. Overholser received his PhD in clinical psychology from the Ohio State University, and he completed a clinical internship as well as a postdoctoral fellowship at the Department of Psychiatry, Brown University. He is a professor of psychology and director of clinical training at Case Western Reserve University. He maintains a part-time clinical practice and serves as a consultant to the Cleveland Veterans Affairs Medical Center. His areas of interest and specialization include depression, suicide risk, and psychotherapy with the Socratic method.
Thomas E. Joiner Jr. received his PhD in clinical psychology from the University of Texas at Austin. He is a distinguished research professor and the Bright-Burton professor of psychology at Florida State University. His areas of research interest are the psychology, neurobiology, and treatment of suicidal behavior and related conditions.
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Professional Psychology: Research and Practice, 2008, Vol. 39, No. 4, 405–413
Copyright 2008 by the American Psychological Association 0735-7028/08/$12.00 DOI: 10.1037/a0012896

Clinical Work with Suicidal Patients: Ethical Issues and Professional Challenges (*PPRP:* Jobes, Rudd, Overholser, & Joiner, 2008)

1. Issues of sufficient informed consent about suicide risk.
2. Issues of competent and thorough assessment of suicide risk.
3. Little use of evidence-based clinical interventions and treatments for suicide risk.
4. Issues with risk management and paralyzing concerns about malpractice liability.

Evidence-Based Treatments for Suicidality

Evidence-Based Psychotherapies for Suicide Prevention

Future Directions

Gregory K. Brown, PhD, Shari Jager-Hyman, PhD

Psychotherapeutic interventions targeting suicidal thoughts and behaviors are essential for reducing suicide attempts and deaths by suicide. To determine whether specific psychotherapies are efficacious in preventing suicide and suicide-related behaviors, it is necessary to rigorously evaluate therapies using RCTs. To date, a number of RCTs have demonstrated efficacy for several interventions focused on preventing suicide attempts and reducing suicidal ideation. Although these studies have contributed greatly to the understanding of treatment for suicidal thoughts and behaviors, the extant literature is hampered by a number of gaps and methodologic limitations. Thus, further research employing increased methodologic rigor is needed to improve psychotherapeutic suicide prevention efforts. The aims of this paper are to briefly review the state of the science for psychotherapeutic interventions for suicide prevention, discuss gaps and methodologic limitations of the extant literature, and suggest next steps for improving future studies.

(Am J Prev Med 2014;47(3S2):S186–S194) © 2014 American Journal of Preventive Medicine

Introduction

The development and implementation of effective interventions are imperative for reducing rates of suicide and related behaviors. In response to the ongoing need for effective treatments aimed at preventing suicide and self-directed violence, the National Action Alliance for Suicide Prevention's (Action Alliance) Research Prioritization Task Force (RPTF)[1] has proposed the following Aspirational Goal focused on psychotherapeutic interventions: "…develop widely available, more effective and efficient psychosocial interventions targeted at individuals, families, and community levels."

The current paper has three main aims in discussing this Aspirational Goal. First, with a focus on RCTs, the state of the science for evidence-based psychotherapy interventions for suicidal ideation and behavior is reviewed. Second, limitations of the current research and suggestions for future research are discussed. Finally, a step-by-step pathway for evaluating psychotherapy interventions for suicide prevention is proposed.

From the Perelman School of Medicine of the University of Pennsylvania, Philadelphia, Pennsylvania

Address correspondence to: Gregory K. Brown, PhD, Department of Psychiatry, University of Pennsylvania, 3535 Market Street, Room 2032, Philadelphia PA 19104-3309. E-mail: gregbrow@mail.med.upenn.edu.

0749-3797/$36.00

http://dx.doi.org/10.1016/j.amepre.2014.06.008

State of the Science of Evidence-Based Treatments for Suicide Prevention

Several RCTs[2–5] have demonstrated promising results in reducing suicide attempts and self-directed violence. A comprehensive review of the literature is beyond the scope of this paper; however, reviews[2–5] were used to identify studies to include in this brief review. A selection of studies yielding positive effects will be highlighted and presented in Table 1. Briefly, cognitive therapy for suicide prevention (CT-SP)[6]; cognitive–behavioral therapy (CBT)[7]; dialectical behavior therapy (DBT)[8]; problem-solving therapy (PST)[9]; mentalization-based treatment (MBT)[10]; and psychodynamic interpersonal therapy (PIT)[11] have all evidenced positive effects for preventing suicide attempts or self-directed violence in adults.

More specifically, recent suicide attempters who received CT-SP were 50% less likely to reattempt than participants who received enhanced usual care (EUC) with tracking and referrals.[6] CBT plus treatment as usual (TAU) also reduced self-harming behaviors relative to TAU alone.[7] For individuals with borderline personality disorder (BPD), DBT demonstrated a greater reduction in suicide attempts relative to community treatment by experts.[8] However, DBT was not statistically more effective than a manualized general psychiatric management condition, consisting of case management, dynamically informed psychotherapy, and medication management.[12]

Also focused on BPD, MBT, a psychoanalytically oriented partial hospitalization program, was more

- With 50+ studies there are few evidence-based treatments
- There is little to no support for medication-only or hospitalization
- RCT's and *replications* support:
  - Dialectical Behavior Therapy (DBT)
  - Cognitive Therapy for Suicide Prevention (CBT-SP)
  - Collaborative Assessment and Management of Suicidality (CAMS)
  - Non-demand follow-up contact

ORIGINAL ARTICLE

Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behavior Therapy vs Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder

Marsha M. Linehan, PhD; Katherine Anne Comtois, PhD; Angela M. Murray, MA, MSW; Milton Z. Brown, PhD; Robert J. Gallop, PhD; Heidi L. Heard, PhD; Kathryn E. Korslund, PhD; Darren A. Tutek, MS; Sarah K. Reynolds, PhD; Noam Lindenboim, MS

Context: Dialectical behavior therapy (DBT) is a treatment for suicidal behavior and borderline personality disorder with well-documented efficacy.

Objective: To evaluate the hypothesis that unique aspects of DBT are more efficacious compared with treatment offered by non–behavioral psychotherapy experts.

Design: One-year randomized controlled trial, plus 1 year of posttreatment follow-up.

Setting: University outpatient clinic and community practice.

Participants: One hundred one clinically referred women with recent suicidal and self-injurious behaviors meeting *DSM-IV* criteria, matched to condition on age, suicide attempt history, negative prognostic indication, and number of lifetime intentional self-injuries and psychiatric hospitalizations.

Intervention: One year of DBT or 1 year of community treatment by experts (developed to maximize internal validity by controlling for therapist sex, availability, expertise, allegiance, training and experience, consultation availability, and institutional prestige).

Main Outcome Measures: Trimester assessments of suicidal behaviors, emergency services use, and general psychological functioning. Measures were selected based on previous outcome studies of DBT. Outcome variables were evaluated by blinded assessors.

Results: Dialectical behavior therapy was associated with better outcomes in the intent-to-treat analysis than community treatment by experts in most target areas during the 2-year treatment and follow-up period. Subjects receiving DBT were half as likely to make a suicide attempt (hazard ratio, 2.66; $P=.005$), required less hospitalization for suicide ideation ($F_{1,87}=7.3$; $P=.004$), and had lower medical risk ($F_{1,99}=3.2$; $P=.04$) across all suicide attempts and self-injurious acts combined. Subjects receiving DBT were less likely to drop out of treatment (hazard ratio, 3.2; $P<.001$) and had fewer psychiatric hospitalizations ($F_{1,87}=6.0$; $P=.007$) and psychiatric emergency department visits ($F_{1,87}=2.9$; $P=.04$).

Conclusions: Our findings replicate those of previous studies of DBT and suggest that the effectiveness of DBT cannot reasonably be attributed to general factors associated with expert psychotherapy. Dialectical behavior therapy appears to be uniquely effective in reducing suicide attempts.

Arch Gen Psychiatry. 2006;63:757-766

SUICIDAL BEHAVIOR IS A BROAD term that includes death by suicide and intentional, nonfatal, self-injurious acts committed with or without intent to die. It is associated with several mental disorders, including depression, substance dependence, and schizophrenia. Borderline personality disorder (BPD) is 1 of only 2 *DSM-IV* diagnoses for which suicidal behavior is a criterion.[1] Borderline personality disorder is a severe and persistent mental disorder experience of severe emotional distress and behavioral dyscontrol.[1-3] Among patients with BPD, 69% to 80% engage in suicidal behavior,[4-9] with a suicide rate of up to 9%.[10] Forty percent of the highest users of inpatient psychiatric services receive a diagnosis of BPD.[11,12] Patients with BPD use more services than those with major depression[13] and other personality disorders.[14] Among patients with BPD seen for treatment, 72% have had at least 1 psychiatric hospitalization and 97% have received outpatient treatment from a mean of 6.1 previous therapists.[15,16] Despite this high-use pattern, patients with BPD have high rates of treatment failure.[17,18]

Outpatient dialectical behavior therapy (DBT)[20,21] and mentalization-based treatment provided in a partial hospital pro-

Author Affiliations are listed at the end of this article.

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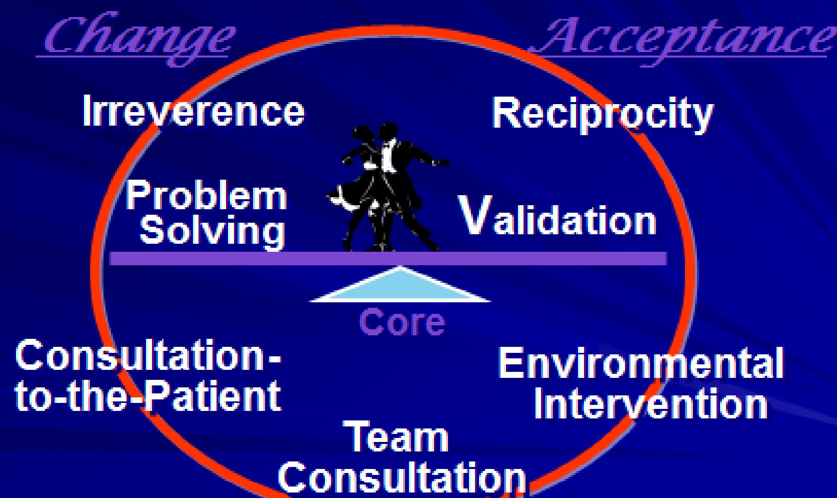


DBT's impact on Non-Suicidal Self-Injury Behavior

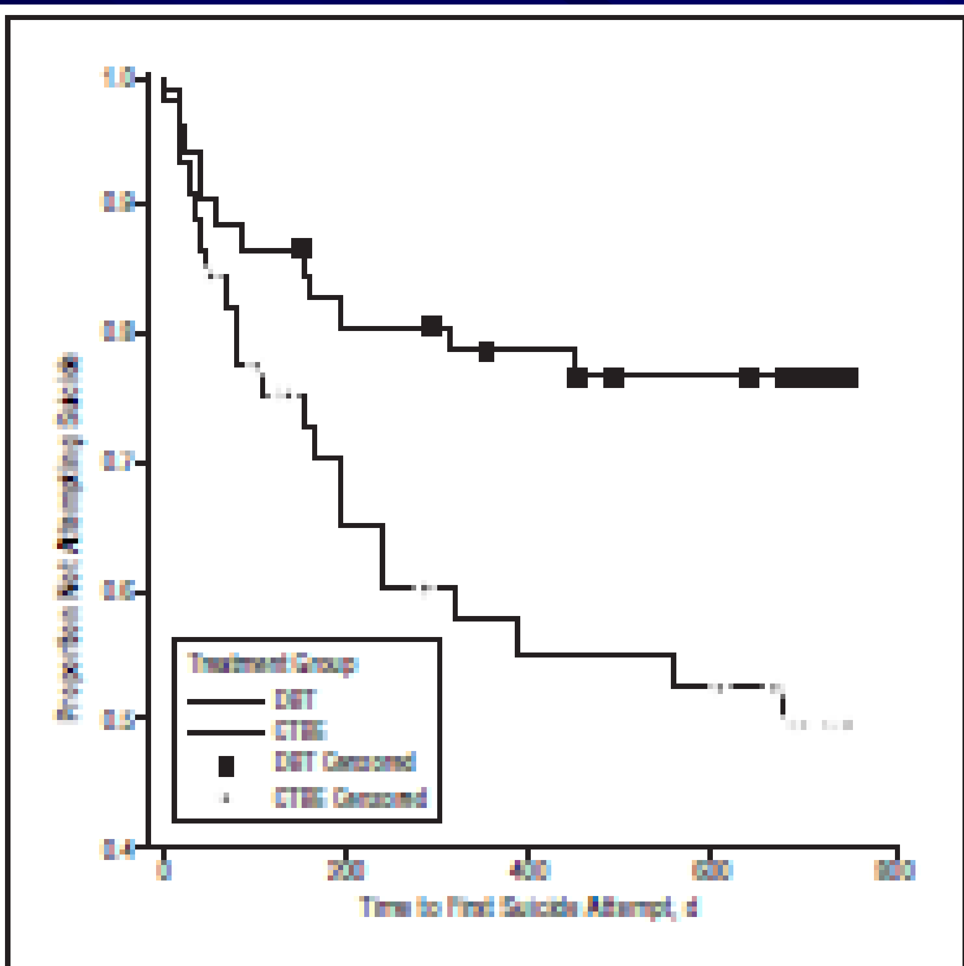


Figure 3. Survival analysis for time to first suicide attempt. The treatment period ended at 365 days, and the follow-up period ended at 730 days. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

DBT's Impact on Suicide Attempt Behavior

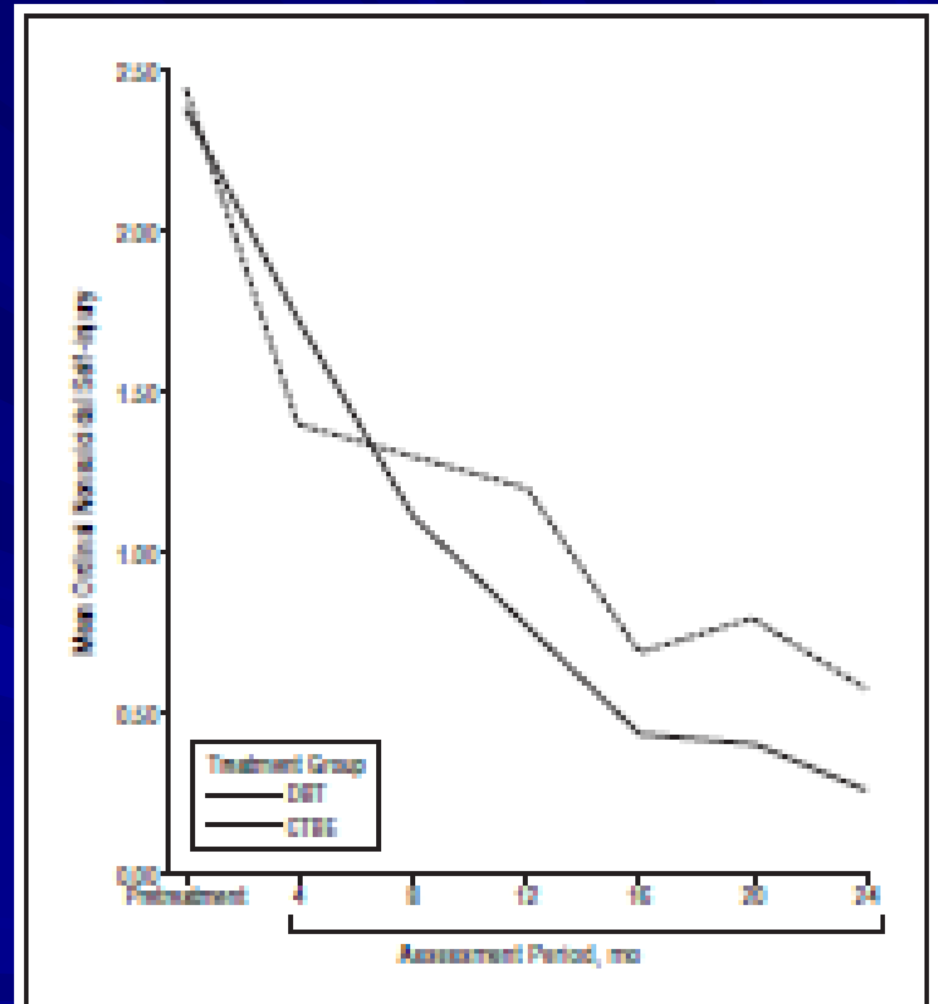
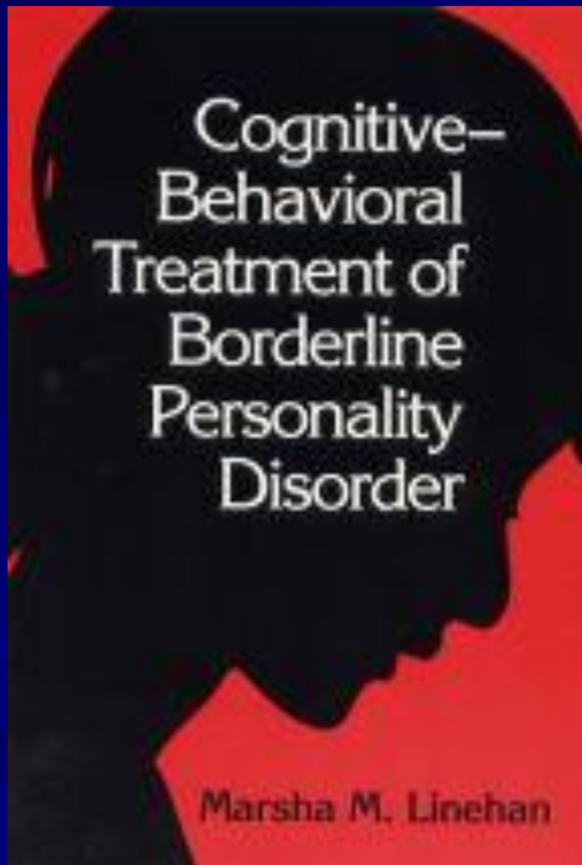
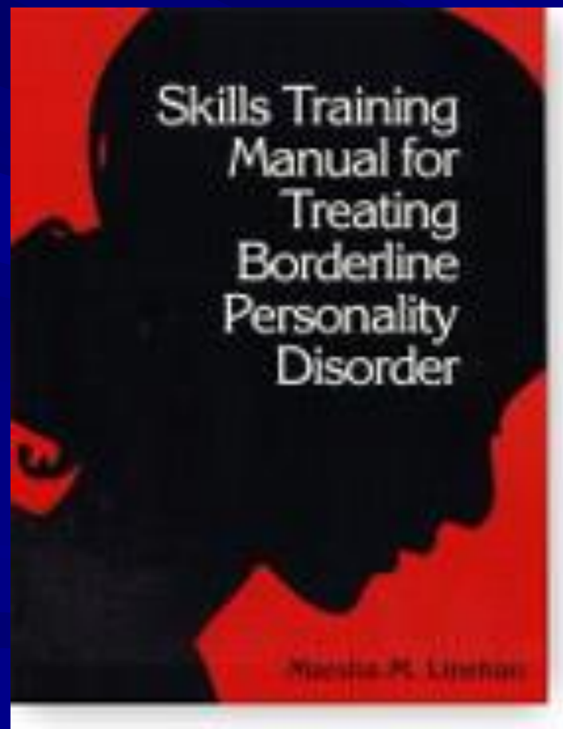


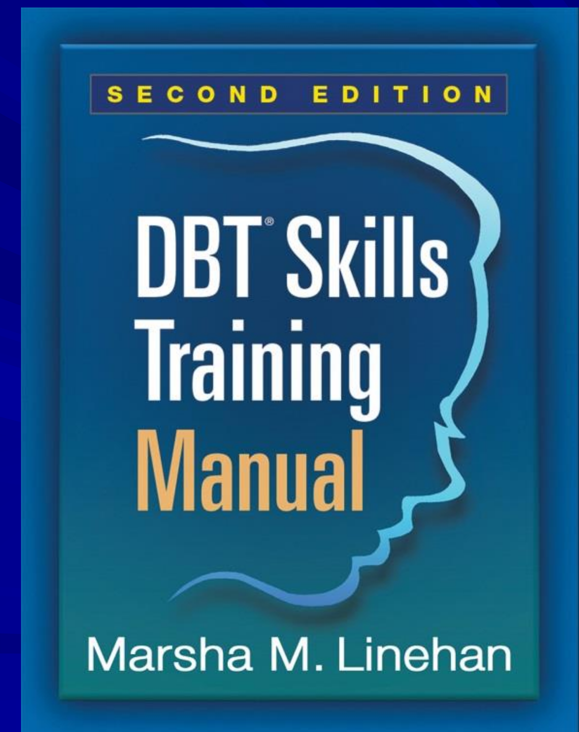
Figure 4. Mean ordinal nonsuicidal self-injury during the 2-year study.[1] The treatment period ended at 12 months, and the follow-up period ended at 24 months. The 5-level ordinal categories per assessment period were 0, 0.01 to 1, 1.01 to 2, 2.01 to 4, and 4.01 and higher. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

Resources for Dialectical Behavior Therapy

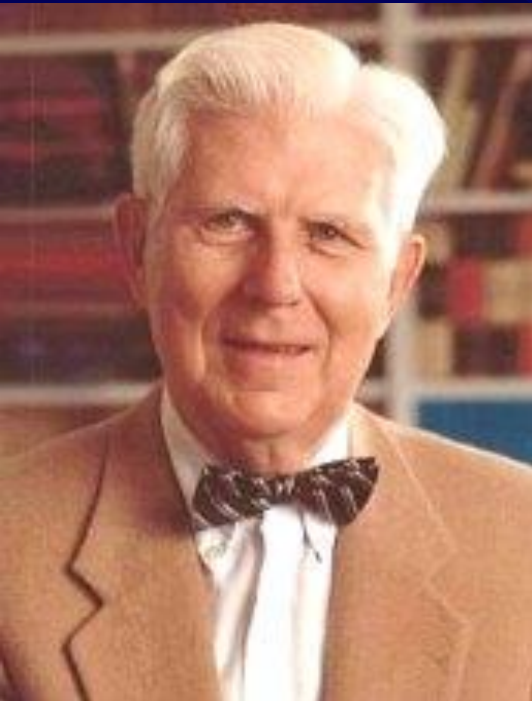
Source Texts:
http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/linehan.htm&dir=pp/pd







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



CBT for Suicidal Risk: Beck, Brown, Rudd, Bryan, & Holloway

- Identify Reasons for Living
- Review Advantages & Disadvantages of Living
- Construct a Hope Box or Survivor Kit
  - Pictures
  - Letters
  - Poetry
  - Prayer Card
  - Coping Cards

Cognitive Therapy for the Prevention of Suicide Attempts

A Randomized Controlled Trial

Gregory K. Brown, PhD
Thomas Ten Have, PhD
Gregg R. Henriques, PhD
Sharon X. Xie, PhD
Judd E. Hollander, MD
Aaron T. Beck, MD

Context Suicide attempts constitute a major risk factor for completed suicide, yet few interventions specifically designed to prevent suicide attempts have been evaluated.

Objective To determine the effectiveness of a 10-session cognitive therapy intervention designed to prevent repeat suicide attempts in adults who recently attempted suicide.

Design, Setting, and Participants Randomized controlled trial of adults (N = 120) who attempted suicide and were evaluated at a hospital emergency department within 48 hours of the attempt. Potential participants (N = 350) were consecutively recruited from October 1999 to September 2002; 66 refused to participate and 164 were ineligible. Participants were followed up for 18 months.

Intervention Cognitive therapy or enhanced usual care with tracking and referral services.

Main Outcome Measures Incidence of repeat suicide attempts and number of days until a repeat suicide attempt. Suicide ideation (dichotomized), hopelessness, and depression severity at 1, 3, 6, 12, and 18 months.

Results From baseline to the 18-month assessment, 13 participants (24.1%) in the cognitive therapy group and 23 participants (41.6%) in the usual care group made at least 1 subsequent suicide attempt (asymptotic z score, 1.97; $P = .049$). Using the Kaplan-Meier method, the estimated 18-month reattempt-free probability in the cognitive therapy group was 0.76 (95% confidence interval [CI], 0.62-0.85) and in the usual care group was 0.58 (95% CI, 0.44-0.70). Participants in the cognitive therapy group had a significantly lower reattempt rate (Wald $\chi^2_1 = 3.9$; $P = .049$) and were 50% less likely to reattempt suicide than participants in the usual care group (hazard ratio, 0.51; 95% CI, 0.26-0.997). The severity of self-reported depression was significantly lower for the cognitive therapy group than for the usual care group at 6 months ($P = .02$), 12 months ($P = .009$), and 18 months ($P = .046$). The cognitive therapy group reported significantly less hopelessness than the usual care group at 6 months ($P = .045$). There were no significant differences between groups based on rates of suicide ideation at any assessment point.

Conclusion Cognitive therapy was effective in preventing suicide attempts for adults who recently attempted suicide.

JAMA. 2005;294:563-570 www.jama.com

In 2002, suicide was the fourth leading cause of death for adults between the ages of 18 and 65 years with approximately 25 000 suicides for this age group in the United States.[1] As recommended by the *National Strategy for Suicide Prevention*, one public health approach for the prevention of suicide involves identifying and providing treatment for those individuals who are at high risk for suicide.[2]

Attempted suicide is one of the strongest risk factors for completed suicide in adults. A meta-analysis of follow-up mortality studies estimated that individuals who attempted suicide were 38 to 40 times more likely to commit suicide than those who had not attempted suicide.[3] Prospective research also has supported the validity of attempted suicide as a risk factor for eventual suicide.[4-7]

Empirical evidence for treatments that effectively prevent repetition of suicide attempts is limited.[8] Randomized controlled trials of individuals who have attempted suicide have used intensive follow-up treatment or intensive case management,[9-11] interpersonal psychotherapy,[12] or cognitive behavior therapy.[13] Several studies supporting the efficacy of cognitive behavior therapy or problem-solving therapy for reducing suicide behavior[13,14] have highlighted the need for randomized controlled trials with sufficient power to detect treatment differences.[15]

For editorial comment see p 623.

Author Affiliations: Departments of Psychiatry (Drs Brown and Beck) and Emergency Medicine (Dr Hollander) and Center for Clinical Epidemiology and Biostatistics (Drs Ten Have and Xie), University of Pennsylvania, Philadelphia; and Department of Graduate Psychology, James Madison University, Harrisonburg, Va (Dr Henriques).
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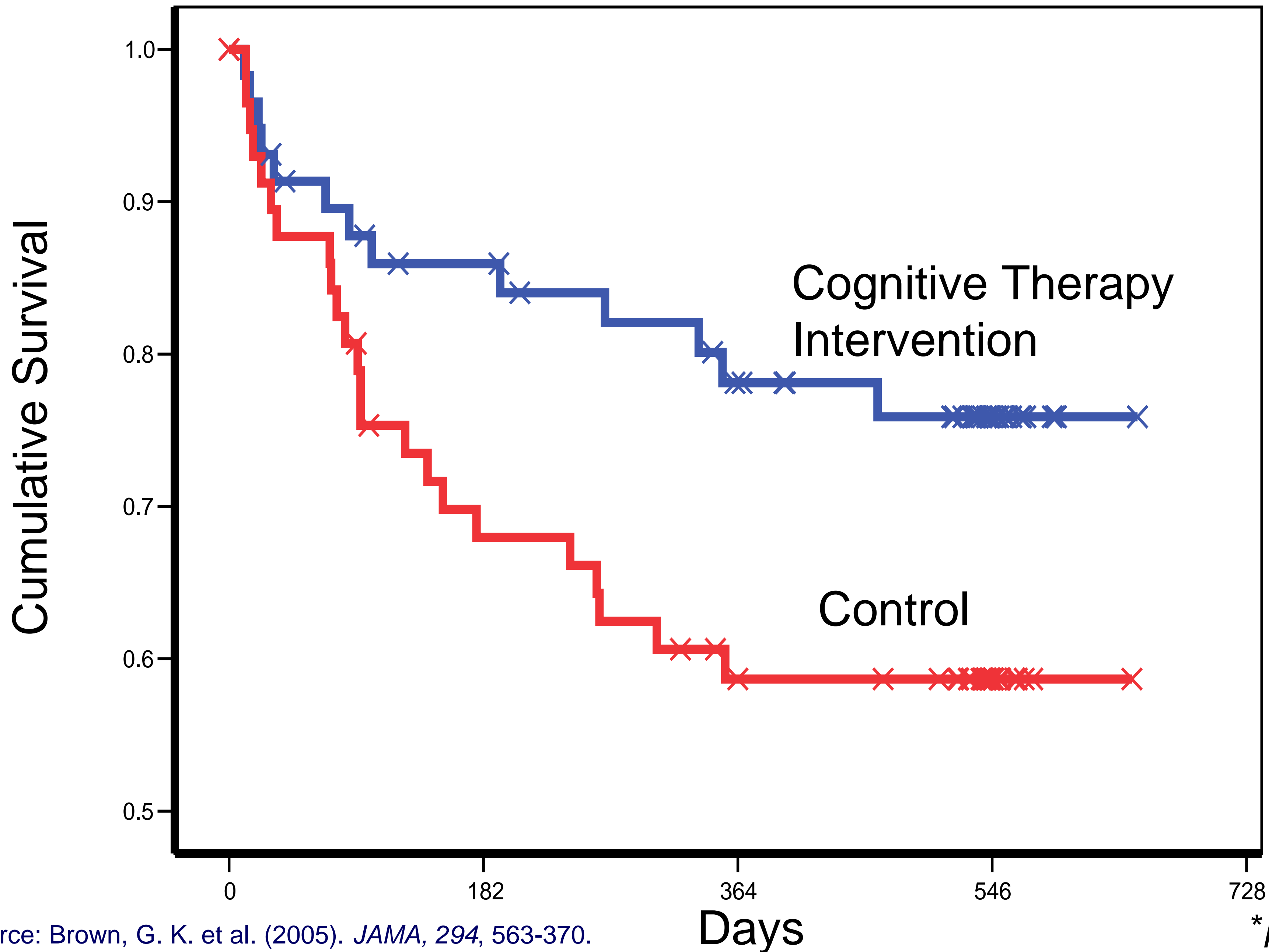
Downloaded from www.jama.com at University of Pennsylvania, on August 3, 2005

Survival Functions for Repeat Suicide Attempt by Study Condition



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

$^{*}p < .05$

Brief Cognitive Behavior Therapy (B-CBT)

M. David Rudd, Ph.D. & Craig Bryan, Psy.D.
Ft. Carson Randomized Clinical Trial

Brief Cognitive Behavioral Therapy
(B-CBT)
For Suicidal Soldiers

Treatment Manual

M. David Rudd, PhD, ABPP
University of Utah

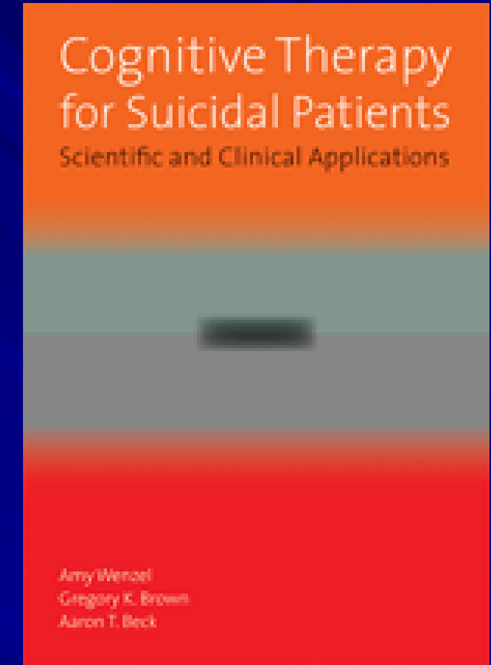
Craig J. Bryan, PsyD, ABPP
University of Texas Health Science Center at San Antonio

60% between-group reduction in suicide attempts (American Journal of Psychiatry, in press)

Resources for Cognitive Behavioral Therapy

Source Text:

http://www.apa.org/pubs/books/images/431 7169-150.gif



Cognitive Therapy Training:

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

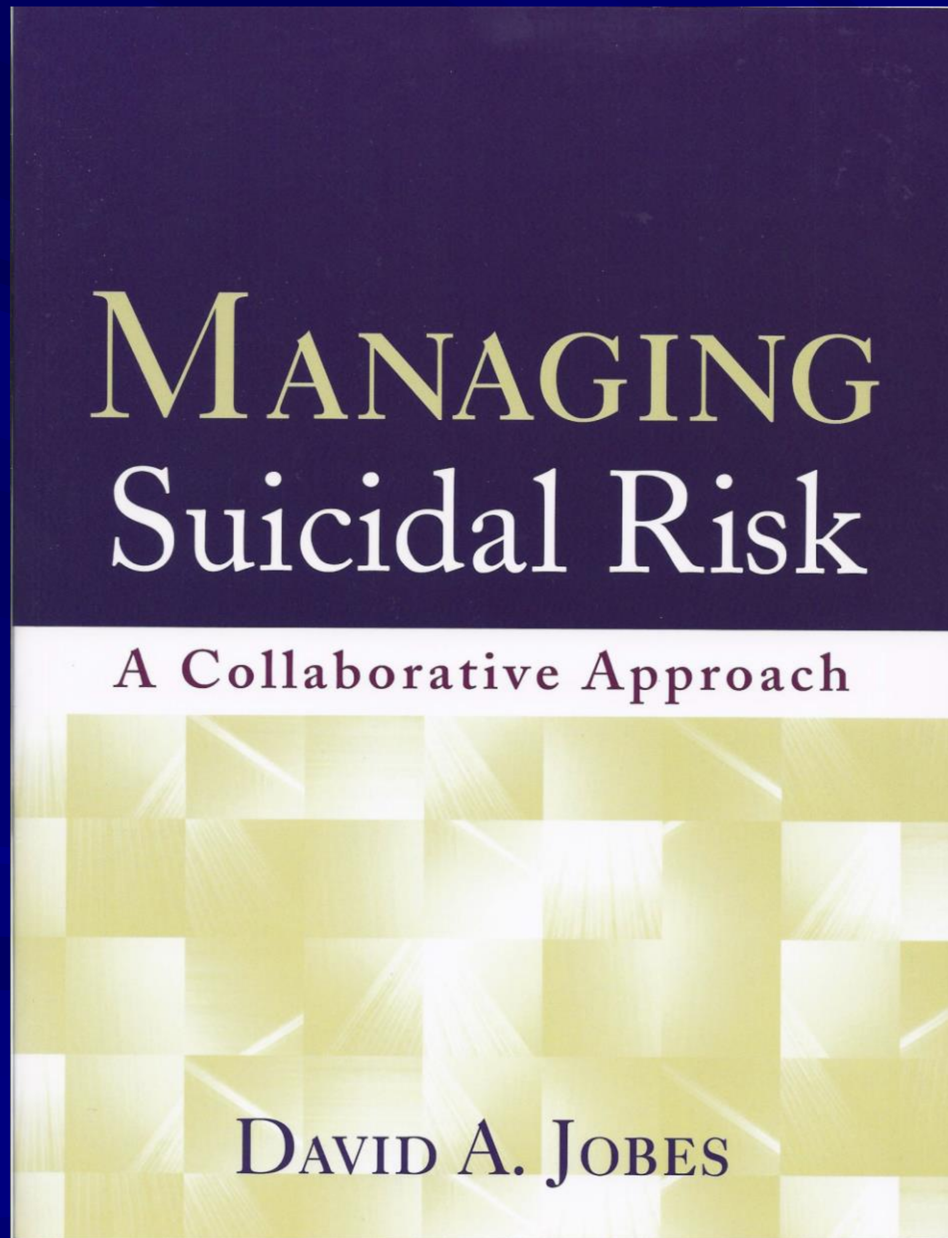
Other Key Websites:

http://veterans.utah.edu/home

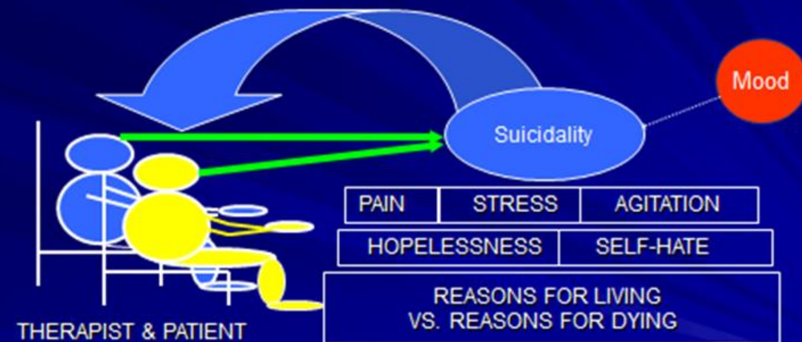
http://www.usuhs.mil/faculty/holloway/index.html

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

The Collaborative Assessment and Management of Suicidality (CAMS)



The Collaborative Assessment and Management of Suicidality (CAMS) identifies and targets ***Suicide*** as the primary focus of assessment and intervention…

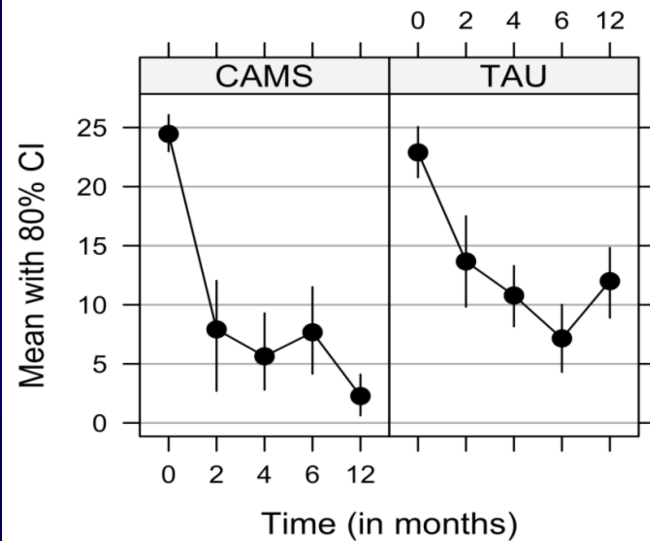


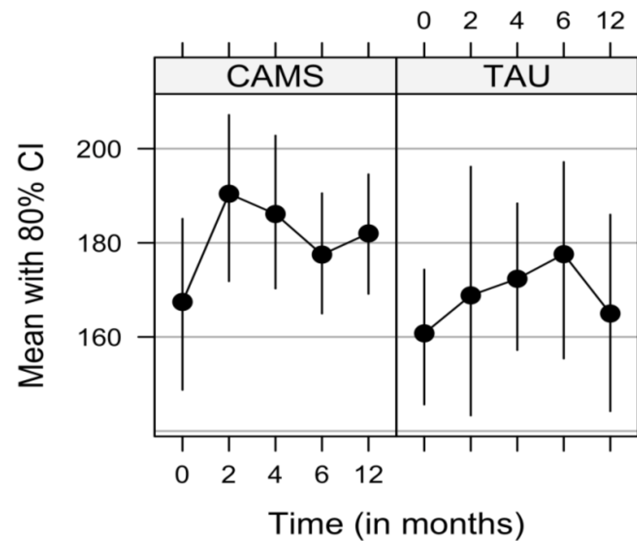
CAMS assessment uses the Suicide Status Form (SSF) as a means of deconstructing the "functional" utility of suicidality; CAMS as an intervention emphasizes a problem-focused intensive outpatient approach that is suicide-specific and "co-authored" with the patient…

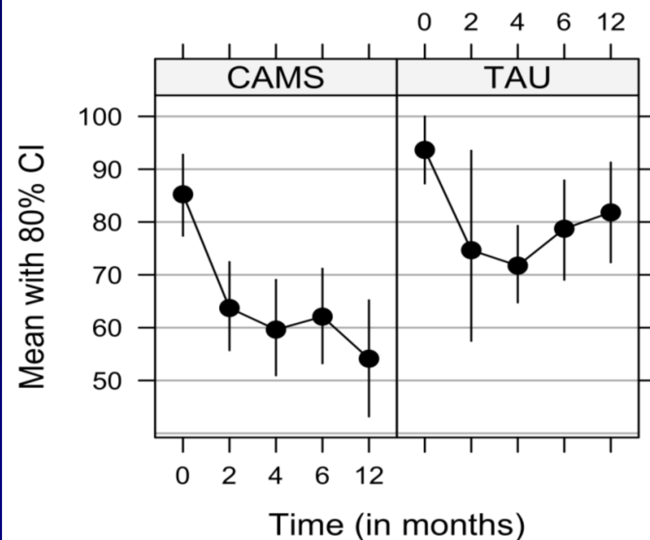
Strong Correlational and Open Trial Support for SSF/CAMS

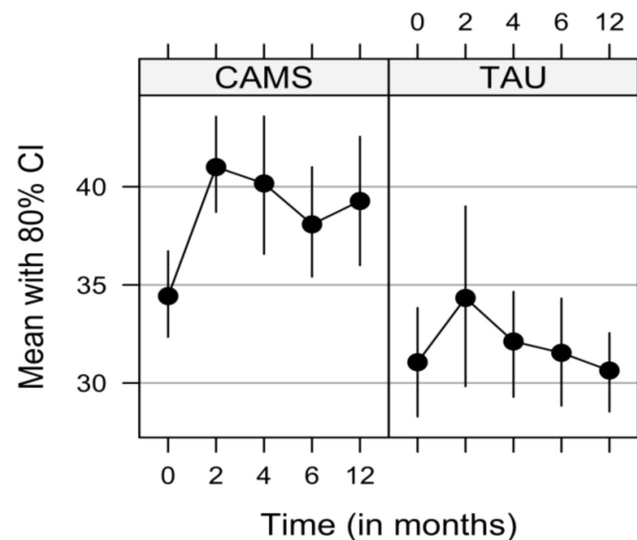
Authors	Sample/Setting	n =	Significant Results
Jobes et al., 1997	College Students Univ. Counseling Ctr.	106	Pre/Post Distress Pre/Post Core SSF
Jobes et al., 2005	Air Force Personnel Outpatient Clinic	56	Between Group Suicide Ideation, ED/PC Appts.
Arkov et al., 2008	Danish Outpatients CMH Clinic	27	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…

DEPRESSION AND ANXIETY 28 : 963–972 (2011)

Research Article

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

Katherine Anne Comtois, Ph.D. M.P.H.,[1*] David A. Jobes, Ph.D.,[2] Stephen S. O'Connor, Ph.D.,[1] David C. Atkins, Ph.D.,[1] Karin Janis, B.A.,[1] Chloe E. Chessen, B.A.,[1] Sara J. Landes, Ph.D.,[1,3] Anna Holen, M.D.,[1] and Christine Yuodelis-Flores, M.D.[1]

Background: *Despite the ubiquity of suicidality in behavioral health settings, empirically supported interventions for suicidality are surprisingly rare. Given the importance of resolving suicidality and therapists' anxieties about treating suicidal patients, there is a clear need for innovative services and clinical approaches. The purpose of the current study was an attempt to address some of these needs by examining the feasibility and use of a new intervention called the "Collaborative Assessment and Management of Suicidality" (CAMS) within a "Next-Day Appointment" (NDA) outpatient treatment setting.* Methods: *As part of a larger feasibility study, n = 32 suicidal patients were randomly assigned to CAMS care versus Enhanced Care as Usual (E-CAU) in an outpatient crisis intervention setting attached to a safety net hospital. Intent to treat suicidal patients were seen and assessed before, during, and after treatment (with follow-up assessments conducted at 2, 4, 6, and 12 months).* Results: *The feasibility of using CAMS in the NDA setting was clear; both groups appeared to initially benefit from their respective treatments in terms of decreased suicidal ideation and overall symptom distress. Although patients rated both treatments favorably, the CAMS group had significantly higher satisfaction and better treatment retention than E-CAU. At 12 months post-treatment, CAMS patients showed significantly better and sustained reductions in suicidal ideation, overall symptom distress, and increased hope in comparison to E-CAU patients.* Conclusions: *CAMS was both feasible in this NDA setting and effective in treating suicidal ideation, distress, and hopelessness (particularly at 12 month follow-up). Depression and Anxiety 28:963–972, 2011.* © 2011 Wiley Periodicals, Inc.

Key words: *suicide; attempted suicide; psychotherapy; risk assessment; crisis intervention; feasibility studies; clinical trial*

INTRODUCTION

More than 33,000 suicides occurred in the United States in 2006—91 suicides per day or one suicide every 16 min.[1,2] Death by suicide is part of a much larger problem; millions of Americans have suicidal thoughts and hundreds of thousands make suicide attempts each year.[3] In 2008, 2.3 million people made

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Study conducted at Harborview Medical Center, 325 9th Avenue, Seattle, WA 98104.

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

Consenting Suicidal Soldiers (n=150)

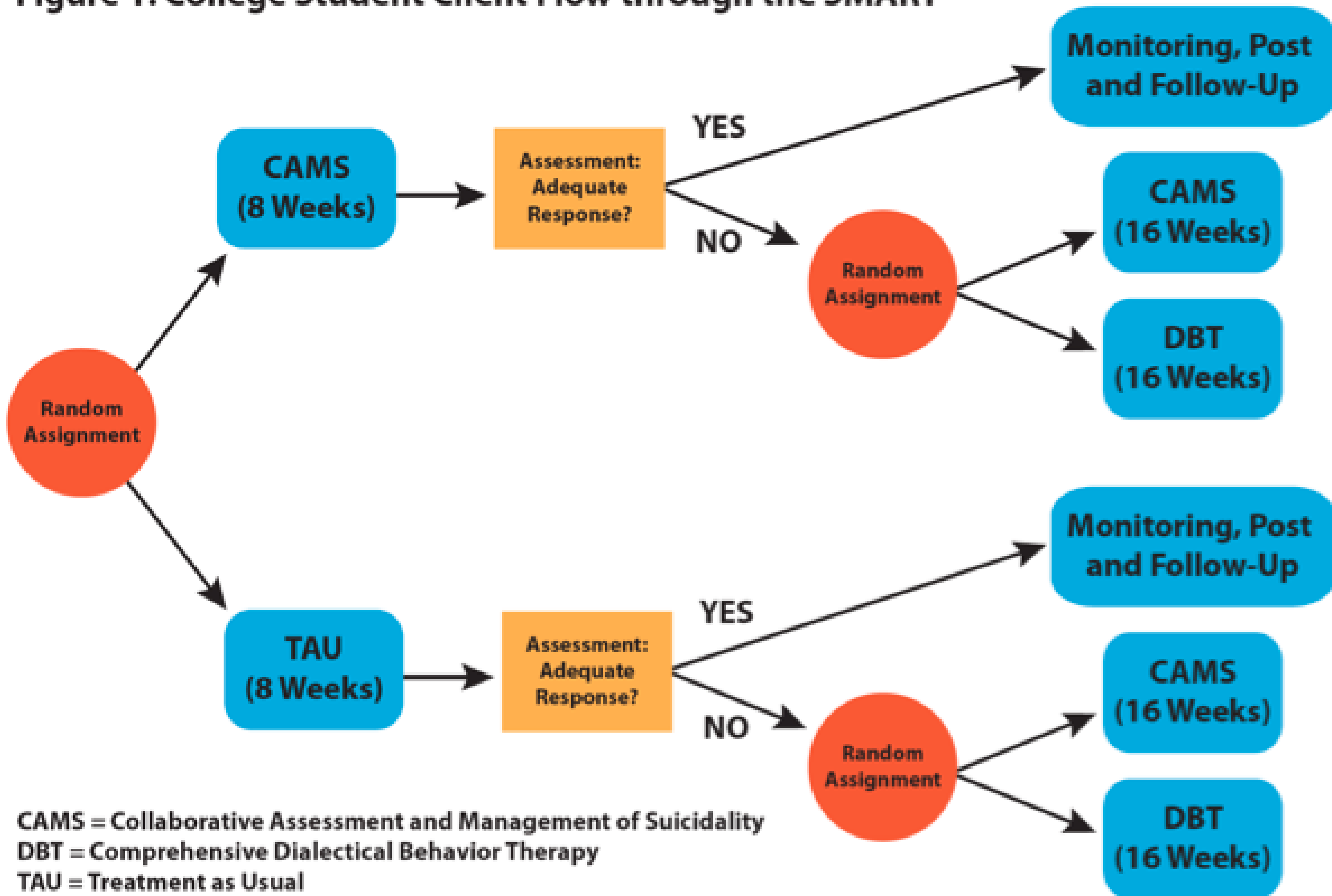
Control Group
E-CAU
3 months of
outpatient care (n=75)

Experimental Group
CAMS
3 months of
outpatient care (n=75)

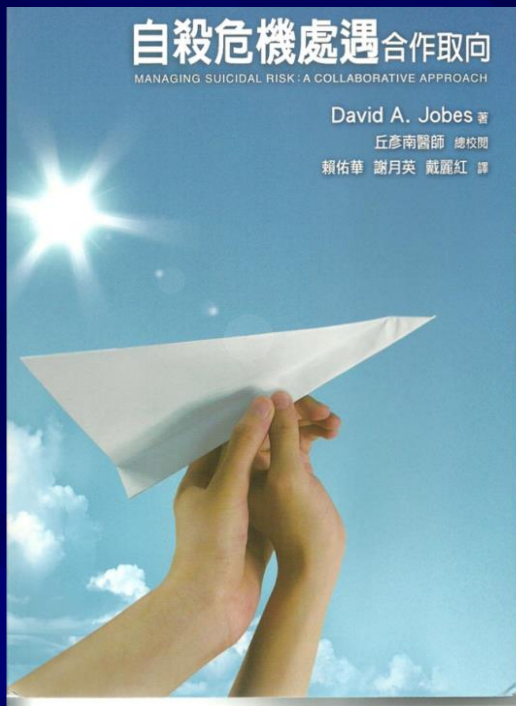
Dependent Variables: Suicidal Ideation/Attempts, Symptom Distress, Resiliency, Primary Care visits, Emergency Department Visits, and Hospitalizations.

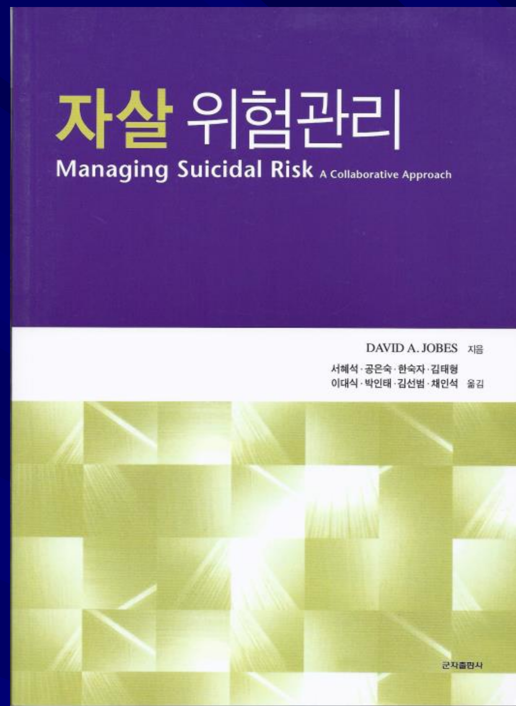
Measures: SSI, OQ-45, SHBQ, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 months)

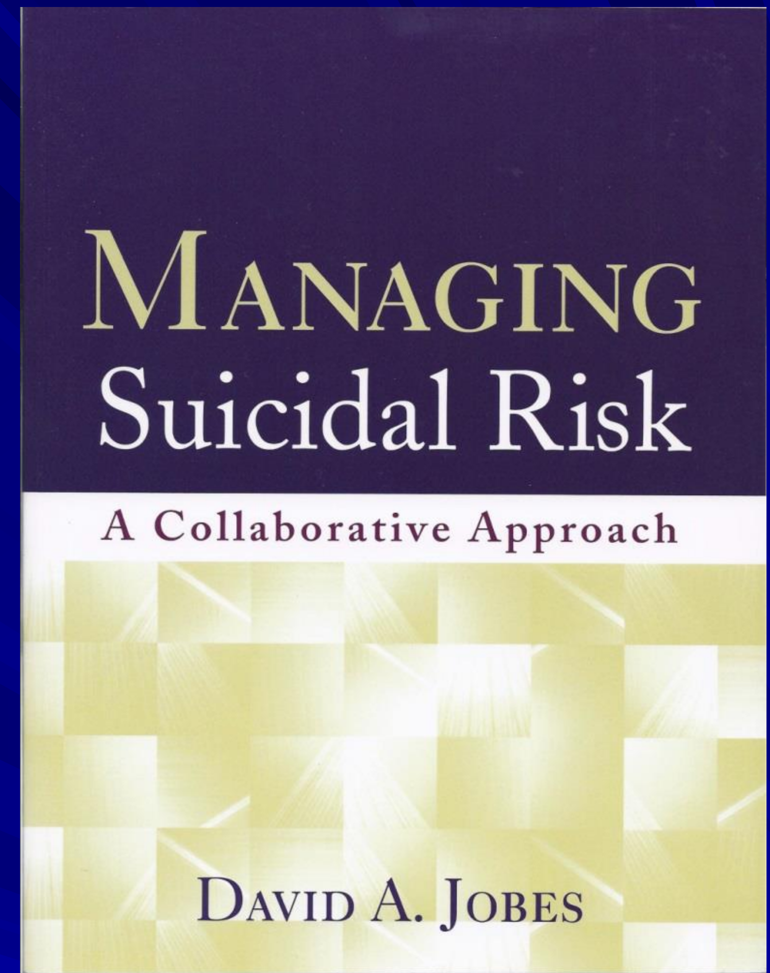
NIMH-Funded R-34



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







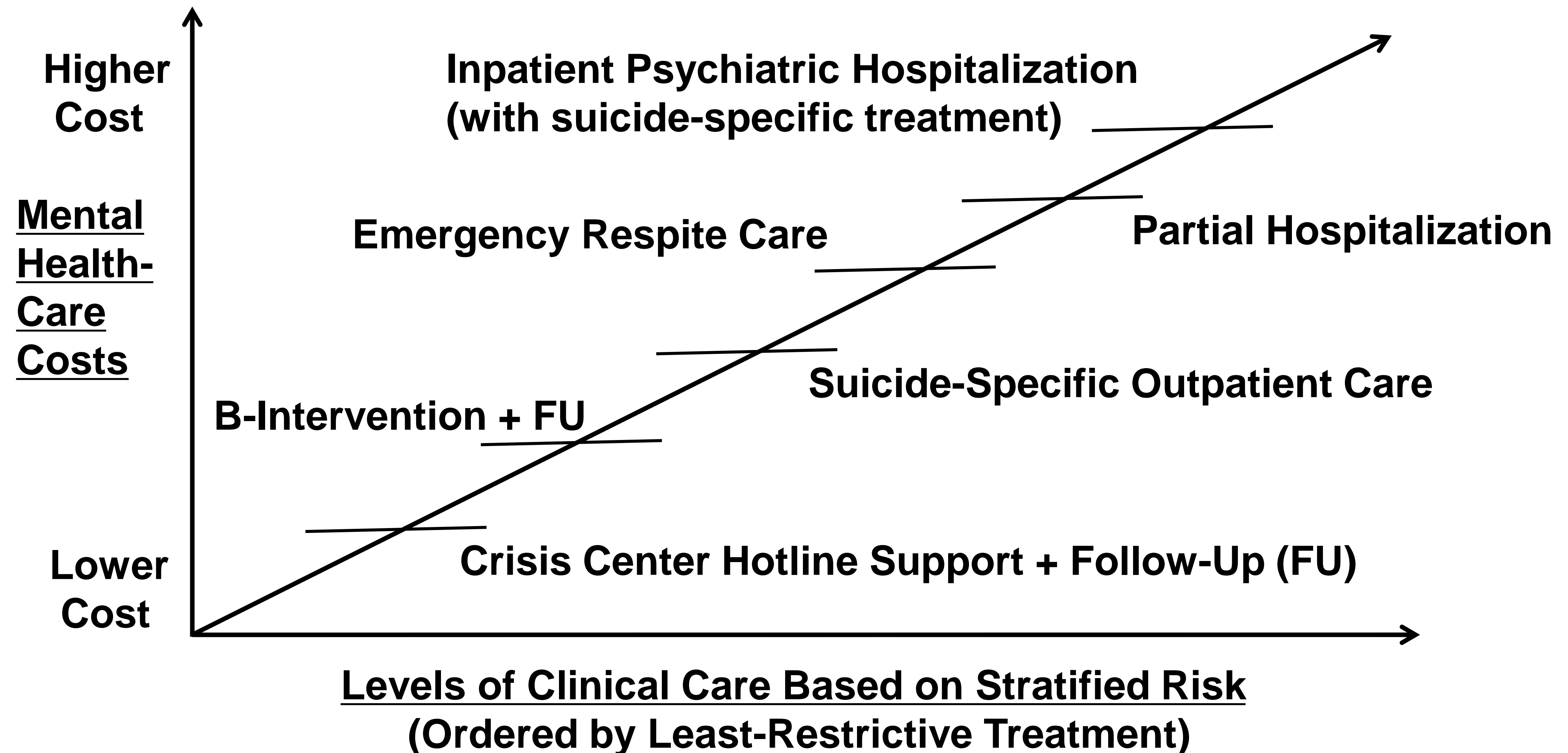
Resources for CAMS

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

Matching Interventions to Suicidal States



Key post health care reform constructs: ***Evidence-Based, Least-Restrictive, and Cost-Effective…***

Presenter

Marsha Linehan, PhD, ABPP

Professor of Psychology and Psychiatry and Behavioral Sciences

Director of the Behavioral Research and Therapy Clinics

University of Washington

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On Creating a Life Worth Living When Suicide Feels Like the Only Option

Marsha M. Linehan
University of Washington

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What is DBT and How does it Treat suicide

DBT is a Modular, Principle-Driven Multi diagnostic behavioral treatment

originally developed for high suicide risk with high comorbidity and since expanded to treat multiple mental disorders and problems in living

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DBT IS
Dialectical

DIALECTICAL

Change Communication Acceptance

Irreverent

Reciprocal

Problem Solving

Validation

Core

Consultation-to-the-Patient

Environmental Intervention

Team Consultation

Case Management

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Comprehensive DBT Functions:

1. Enhance <u>capabilities</u>
2. Improve <u>motivational</u> factors
3. Assure <u>generalization</u> to the natural environment
4. Structure the <u>environment</u>
5. Enhance <u>therapist</u> capabilities and motivation to treat effectively

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Standard DBT Modes

- Outpatient Individual Psychotherapy
- Outpatient Group Skills Training
- Telephone Consultation
- Therapists' Consultation Meeting

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DBT STRATEGIES FOR SUICIDE

REDUCE SUICIDAL BEHAVIOR BY: ASSESSING AND SOLVING THE CORE PROBLEM

Suicide is a solution
for the Client
And a Problem
for the Therapist

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REDUCE SUICIDAL BEHAVIOR BY:

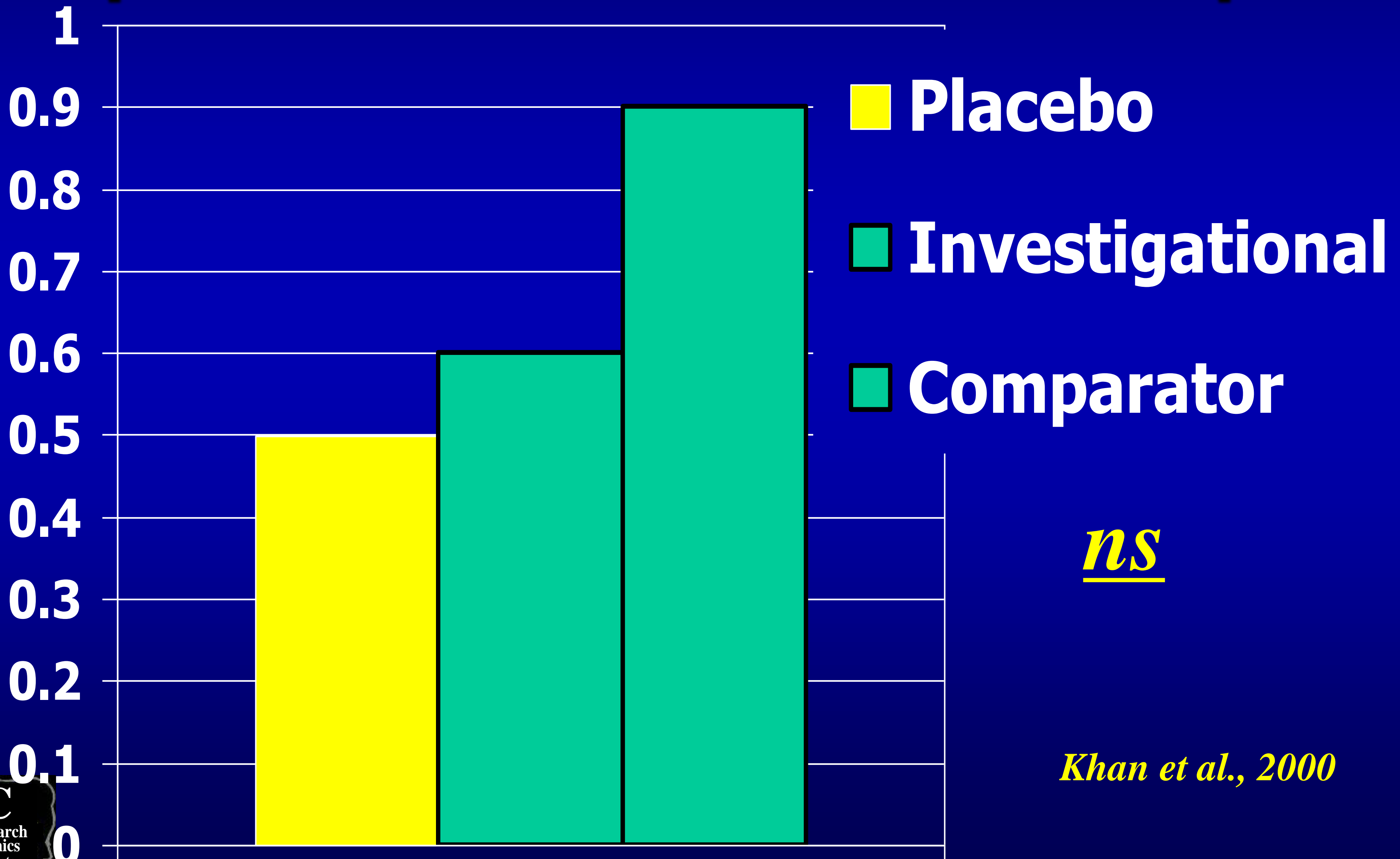
REDUCING EXCESSIVE MEDICATIONS

Usual findings: DBT significantly reduces medications more than control conditions

DBT Medication Protocols

1. Get a second opinion on multiple meds.
2. Guide client to ask for low enough quantity of meds to lessen potential for serious overdose.
3. Monitor prescription meds, over the counter meds, and illicit meds at every session.
4. Taper meds; replace pills with skills.
5. Collect weapons; become friends with those making laws on weapons

Rates/Year of Suicide: n = 23,201 Replication Trial for FDA Sample



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DBT Rescue Medication Protocol

1. Treat psychosis and bi-polar disorders
2. Opiate addiction: methadone or suboxone
3. Chronic insomnia : treat if non-responsive to behavioral insomnia intervention
4. Severe insomnia combined with escalating agitation or suicide ideation: treat immediately
5. If psychotic episode: brief trial (3 weeks) of anti-psychotic medication; continue if psychosis resumes when tapering off medication

REDUCE SUICIDAL BEHAVIOR BY:

REDUCING EXCESSIVE HOSPITALIZATION

FAVOR OUTPATIENT OVER INPATIENT

DBT compared to Expert Community Therapy

- **Suicide attempts:** 50% ↓
- **ER visits for suicidality:** 53% ↓
- **Inpt. admits for suicidality:** 73% ↓
  - All remain 50% lower during follow-up

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REDUCE SUICIDAL BEHAVIOR BY:

USING THE DBT SUICIDE SAFETY NET, INCLUDING THE DBT RISK ASSESSMENT AND MANAGEMENT PROTOCOL (LRAMP)

(GO TO LINEHAN INSTITUTE)
HTTP://WWW.LINEHANINSTITUTE.ORG/

SUICIDE SAFETY NET (LRAMP)

Characteristics

- Long term risk assessment required at session1
- Monitor suicidality, wish to escape, and wish to quit therapy at each session
- Fill out check list after any increase in suicidality
- Document interventions from lists provided
- Document evaluation for hospitalization
- Justify all interventions NOT used
- Consult with colleagues (at least weekly)

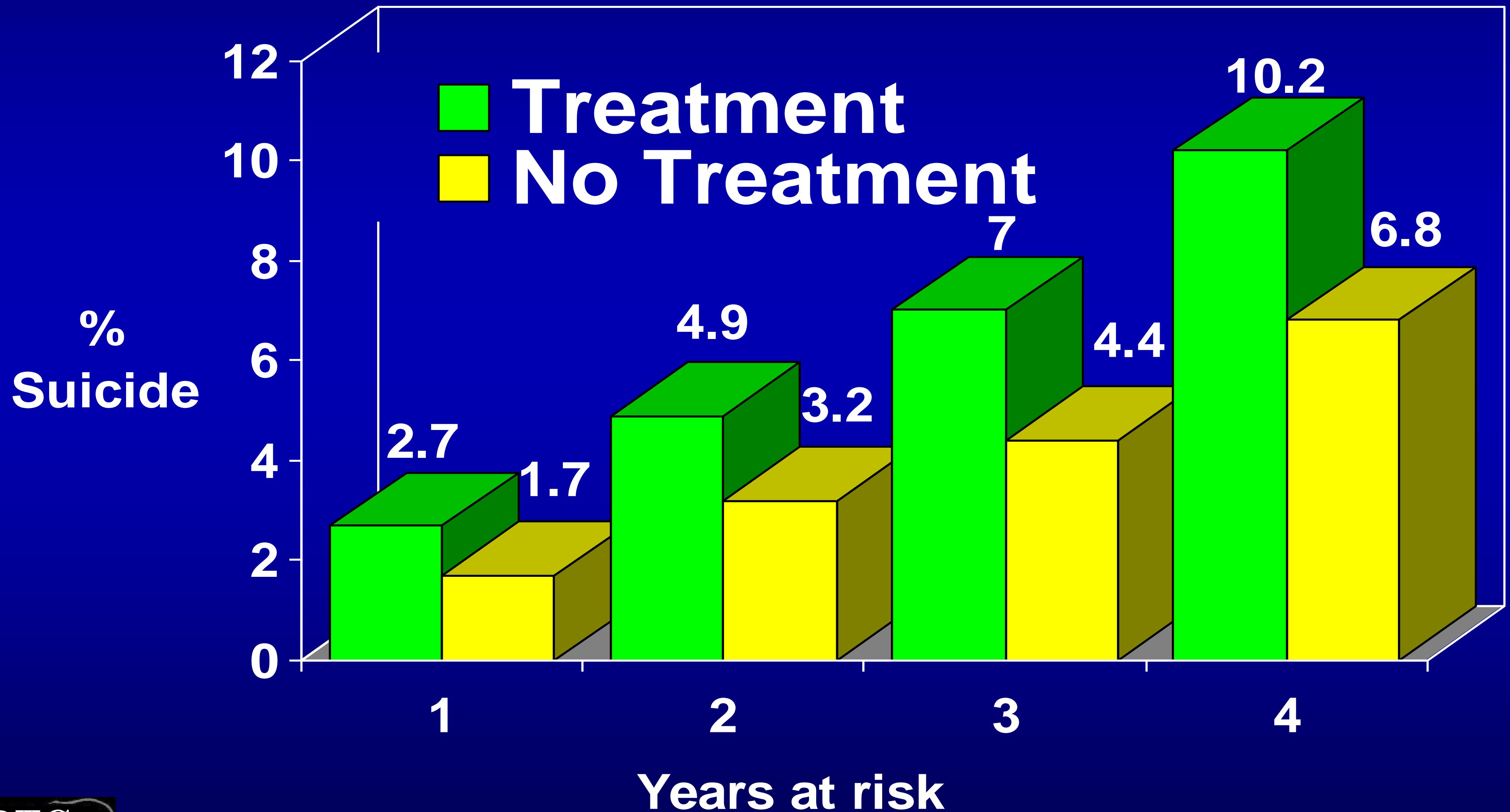
REDUCE SUICIDAL BEHAVIOR BY:

TEACHING DBT SKILLS FOR "BUILDING A LIFE EXPERIENCED AS WORTH LIVING"

Use of DBT Skills Mediates reductions in both suicide attempts and intentional self-injury

Send Caring Letters/Card to clients and former clients

Percent Eventual Suicide of Persons at High Risk for Suicide Who Obtain Treatment as Usual vs. Refuse Treatment



Motto (1976)

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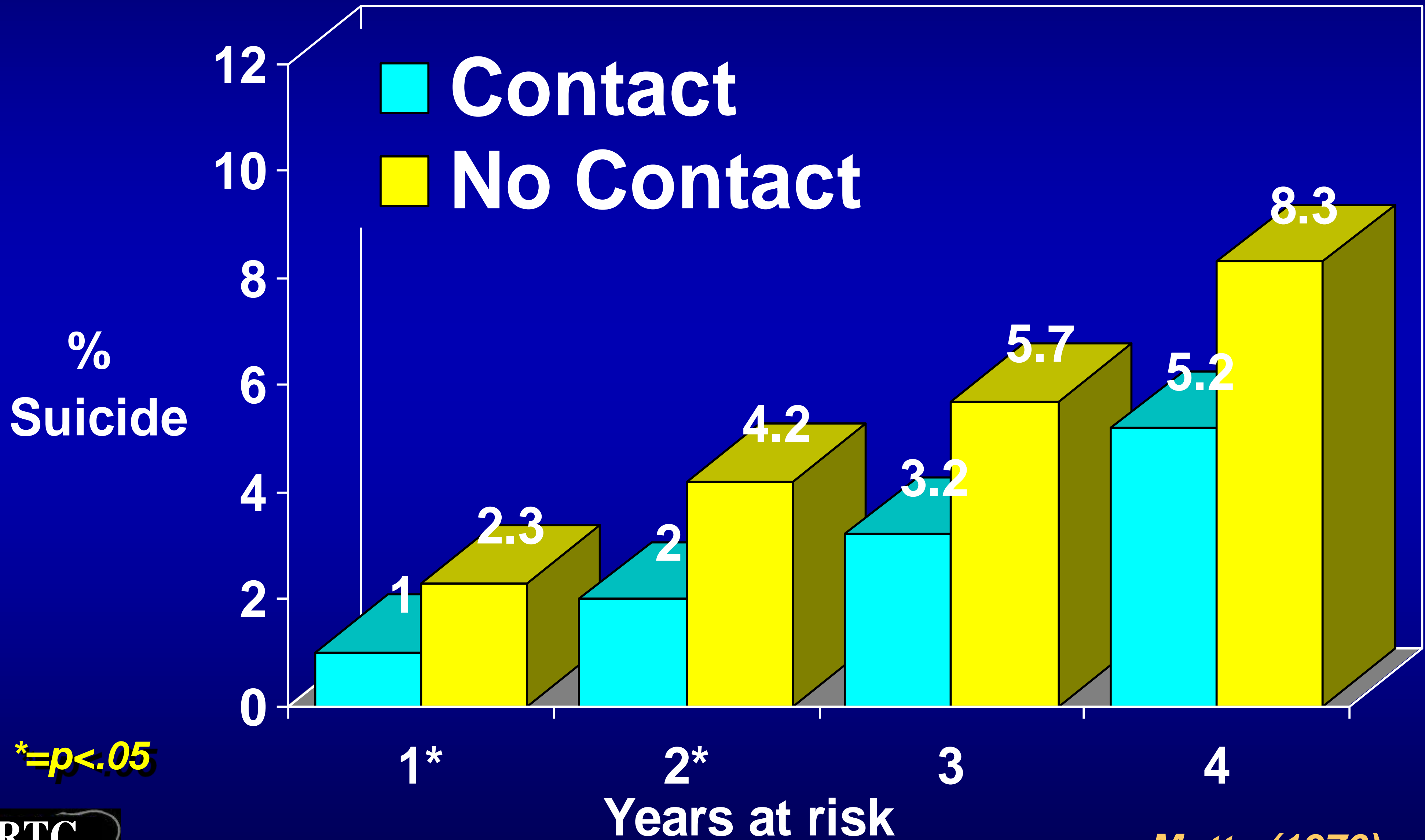
Percent Suicide for Contacted vs. Non-Contacted High Suicide Risk Persons Who Refuse Further Treatment



Motto (1976)

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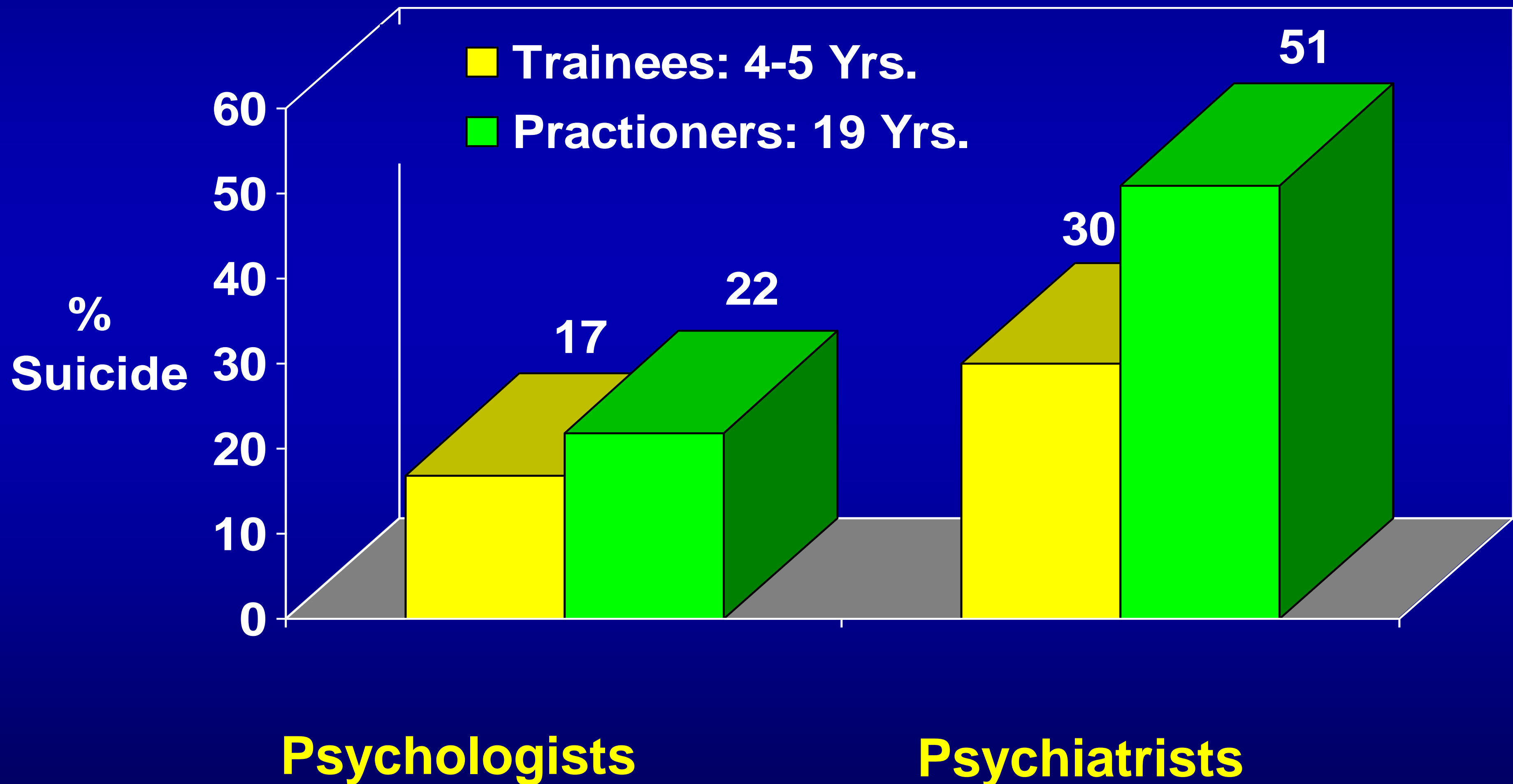
Percent of Psychotherapists with a Patient Suicide by Discipline and Training Status



Chemtob et al, 1988; Kleespies et al., 1990; Brown, 1987

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PRACTICE COPING AHEAD FOR DISASTER OF A CLIENT COMMITTING SUICIDE

LEARN EVIDENCE BASED TREATMENTS

DBT IS DEFINITELY EVIDENCE BASED AND

IS OVERWHELMINGLY COST EFFECTIVE.
For training: contact our UW Experimental Training Program (efranks @ uw.edu)

Fight for evidence based-treatment.

Strive for Excellence: Become certified in DBT if you offer it.

Contribute to our on-going efforts to increase certification.
https://dbt-lbc.org Suicidal individuals deserve to get the real effective treatment when it is promised.

Presenter

Diana Cortez Yanez
Lived Experience Consultant
NowMattersNow.org

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My Lived Experience

Context: I am ONE person with ONE experience.

- **I am a Hispanic female who felt like there was no one else in my social world who had been suicidal or who would understand.**
- **I have been treated for suicide attempts in the ER, in inpatient settings, and in individual therapy.**
- **I have received supportive psychotherapy and an empirical treatment, Dialectical Behavior Therapy.**

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Barriers to Addressing Suicidal Thoughts

I didn’t bring suicide up because:

- I was afraid.
- I didn’t know suicidal thoughts were something that many people had.
- Bringing things up or being direct with authority wasn’t ‘normal’ in my cultural and religious group.
- My trauma history made it difficult to bring up with authority.
- I didn’t know what I didn’t know.

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Supportive Therapy

Things that were Helpful

- Hand holding listeners → Felt less alone, valuable, and heard
- Had access to an educated professional who cared and was patient

Things that were less Helpful

- Didn't talk about suicide and it progressed
- They didn't know how to help
- I didn't improve

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DBT-ACES Recovery Goal:

A life worth living outside the social service system. This means the ability to live successfully without continuous psychosocial treatment and off psychiatric disability benefits, despite life's inevitable setbacks.

Video of Dr. Comtois at: http://bit.ly/1CUFNzL

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Empirically Supported Therapy

Things that were helpful

- Measuring and addressing my suicidal behavior
- Focusing on learning and practicing skills
- Not ‘getting off the hook’ – being accountable

Things that were challenging

- Trying new things (opposite action)
- Practicing consistency…skills day in and day out
- Erasing old tapes (not doing old things)

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What I want you to take away as a clinician

The experience of what it feels like to be sitting in your office as a suicidal person:

1) What I was thinking

2) What I thought your body language, words, and actions were communicating

3) How convinced I was that I should die by suicide

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What I want you to take away as a clinician

The stages of being suicidal, from regular suicidal thoughts to planning to attempting suicide…

1) Daily suicidal thoughts

2) Planning Suicide

3) Attempting Suicide

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TYPE IN THE CHAT

What questions do you have for any of our presenters?

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Getting Started with Zero Suicide

- Create an Implementation Team
- Take *Zero Suicide Organizational Self-Assessment*
- Complete *Organizational Work Plan Template*
- Administer *Zero Suicide Work Force Survey*
- Determine how to educate all staff about adoption of Zero Suicide approach
- Join the Zero Suicide listserv
- Visit www.zerosuicide.com for more information

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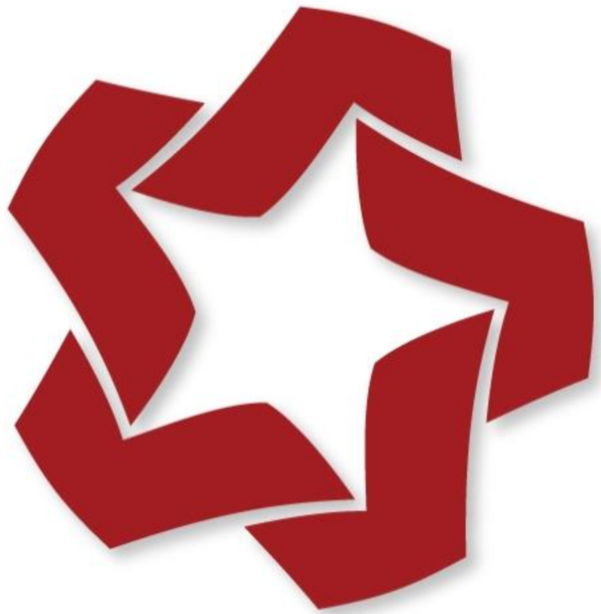

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