Innovations in Clinical Assessment and Treatment of Suicide Risk

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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 Non-Suicidal Self-Injury Behavior

DBT’s Impact on Suicide Attempt 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

58 Received CT
350 Assessed for Eligibility
120 Randomized
60 Assigned to Cognitive Therapy + Usual Care
58 Received CT
2 Did not receive CT
65 Assigned to Usual Care
62 Received Usual Care

Follow-up Assessments
1, 3, 6, 12, 18 Months

20 Lost to Follow-up at 18 mo
16 No Contact
2 Died Natural Causes
1 Refused

15 Lost to Follow-up at 18 mo
12 No Contact
1 Died Suicide
2 Refused


Survival Functions for Repeat Suicide Attempt by Study Condition

Cognitive Therapy Intervention
Control

Days
Cumulative Survival

Post Admission Cognitive Therapy (PACT)
Individual Therapy – 6 TOTAL Sessions: 90 Minutes Each

<table>
<thead>
<tr>
<th>Treatment Phase</th>
<th>Therapeutic Goals</th>
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</thead>
<tbody>
<tr>
<td><strong>Phase I</strong></td>
<td></td>
</tr>
<tr>
<td>Sessions 1 and 2</td>
<td>❑ Build Therapeutic Alliance</td>
</tr>
<tr>
<td></td>
<td>❑ Provide Psychoeducation</td>
</tr>
<tr>
<td></td>
<td>❑ Develop Collaborative Safety Plan</td>
</tr>
<tr>
<td></td>
<td>❑ Construct Suicide Attempt Story</td>
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<tr>
<td><strong>Phase II</strong></td>
<td></td>
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<tr>
<td>Sessions 3 and 4</td>
<td>❑ Instill Hope – Increase Reasons for Living</td>
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<tr>
<td></td>
<td>❑ Teach Adaptive Coping Strategies</td>
</tr>
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<td></td>
<td>❑ Target Deficits in Problem Solving</td>
</tr>
<tr>
<td><strong>Phase III</strong></td>
<td></td>
</tr>
<tr>
<td>Sessions 5 and 6</td>
<td>❑ Promote Linkage to Outpatient Aftercare</td>
</tr>
<tr>
<td></td>
<td>❑ Teach Relapse Prevention Strategies</td>
</tr>
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<td></td>
<td>❑ Refine Safety Plan before Discharge</td>
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</table>
Safety Planning Intervention
(Stanley & Brown, 2008; 2012)

A collaborative 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

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

<table>
<thead>
<tr>
<th>Sample/Setting</th>
<th>n</th>
<th>Significant Results</th>
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<tbody>
<tr>
<td>Jobes et al., 1997</td>
<td>106</td>
<td>Pre/Post Distress Pre/Post Core SSF</td>
</tr>
<tr>
<td>Jobes et al., 2005</td>
<td>56</td>
<td>Between Group Suicide Ideation, ED/PC Appts.</td>
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<tr>
<td>Arkov et al., 2008</td>
<td>27</td>
<td>Pre/Post Core SSF Qualitative findings</td>
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<tr>
<td>Jobes et al., 2009</td>
<td>55</td>
<td>Linear reductions Distress/Ideation</td>
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<td>Nielsen et al., 2011</td>
<td>42</td>
<td>Pre/Post Core SSF</td>
</tr>
<tr>
<td>Ellis et al., 2012</td>
<td>20</td>
<td>Pre/Post Core SSF Suicidal ideation, depression, hopelessness</td>
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<tr>
<td>Ellis et al., 2015</td>
<td>52</td>
<td>Suicide ideation/cognitions</td>
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Strong Correlational and Open Trial Support for SSF/CAMS

CAMS RCT (Comtois et al., 2011) Significantly higher patient satisfaction ratings and better clinical retention...
**Operation Worth Living:**

DOD-Funded CAMS RCT at Ft. Stewart, GA

<table>
<thead>
<tr>
<th>Consenting Suicidal Soldiers (n=148)</th>
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<tbody>
<tr>
<td>Control Group E-CAU</td>
</tr>
<tr>
<td>3 months of outpatient care (n=75)</td>
</tr>
<tr>
<td>Experimental Group CAMS</td>
</tr>
<tr>
<td>3 months of outpatient care (n=73)</td>
</tr>
</tbody>
</table>

**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, NFL, THI (at 1, 3, 6, 12 months)

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

Figure 1. College Student Client Flow through the SMART

**CAMS** = Collaborative Assessment and Management of Suicide Risk

**TBI** = Traumatic Brain Injury

**DST** = Dialectical Behavior Therapy

**NIH** = National Institute of Health

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

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**Resources for CAMS**

- CUA Suicide Prevention Lab: [https://sites.google.com/site/cuajsplab/home](https://sites.google.com/site/cuajsplab/home)
- CAMS e-learning: [www.empathosresources.com](http://www.empathosresources.com)
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...

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

4 Sessions, followed by regular letters over 2 years

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


ASSIP 2-Year Results

<table>
<thead>
<tr>
<th>Follow-up</th>
<th>Group</th>
<th>M</th>
<th>SD</th>
<th>n</th>
<th>p</th>
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<td>6 months</td>
<td>ASSIP</td>
<td>68</td>
<td>1</td>
<td>1</td>
<td>.034, p &lt; .001</td>
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<td></td>
<td>CO</td>
<td>57</td>
<td>18</td>
<td>7</td>
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<tr>
<td>12 months</td>
<td>ASSIP</td>
<td>68</td>
<td>1</td>
<td>1</td>
<td>.034, p &lt; .001</td>
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<tr>
<td></td>
<td>CO</td>
<td>58</td>
<td>0</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>1.5 years</td>
<td>ASSIP</td>
<td>66</td>
<td>2</td>
<td>2</td>
<td>.034, p &lt; .001</td>
</tr>
<tr>
<td></td>
<td>CO</td>
<td>42</td>
<td>16</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: ASSIP: Therapy plus TAU; CO: 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

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

Cumulative Percentage of Suicides

Source: Motto & Bostrom, 2001