Suicide Prevention Training
Options for Providers:
The Evidence-Based Approaches

David A. Jobes, Ph.D., ABPP
Professor of Psychology
Associate Director of Clinical Training
The Catholic University of America
Washington, DC

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Evidence-Based Treatments for Suicidality

Opportunities to Improve Interventions to Reduce Suicidality: Civilian “Best Practices” for Army Consideration

Michael Schoenbaum, PhD
schoenbaum@nih.gov

Robert Heimssen, PhD
rheinssen@nih.gov

Jane Pearson, PhD
jpearson@nih.gov

Author affiliations: All authors are affiliated with the Division of Services and Intervention Research, National Institute of Mental Health, 6001 Executive Blvd, Bethesda, MD 20892.

The views expressed in this document do not necessarily represent the views of the National Institute of Mental Health, the National Institutes of Health, the Department of Health and Human Services, or the United States government.

* This document was developed in support of the US Army’s ongoing efforts to reduce suicides and suicidality among Army Soldiers, and submitted to General Peter Chiarelli, Vice Chief of Staff of the Army, in December 2009. An earlier version of this document was submitted to Mr. Robert Androwe, Special Assistant to the Secretary of the Army, and General Chiarelli, in May 2009. The current version has been updated and somewhat expanded, in particular by adding a section on quality assurance and performance metrics (Section III).
Thus far, certain coping oriented psychotherapies have the most research support for effectively treating suicidal risk. In particular, the research supports highly-structured, problem solving approaches. The following evidence-based approaches are highlighted in the overview report:

- **Dialectical Behavior Therapy** – the most thoroughly studied and efficacious psychotherapy for suicidal behavior
- **Cognitive Therapy** – the next most studied and supported suicide-relevant psychotherapy
- **Other Promising Interventions** – The authors cited two other interventions that exhibit strong correlational support and are now being studied in randomized clinical trials – **Safety Planning Intervention** and **Collaborative Assessment and Management of Suicidality**

**GOOD NEWS:** There are now 26 RCT’s underway!
Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behavior Therapy vs Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder

Marshia M. Linehan, PhD; Katherine Anne Contos, PhD; Angela M. Murray, MA, MSW; Milton Z. Brown, PhD; Robert J. Gallop, PhD; Harold L. Heard, PhD; Kathryn E. Korsland, PhD; Darren A. Turek, MS; Sarah K. Reynolds, PhD; Noam Lindenkrantz, MS

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

Objectives: To evaluate the hypotheses 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-injures 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 = .003), required less hospitalization for suicide ideation (hazard ratio, 2.8; P = .004), and had lower medical risk (F_{1,10}=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_{1,10}=6.0; P = .007) and psychiatric emergency department visits (F_{1,9}=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

Dialectical Behavior Therapy (Linehan)

Change

Acceptance

Irreverence

Reciprocity

Problem Solving

Validation

Consultation-to-the-Patient

Team Consultation

Environmental Intervention
Suicide Attempt Behavior

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.

Figure 4. Mean ordinal nonsuicidal self-injury during the 2-year study. 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
Number of Patients with Repeat Suicide Attempts

Study 2

- Cognitive Therapy (n = 60): 24%
- Control (n = 60): 42%

*p < .05*
Brief Cognitive Behavior Therapy (B-CBT)

M. David Rudd, Ph.D. & Craig Bryan, Psy.D.

Ft. Carson Randomized Clinical Trial
Phased Approach to Treatment

- Phase I: Engagement
- Phase II: Self-management
- Phase III: Skill development
- Phase IV: Relapse prevention
Figure 1. Flow of Participants in the Pilot Trial for Post Admission Cognitive Therapy (PACT)

Individual with a Recent Suicide Attempt Admitted to Inpatient Psychiatric Unit at WRAMC

Eligible Patients Referred by Attending Physician

RA Recruits & Consents Eligible Patients from the Permission to Approach Form

Baseline Assessments Conducted by Study Assessor/Therapist

Randomization 50 Patients

25 Patients PACT + Enhanced Usual Care (Six 60-90 Minute PACT Sessions)

1-Month, 2-Month, 3-Month Follow-up
   Follow-Up A Web-Based Self-Administered Questionnaires (35-75 Minutes)
   Follow-Up B Phone Clinical Interview (15-90 Minutes)

25 Patients Enhanced Usual Care (No PACT Sessions)

1-Month, 2-Month, 3-Month Follow-up
   Follow-Up A Web-Based Self-Administered Questionnaires (35-75 Minutes)
   Follow-Up B Phone Clinical Interview (15-90 Minutes)
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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</table>
| **Phase I**     | □ Build Therapeutic Alliance  
                     □ Provide Psychoeducation  
                     □ Develop Collaborative Safety Plan  
                     □ Construct Suicide Attempt Story |
| Sessions 1 and 2|                   |

**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
Resources for Cognitive Behavioral Therapy

Source Text:

http://www.apa.org/pubs/books/images/4317169-150.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
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), Safety Planning Intervention

Compilation of evidenced-based strategies (e.g., means restriction, social support, etc.)

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 and 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 service professionals.

Safety Planning Intervention (Stanley & Brown, 2008; 2012)

Phone app site: https://itunes.apple.com/us/app/safety-plan/id695122998?ls=1&mt=8
A Brief Intervention to Reduce Suicide Risk in Military Service Members and Veterans

SAFE-MIL: Using Safety Planning Intervention for suicidal inpatient Soldiers
SAFE-VET: Using Safety Planning + Follow-up Intervention for Veterans

Principal Investigators (alphabetical):
Lisa Brenner, PhD, VA VISN 19 MIRECC, Denver and U. of Colorado
Gregory Brown, PhD, U. of Pennsylvania and VA VISN 4 MIRECC, Philadelphia
Glenn Currier, MD, MPH, U. of Rochester and VA Center of Excellence, Canandaigua
Marjan Holloway, PhD, Uniformed Services University of the Health Sciences
Kerry Knox, PhD, U. of Rochester and VA Center of Excellence, Canandaigua
Barbara Stanley, PhD, Columbia University
The Collaborative Assessment and Management of Suicidality (CAMS)

MANAGING Suicidal Risk
A Collaborative Approach

DAN A. JOBES
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<td>Jobes et al., 1997</td>
<td>College Students</td>
<td>106</td>
<td>Pre/Post Distress</td>
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<td>Univ. Counseling Ctr.</td>
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<td>Pre/Post Core SSF</td>
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<td>Jobes et al., 2005</td>
<td>Air Force Personnel</td>
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<td>Between Group Suicide Ideation, ED/PC Appts.</td>
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<td>Ideation, Depression, Hopeless, Suic. Cog.</td>
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CAMS RCT (Comtois et al., 2012)

Significantly higher patient satisfaction and better clinical retention...
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)
Resources for CAMS

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

Guilford Press book:  
http://www.guilford.com/cgi-bin/cartscript.cgi?page=pr/jobes.htm&dir=pp/law
New treatment research is on the way:

Model for Teachable Moments as Related to a Suicide Attempt

Perceived risk & positive outcomes increased

Emotion is increased

Motivation

Acquisition of skills

Self-concept/social role is defined

Self-efficacy

Cuing Event

Rejecting Suicide as an Option for Solving Problems

(Adapted from McBride, Emmons, & Lipkus, 2003)

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

Session Therapeutic elements
1. Establish a therapeutic relationship
2. Emotional activation, restructuring
3. Develop a shared understanding
4. Protocol rehearsal
5. Continuous therapeutic relationship

Reinforcing safety strategies

ASSIP Modules

A 4 Sessions, followed by regular letters over 2 years


Stephen O’Connor, Ph.D.
Konrad Michel, M.D.

Craig Bryan, Psy.D.
Lora Johnson, Ph.D.
Tom Ellis, Psy.D.