State of the art in the 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 (Secretary’s Task Force)
- The birth of the suicide (loss) survivor movement
- Routine use of lengthy inpatient hospitalization
- Routine use of “no-suicide” contracts—“commitment to safety”

Today the field is exploding...

- Suicidology is increasing exponentially
- VA and DOD are spending millions on suicide prevention
- State legislation requiring suicide-specific training for licensed professionals continuing education (CEU’s)
- The impact of “lived-experience and attempt survivors”
- National Action Alliance (Clinical Care Task Force → “Zero Suicide” raising the standard of clinical care)
- An increasing emphasis on evidence-based treatments

Shneidman’s Cubic Model of Suicide

Shneidman’s Cubic Model of Suicide

Joiner’s Interpersonal Theory

Joiner’s Interpersonal Theory

Integrated Motivational–Volitional Model (IMV)

Integrated Motivational–Volitional Model (IMV)
Suicide-Specific Assessment Measures (from Brown, 2001)
- Scale for Suicide Ideation
- Beck Scale for Suicide Ideation
- Modified Scale for Suicide Ideation
- Self Monitoring Suicide Ideation Scale
- Suicide Intent Scale
- Parasuicide History Inventory
- Suicide Behavior Questionnaire—Revised
- Suicide Behavior Interview
- Suicide Probability Scale
- Positive and Negative Suicide Ideation
- Adult Suicide Ideation Questionnaire
- Suicide Ideation Scale
- Suicide Status Form

Mayo Clinic RFL/RFD Cross Sectional Data (n=108) (Jobes, Stone, Wagner, & Lineberry, 2010)

<table>
<thead>
<tr>
<th>Measures</th>
<th>RFL</th>
<th>AMB</th>
<th>RFD</th>
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<tr>
<td>Beck Hopelessness Scale</td>
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<td>Suicide Index Score</td>
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<tr>
<td>Suicide Attempts</td>
<td>RFL</td>
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<tr>
<td>0-1 Attempts</td>
<td>15</td>
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<tr>
<td>2 or more Attempts</td>
<td>5</td>
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<tr>
<td>Chi-Sq</td>
<td>7.83*</td>
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</table>

* p < .05, ** p < .01, *** p < .001

Craig Bryan, Psy.D.
Crisis Response Plans vs. No-Suicide Contracts
Evidence-Based Treatments for Suicidality

- There are 50-80 RCT’s with suicidal ideation and behaviors as treatment outcomes
- There is no support for the use of inpatient hospitalization and there are concerns about increased risk for suicide post-discharge
- There is a lot of interest in brief suicide-specific interventions
- RCT’s with replicated support:
  - Dialectical Behavior Therapy (DBT)
  - Two types of suicide-specific CBT (CT-SP & B-CBT)
  - Collaborative Assessment and Management of Suicidality (CAMS)
  - Non-demand follow-up “caring contact”

Medications for Suicidal Risk

- Mann et al (2005): “Treating mood and the underlying psychiatric disorder is “…a central component of suicide prevention.”
- Un-replicated RCT evidence for lithium (Tondo et al., 2001) and clozapine (Meltzer et al., 2003—only FDA approved Rx).
- RCT’s not finding a SSRI effect on suicide ideation/behavior:
  - Gunnell et al (2005)
  - Ferusson et al (2005)
- RCT’s that did find a SSRI effect on suicide ideation/behavior:
  - Zisook et al (2011)
  - Gibbons et al (2012)

Ketamine?
Nitrous oxide?

RCT data supporting medications are mixed at best...

Resources for Dialectical Behavior Therapy

Source Text: http://www.psychotherapy.net/linehan.htm
Training Website: http://behavioraltech.org/index.cfm

Resources for Cognitive Behavioral Therapy


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

Critique of Current Approach to Suicide Risk: THE REDUCTIONISTIC MODEL
(Suicide = Symptom of Psychopathology)

Traditional treatment = inpatient hospitalization, treating the psychiatric disorder, and using no suicide contracts...

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...
**Correlational and Open Clinical Trial Support for SSF/CAMS**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Sample/Setting</th>
<th>n</th>
<th>Significant Results</th>
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<td>Jobes et al., 1997</td>
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**Randomized Controlled Trials of CAMS**

<table>
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<tr>
<th>Principal Investigator</th>
<th>Setting &amp; Design</th>
<th>Sample Size</th>
<th>Status</th>
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<td>Harborview/Seattle CMI patients</td>
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<td>2011 published article</td>
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<td>Andreasson (Nordentoft)</td>
<td>US Army Soldiers in preparation</td>
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<td>2016 published article</td>
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<td>Jobes (Comtois et al)</td>
<td>Ft. Stewart, GA</td>
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<td>in press; in preparation</td>
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<tr>
<td>Pistorello (Jobes)</td>
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<td>62</td>
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<td>Fosse</td>
<td>Norwegian Centers CMI patients</td>
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<td>ITT done; evals on-going</td>
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<td>Comtois (Jobes)</td>
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<td>Santel et al</td>
<td>German Crisis Unit Inpatients</td>
<td>110</td>
<td>ITT underway</td>
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</tbody>
</table>

**CAMS RCT (Comtois et al., 2011)**

- At 28 weeks: DBT Self Harm = 21; CAMS = 12
- DBT Attempts = 12; CAMS = 5

**Operation Worth Living (OWL)**

- Consenting Suicidal Soldiers (n=148)
  - Experimental Group: CAMS 3 months of outpatient care (n=73)
  - Control Group: E-CAU 3 months of outpatient care (n=75)

**Treatment Outcome Results (n=148)**

- Significant 3 month finding for CAMS eliminating suicidal ideation
- No significant between-group differences on suicide attempts (only 5 in the study)
Moderator Analyses supporting CAMS

Outcome: Functional impairment (as reported by the Q-45)

- Condition: CAMS
- E-CAM

Not married
Married

Comments: Among married participants, functional impairment (as measured by the Q-45) dropped more quickly over time for those receiving CAMS.

Moderator outcome: Any Behavioral Health ED Admission

Comments: There is a more rapid decrease in the likelihood of any behavioral health-related ED admission among those receiving CAMS at lower levels of symptoms distress at baseline.

This finding is important as partially replicated 2005 Air Force data.

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

Stage 1

Stage 2

SMART Results (Stage 1 only)

CCAPS findings with n=62 suicidal students

Significant results supporting CAMS for suicidal ideation, depression, and anxiety

CAMS Research Findings Summary

- Across 8 published non-randomized clinical trials of CAMS, 1 meta-analysis, and 3 published randomized controlled clinical trials, (and 2 unpublished RCT’s):
  - CAMS quickly reduces suicidal ideation in 6-8 sessions
  - CAMS reduces overall symptom distress, depression, anxiety, and changes suicidal cognitions
  - CAMS increases hope and improves clinical retention to care
  - Patients like CAMS and the process of doing CAMS
  - CAMS works better with less severe patients at baseline presentation (impact with borderline patients is mixed)
  - CAMS decreases ED visits among certain subgroups
  - CAMS appears to have a promising impact on self-harm behavior and suicide attempts (but replication is needed)
  - CAMS is relatively easy to learn to use with adherence
Safety Planning, CRP + RFL, means restriction can be used throughout.

Suicide-specific Care at Each Step:
- Inpatient Psychiatric Hospitalization
- Partial Hospitalization
- Emergency Room/Patient Care
- Safety Planning, NSSP, TMBI
- Crisis Cenr/Mobile Support + Follow-up

From Least to Most Restrictive Intervention

We NEED a national “MENTAL HEALTH CORP” of para-professionals!