Raising the Standard of Suicide-Care: Clinical Suicidology and Systems of Care

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THE CATHOLIC UNIVERSITY of AMERICA

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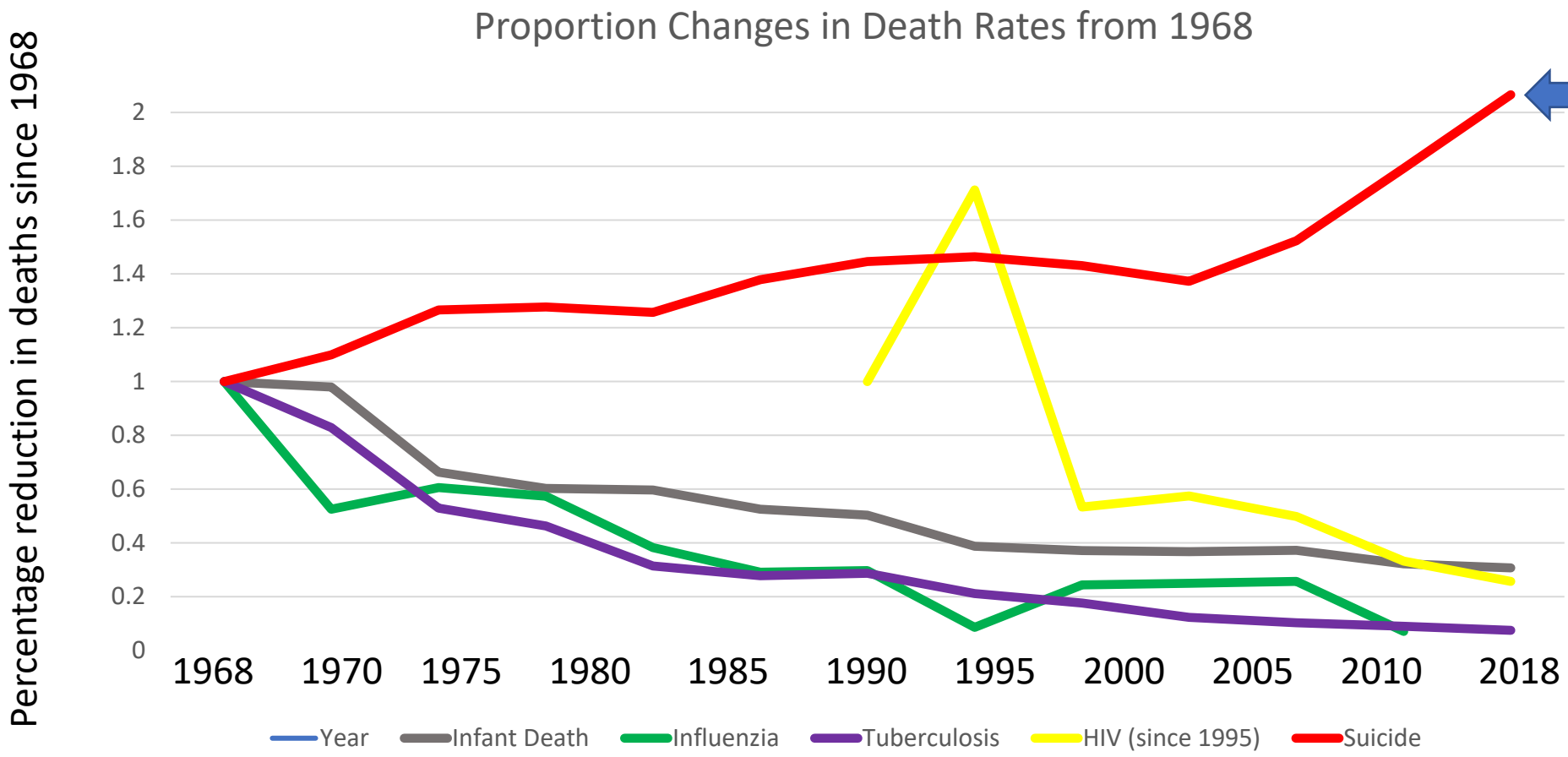
- Founder and Partner, CAMS-care, LLC (a professional training and consultation company)

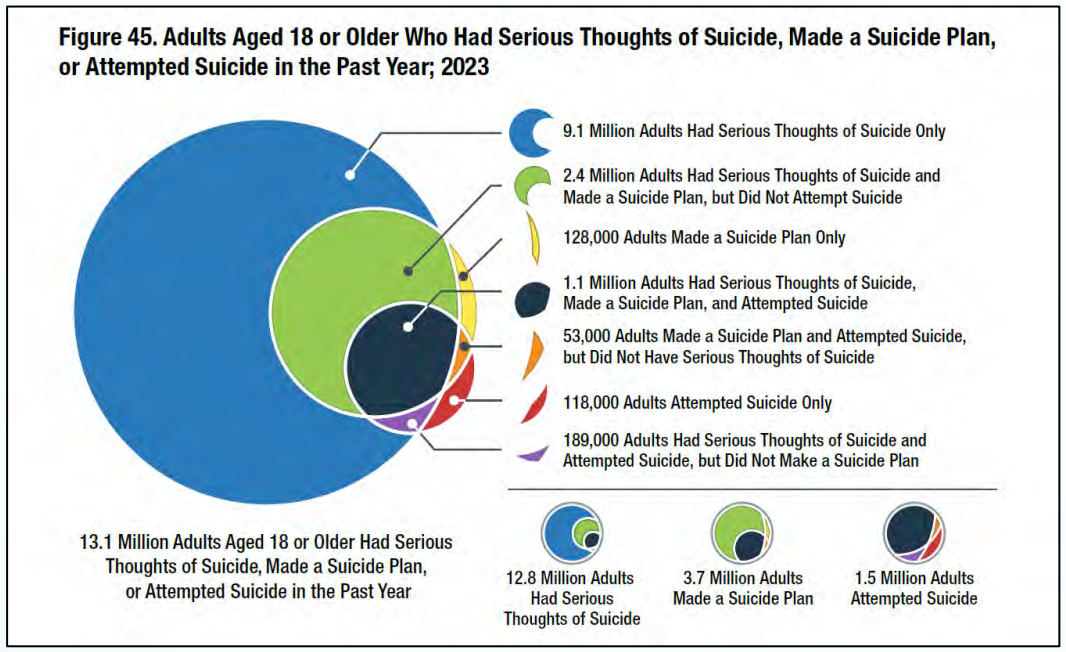
50+ Years Addressing Leading Causes of Death in the United States of America



Rates decreased 2019 and 2020, but increased 2021 and again in 2022 with highest number of suicide deaths in US history (Prov = 49,449)

Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1968-2016 on CDC WONDER Online Database, released June 2017. Data are from the Compressed Mortality File 1999-2016 Series 20 No. 2U, 2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/cmf-icd10.html on Nov 10, 2019 7:07:31 PM

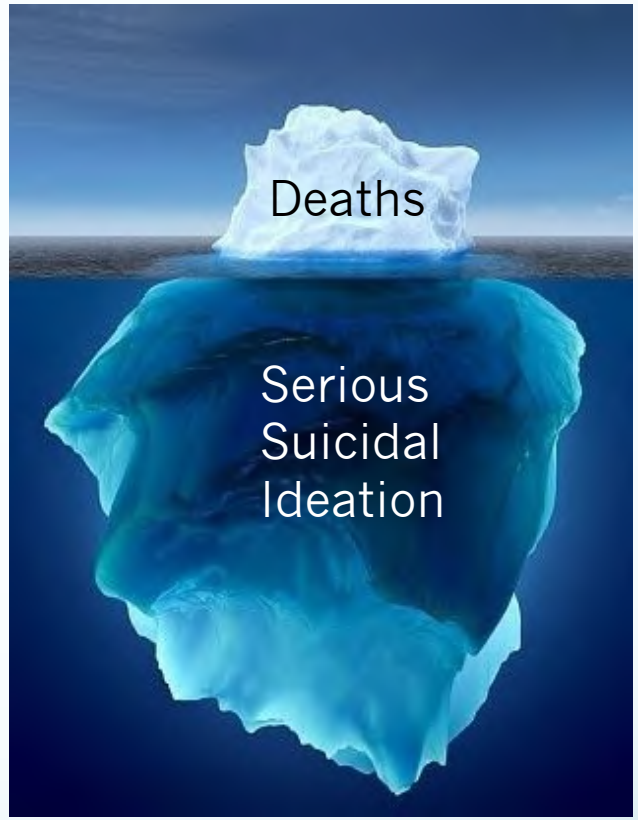
The Importance of Suicidal Ideation




Editorial

Reflections on Suicidal Ideation

David A. Jobes[1] and Thomas E. Joiner[2]

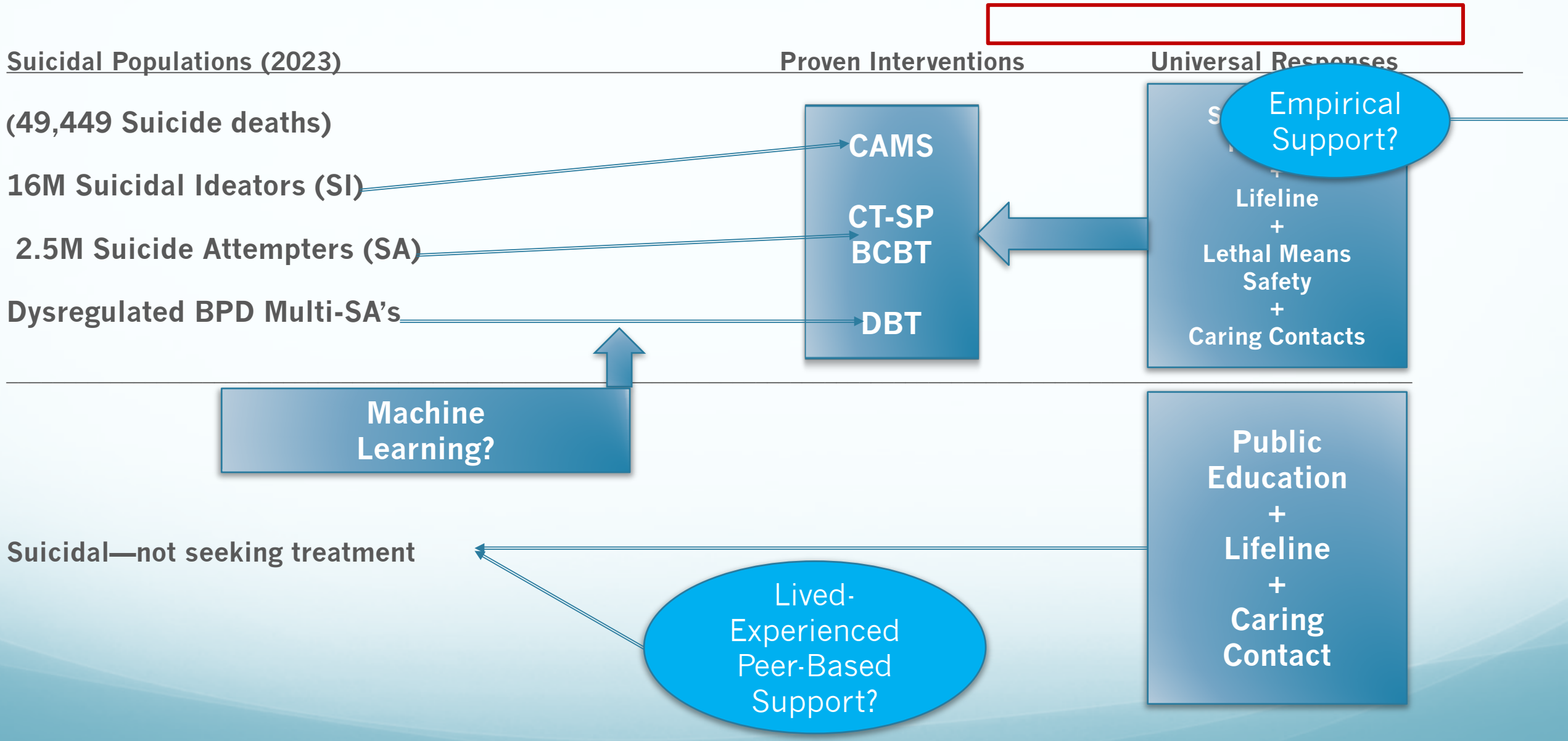


In 2023, there were **16,000,000** total Americans with serious suicidal thoughts!

We are understandably preoccupied with attempts and deaths.
But why do we not appreciate the largest population challenge of all?
Our biggest challenge are those American adults and teens with *serious thoughts of suicide* in the past 30 days.

2023 SAMHSA data adds 3,200,000 teens who also have serious thoughts of suicide

One-Size Does Not Fit All: Matching Proven Treatments to Different Suicidal Populations



But the field has had a professional crisis (2008)

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
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James C. Overholser
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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 in models of health care delivery, the role of research, and issues of diversity). These 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.

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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-Ramos 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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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.

And challenges continued (2017)

Practice Innovations
2017, Vol. 2, No. 4, 207–220

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Clinical Assessment and Treatment of Suicidal Risk: A Critique of Contemporary Care and CAMS as a Possible Remedy

David A. Jobes
The Catholic University of America

There is a significant need to improve clinical practices related to suicidal patients within contemporary mental health practice. It is argued that there is a general over-reliance on psychotropic medications and the use of inpatient psychiatric hospitalizations for suicidal risk. This reliance is puzzling given the lack of empirical support for these approaches; the evidence supporting the use of psychotropics is mixed and there are recent challenges to the routine use of inpatient care that tends not to be suicide-specific and may increase post-discharge risk. Importantly there are several psychological treatments proven effective in rigorous randomized controlled trials (RCTs). Of the *replicated* RCTs, dialectical behavior therapy (DBT), two forms of suicide-specific cognitive-behavioral therapy—cognitive therapy for suicide prevention (CT-SP) and brief cognitive behavioral therapy (BCBT)—and the collaborative assessment and management of suicidality (CAMS) have shown robust data for effectively treating suicidal risk. But despite the data these treatments are not widely used. Possible reasons for an inadequate professional response to suicidality may include: (a) countertransference, (b) fear of malpractice litigation, (c) lack of knowledge about suicide risk assessment, and (d) lack of knowledge about effective treatment for suicidal risk. CAMS is discussed as a possible remedy for the professional and clinical issues raised in this article.

Clinical Impact Statement
This article critiques current contemporary practices related to suicidal patients with general suggestions for raising the standard of clinical care. Various evidence-based approaches to improving practices with suicidal patients are considered and the Collaborative Assessment and Management of Suicidality (CAMS) is discussed in depth.

Keywords: suicide risk assessment, suicide treatment, malpractice liability, CAMS

Suicide is the fatality of mental health practice and is the 10th leading cause of death in the United States with upward of 44,000 deaths per year (Centers for Disease Control and Prevention, 2015). There are over 1 million suicide attempts and 9.8 million Americans struggle with suicidal thoughts each year (Piscopo, Lipari, Cooney, & Glasheen, 2016). Despite these appalling data, many mental health professionals (across disciplines) do not receive suicide-specific assessment and treatment training within their professional curriculums (Bongar, 2013). It has been previously argued that the state of affairs pertaining to the assessment and treatment of suicidal patients amounts to a professional—*even ethical*—crisis for the field of

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- Ten+ years later, not enough has changed in typical clinical practice to save lives.
- There is an over-reliance on psychiatric hospitalizations.
- There is an over-reliance on psychotropic medications.
- There is remarkably little use of effective and proven suicide-specific treatments.
- Why is this?
  - Countertransference
  - Fear of malpractice liability
  - Lack of awareness of suicide assessment innovations
  - Lack of awareness of suicide interventions and treatments

Process Improvement Initiatives

VISN 7 Suicide Risk Reduction Process Improvement Project

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5th VHA Mental Health Conference
August 23, 2011
Baltimore, MD

Raising the Clinical Standard of Care for for Suicidal Soldiers: An Army Process Improvement Initiative

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ABSTRACT

From 2004 to 2008, the suicide rate among US Army Soldiers increased 80%, reaching a record high in 2008 and surpassing the civilian rate for the first time in recorded history. In recent years, the rate of Army suicides rose again; the year 2012 reflects the highest rate of military suicides on record. There is a need to assess current behavioral health practices to identify both effective and ineffective practices, and to adapt services to meet the needs of the Army behavioral health patient population. This paper discusses a process improvement initiative developed in an effort to improve clinical processes for suicide risk mitigation in an Army behavioral health clinic located in the catchment area of the US Army Southern Regional Medical Command.

It has been estimated that in recent years up to 15% of casualties in the wars in Afghanistan and Iraq were the result of suicidal behavior and completed suicide.[1] According to the 2010 Department of Defense Sentinel Event Report (DoDSER),[2] 22.42% of Soldiers who died by suicide (n=63) and 44.15% of those who attempted suicide (n=381) had received outpatient behavioral health treatment during the prior month. The former US Army Vice Chief of Staff cited a document produced by the National Institute of Mental Health entitled "Opportunities to Improve Interventions to Reduce Suicidality: Civilian 'Best Practices' for Army Consideration"[3] to illustrate the current lack of suicide-focused, empirically validated clinical treatments. In response, a number of suicide prevention initiatives have been enacted throughout the Army. Suicide prevention efforts within the Army aim in part to reduce suicidal behaviors through education, encouragement of help-seeking behaviors, and destigmatization.[4] This is evident in the materials and publications developed by the US Army Center for Health Promotion and Preventive Medicine (now the Army Public Health Command) in conjunction with the American Association of Suicidology, and in multimedia publications from the Defense Centers of Excellence. These initiatives largely focus upon the identification of early warning signs in order to implement early intervention, namely, a referral to behavioral health. In spite of the development of these suicide prevention initiatives, Army service member suicide continues to rise. In 2012, a total of 349 US military suicide deaths were recorded across the branches; the largest portion of these deaths, 182 potential suicides, comprised of members of active duty Army.[5] These findings, coupled with the lack of suicide-focused clinical treatments for the military, prompted a flourish of research to understand suicidal behaviors within the military.

Suicide risk may concentrate more in Army Behavioral Health (BH) patient populations for several of the reasons that make military experience unique when compared to civilian life. When suicidality among military members accompanies behavioral health conditions associated with sleep disturbances, concentration problems, and physical symptoms that impact on daily functioning, this can lead to reduced occupational performance, physical conditioning, and combat readiness. Soldiers who are suicidal may also experience somatic concerns and related problems that result in a higher frequency of medical or sick call visits. This may then contribute to increased work stress and increased conflict with coworkers and family members, affecting morale and well-being. Special populations within the military community, such as Wounded Warriors, have their own unique set of risks including chronic pain, decreased level of functioning due to injury or other health problems, and potential prescription drug abuse. Psychological and physical issues are both likely contributors to suicide. Previous factor analytic research with suicidal inpatients has shown the important psychometric role of

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A model for the assessment, care, and treatment of suicidal risk within the military intelligence community

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ABSTRACT

This paper describes the development of a behavioral health and wellness model into the US Army Intelligence and Security Command (INSCOM) to address concerns about suicide within this community. In response to stresses existing within the intelligence community (IC), INSCOM partnered with the Army Public Health Center (APHC) to assess the health and wellbeing of Command personnel. A Community Health Assessment (CHA) survey was conducted (N = 2,704 Soldiers; N = 959 Civilians) that included focus groups across three installations and secondary source data. Six key areas were prioritized: suicide behavior, behavioral health access to care and health promotion, behavioral health stigma and maintaining clearances, workplace environment, sleep health, and overall fitness. Several actions were implemented to address the report's findings and recommendations. A Command Surgeon office was established within INSCOM. An INSCOM Health Assessment and Readiness Team (I-HART) was established. The Deputy Undersecretary of the Army provided support to address suicide within INSCOM by approving 4 highly qualified experts (HQE's) in behavioral health and clinical suicidology to provide research oversight and make recommendations. The Command General approved 8 behavioral health providers. There are planned research efforts within the command focusing on scalable and technology enabled care delivery to improve mental well-being and decrease suicides.

ARTICLE HISTORY
Received 8 August 2020
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KEYWORDS
Suicide; INSCOM; community health assessment

What is the public significance of this article?— To address concerning trends in suicide within the military intelligence community, a behavioral health and wellness model into the US Army Intelligence and Security Command (INSCOM) was developed. A Community Health Assessment (CHA) provided a systematic way to determine the health and quality of life-related needs and strengths of the Command's Soldier and Civilian personnel. Actionable health and wellness needs are identified and future research and support are described with the goal of improving wellness and decreasing suicides.

Introduction

The United States Army's Intelligence Security Command (INSCOM) is a two-star Army Command that conducts intelligence, security, and information operations for Army, Joint services, and our Coalition partners. Headquartered at Fort Belvoir, Virginia, INSCOM is comprised of 18 Brigade-size subordinate commands worldwide, 17 of which are under the Command's direct control. Personnel assigned to INSCOM include approximately 17,500 Active Duty Soldiers, Civilians, and contractors located at nearly 200 locations. The military intelligence (MI) community has been called upon to provide increased global support to fight terrorism and to mitigate national security threats. These threats are broad and our forces are continuously tasked with providing protection under increasingly challenging circumstances including high operation tempo (OPTEMPO), operation control (OPCON) and administrative control (ADCON) conflicts, shift work and sleep challenges, and deployed-in place personnel sustaining 365 24/7 operations (Prince et al., 2015).

The psychological wellbeing of the MI warfighter is a critical factor in successfully implementing the mission and goals of this community and in mitigating adversaries' attempts to undermine the moral and psychological conditioning of Soldiers. As the frontlines are

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The views expressed are those of the authors and do not reflect the official policy or position of the US Army, Intelligence and Security Command, Department of Defense, or the US Government.

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

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MDPI

Article

Embedding an Evidence-Based Model for Suicide Prevention in the National Health Service: A Service Improvement Initiative

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Abstract: Despite the improved understanding of the determinants of suicide over recent decades, the mean suicide rate within the United Kingdom (UK) has remained at 10 per 100,000 per annum, with about 28% accessing mental health services in the 12 months prior to death. In this paper, we outlined a novel systems-level approach to tackling this problem through objectively differentiating the level of severity for each suicide risk presentation and providing fast-track pathways to care for all, including life-threatening cases. An additional operational challenge addressed within the proposed model was the saturation of local crisis mental health services with approximately 150 suicidality referrals per month, including non-mental health cases. This paper discussed a service improvement initiative undertaken within a National Health Service (NHS) secondary care mental health provider's open-access 24/7 crisis and home treatment service. An organisation-wide bespoke "suicide risk triage" system utilising the Collaborative Assessment and Management of Suicidality (CAMS) was implemented across all services. The preliminary impacts on suicidality, suicide rates and service user outcomes were described.

Keywords: suicide prevention; suicidality; CAMS; service improvement; service model

1. Introduction

On average, someone dies by suicide every 40 s somewhere in the world [1]. Many more people die by suicide each year than in road traffic accidents, yet the funding for suicide prevention is significantly lower in comparison to road accident prevention [2], with the economic cost of suicide estimated at £1.7 million per individual [3]. Recent findings indicate that over 100 people are affected by every single suicide [4], with an increased likelihood of suicidal ideation and poor psychiatric outcomes for those closest to the individual [5]. Further, one in five adults in England report experiencing suicidal thoughts at some point in their lifetime [6]; broadening the focus of clinical treatments to include this larger population may have implications for reducing morbidity [7]. Historically, and in spite of the focus on suicide prevention in national policy, suicide rates have remained high, suggesting that certain components of the UK's national strategy require elucidation.

An important issue for suicide prevention is to identify those at risk of suicide and direct treatment efforts accordingly to prevent those individuals from taking their own lives [8]. Nationally, mental

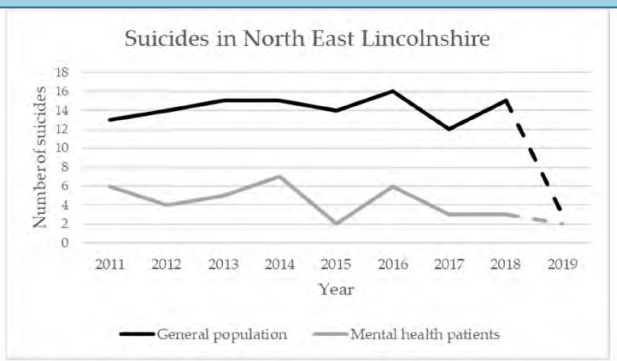


Figure 1. Suicides in North East Lincolnshire 2011–2019 (2018/19 data subject to ratification). The continuous line represents confirmed deaths by suicide, whereas dashed lines for years 2018/19 are tentative until legally confirmed via judgement at Coroner's Court where conclusions of death by suicide are formally established in the United Kingdom.


ZEROSuicide
INSTITUTE
ZEROSuicide
Suicide deaths for people under the care of health and behavioral health systems are preventable.
www.zerosuicideinstitute.com
www.zerosuicide.com

Seven Elements of Zero Suicide

www.zerosuicide.com

The National Action Alliance for Suicide Prevention outlined seven core components necessary to transform suicide prevention in health care systems:

LEAD	Lead system-wide culture change committed to reducing suicide.
TRAIN	Train a competent, confident, and caring workforce.
IDENTIFY	Identify individuals at-risk of suicide via comprehensive screening and assessment.
ENGAGE	Engage all individuals at-risk of suicide using a suicide care management plan.
TREAT	Treat suicidal thoughts and behaviors using evidence-based treatments.
TRANSITION	Transition individuals through care with warm hand-offs and supportive contacts.
IMPROVE	Improve policies and procedures through continuous quality improvement.

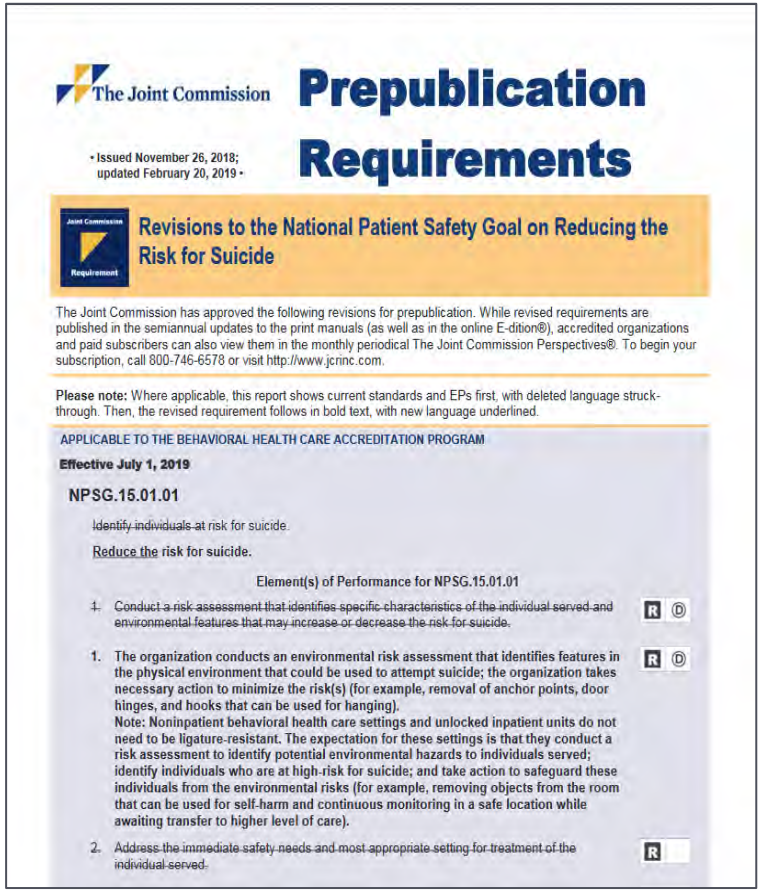
Why focus on health care?

- 84% of those who die by suicide have a health care visit in the year before their death.(1)
- 92% of those who make a suicide attempt have seen a health care provider in the year before their attempt.(1)
- Almost 40% of individuals who died by suicide had an ED visit but not a mental health diagnosis.(2)

(1) Ahmedani, B. K., et al. (2014). Health care contacts in the year before suicide death. *J Gen Intern Med 29*(6):870-7. 10.1007/s11606-014-2767-3

(2) Ahmedani, B. K., Stewart, C., Simon, G. E., Lynch, F., Lu, C. Y., Waitzfelder, B. E., ... & Hunkeler, E. M. (2015). Racial/ethnic differences in healthcare visits made prior to suicide attempt across the United States. *Medical care*, *53*(5), 430.

The Joint Commission National Patient Safety Goal 15.01.01: Reduce the Risk for Suicide



The Joint Commission **Prepublication Requirements**

• Issued November 26, 2018; updated February 20, 2019 •

Revisions to the National Patient Safety Goal on Reducing the Risk for Suicide

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online E-dition®), accredited organizations and paid subscribers can also view them in the monthly periodical The Joint Commission Perspectives®. To begin your subscription, call 800-746-6578 or visit http://www.jcrinc.com.

Please note: Where applicable, this report shows current standards and EPs first, with deleted language struck-through. Then, the revised requirement follows in bold text, with new language underlined.

APPLICABLE TO THE BEHAVIORAL HEALTH CARE ACCREDITATION PROGRAM

Effective July 1, 2019

NPSG.15.01.01

~~Identify individuals at risk for suicide.~~

Reduce the risk for suicide.

Element(s) of Performance for NPSG.15.01.01

~~1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.~~ R D

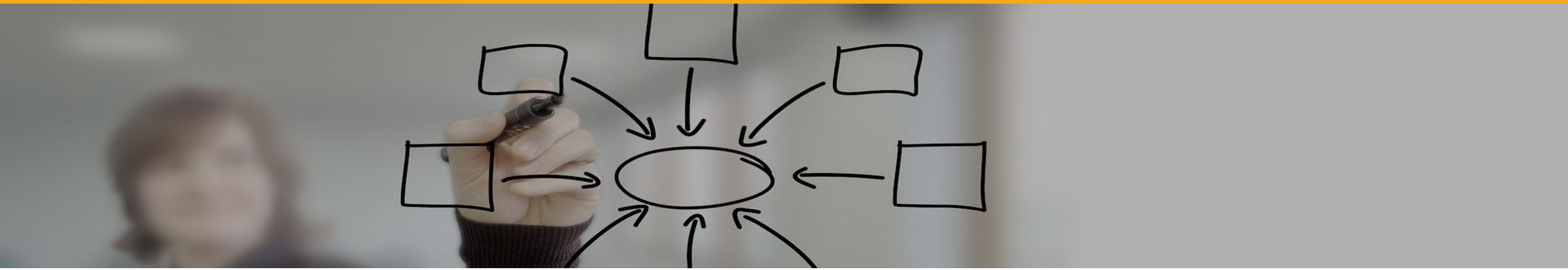
1. The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the organization takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
Note: Noninpatient behavioral health care settings and unlocked inpatient units do not need to be ligature-resistant. The expectation for these settings is that they conduct a risk assessment to identify potential environmental hazards to individuals served; identify individuals who are at high risk for suicide; and take action to safeguard these individuals from the environmental risks (for example, removing objects from the room that can be used for self-harm and continuous monitoring in a safe location while awaiting transfer to higher level of care). R D

~~2. Address the immediate safety needs and most appropriate setting for treatment of the individual served.~~ R

"The new and revised requirements address:

- Environmental risk assessment and action to minimize suicide risk
- Use of a validated screening tool to assess patients at risk
- Evidence-based process for conducting suicide risk assessments of patients screened positive for suicidal ideation
- Documentation of patients' risk and the plan to mitigate
- Written policies and procedures addressing care of at-risk patients, and evidence they are followed
- Policies and procedures for counseling and follow-up care for at-risk patients at discharge
- Monitoring of implementation and effectiveness, with action taken as needed to improve compliance"

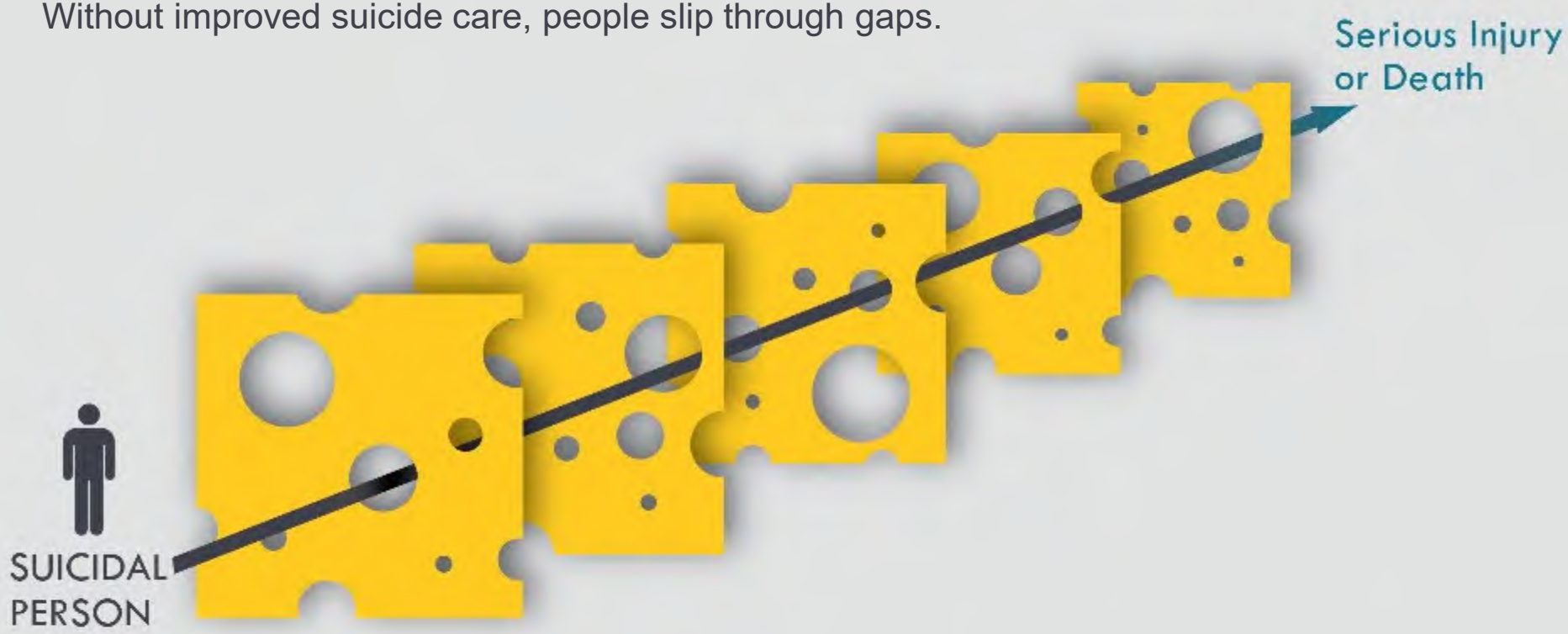
Zero Suicide



- Is an aspirational goal
- Focuses on error reduction & continuous quality improvement
- Fills in the gaps that exist in suicide care
- Supports the use of evidence-based practices

A FOCUS ON PATIENT SAFETY AND ERROR REDUCTION

Without improved suicide care, people slip through gaps.



Adapted from James Reason's "Swiss Cheese framework of Accidents"

What's Different About Zero Suicide?

- Suicide prevention is accepted as a core responsibility of health care
- Patient deaths by suicides are not treated as inevitable
- Emphasizes data, best practices, and continuous quality improvement
- A systematic clinical approach in health systems, not "the heroic efforts of crisis staff and individual clinicians."

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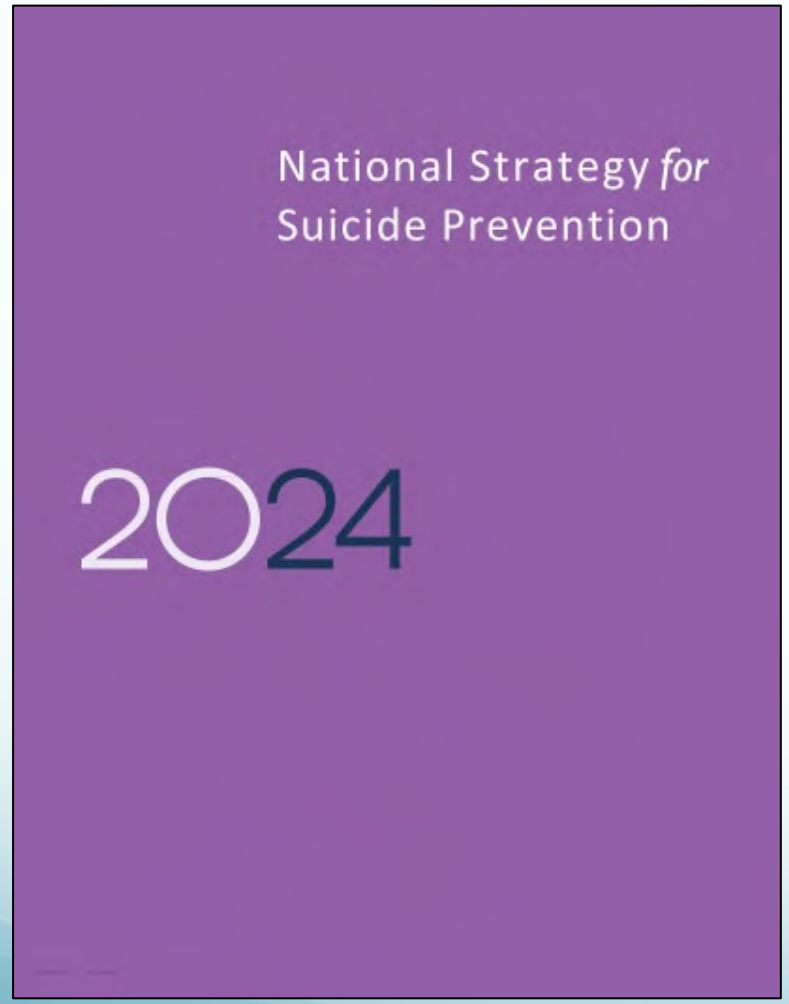
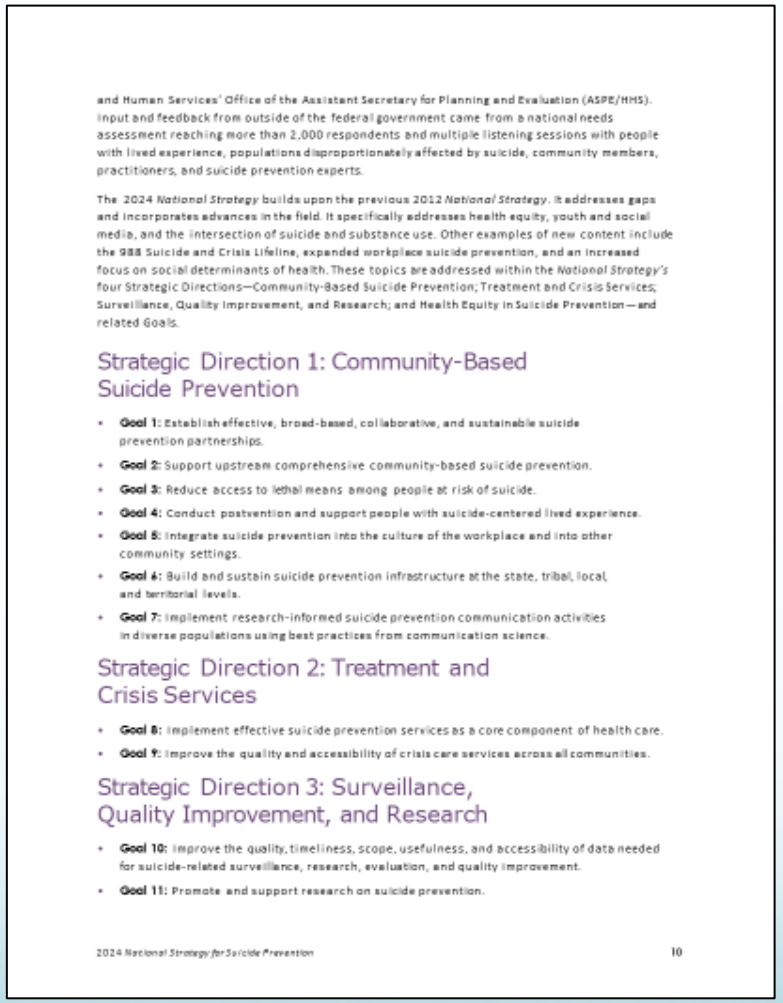
ZEROSuicide Framework

National Strategy for Suicide Prevention





and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE/HHS). Input and feedback from outside of the federal government came from a national needs assessment reaching more than 2,000 respondents and multiple listening sessions with people with lived experience, populations disproportionately affected by suicide, community members, practitioners, and suicide prevention experts.

The 2024 *National Strategy* builds upon the previous 2012 *National Strategy*. It addresses gaps and incorporates advances in the field. It specifically addresses health equity, youth and social media, and the intersection of suicide and substance use. Other examples of new content include the 988 Suicide and Crisis Lifeline, expanded workplace suicide prevention, and an increased focus on social determinants of health. These topics are addressed within the *National Strategy's* four Strategic Directions—Community-Based Suicide Prevention; Treatment and Crisis Services; Surveillance, Quality Improvement, and Research; and Health Equity in Suicide Prevention—and related Goals.

Strategic Direction 1: Community-Based Suicide Prevention

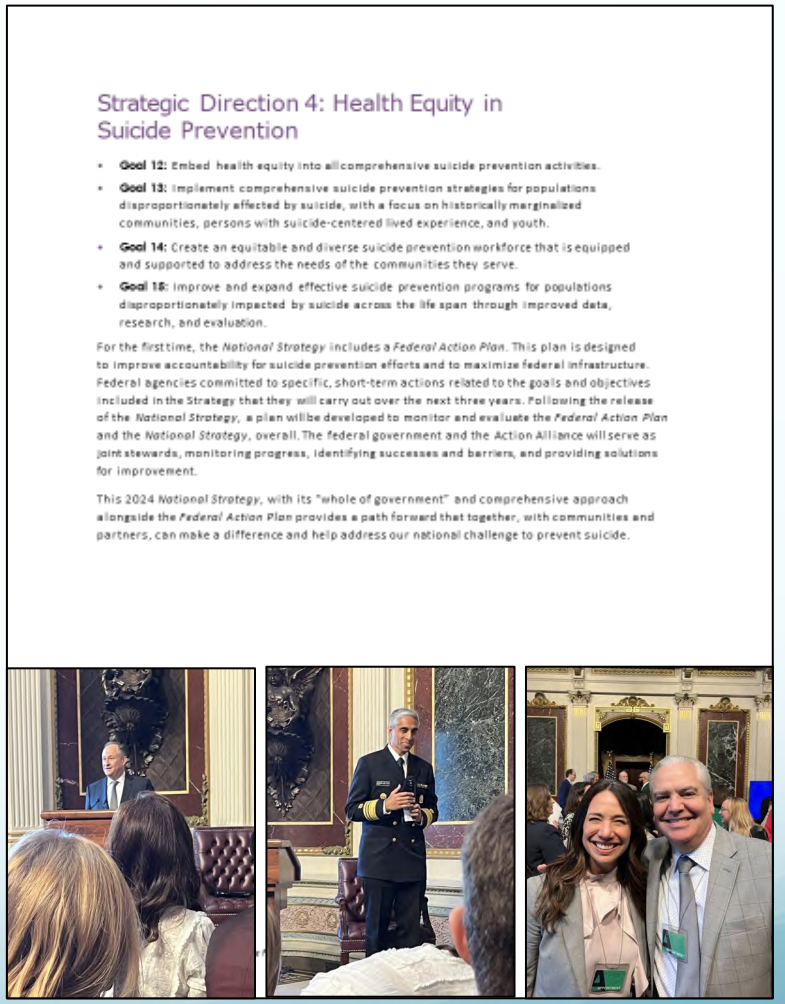
- **Goal 1:** Establish effective, broad-based, collaborative, and sustainable suicide prevention partnerships.
- **Goal 2:** Support upstream comprehensive community-based suicide prevention.
- **Goal 3:** Reduce access to lethal means among people at risk of suicide.
- **Goal 4:** Conduct postvention and support people with suicide-centered lived experience.
- **Goal 5:** Integrate suicide prevention into the culture of the workplace and into other community settings.
- **Goal 6:** Build and sustain suicide prevention infrastructure at the state, tribal, local, and territorial levels.
- **Goal 7:** Implement research-informed suicide prevention communication activities in diverse populations using best practices from communication science.

Strategic Direction 2: Treatment and Crisis Services

- **Goal 8:** Implement effective suicide prevention services as a core component of health care.
- **Goal 9:** Improve the quality and accessibility of crisis care services across all communities.

Strategic Direction 3: Surveillance, Quality Improvement, and Research

- **Goal 10:** Improve the quality, timeliness, scope, usefulness, and accessibility of data needed for suicide-related surveillance, research, evaluation, and quality improvement.
- **Goal 11:** Promote and support research on suicide prevention.



Strategic Direction 4: Health Equity in Suicide Prevention

- **Goal 12:** Embed health equity into all comprehensive suicide prevention activities.
- **Goal 13:** Implement comprehensive suicide prevention strategies for populations disproportionately affected by suicide, with a focus on historically marginalized communities, persons with suicide-centered lived experience, and youth.
- **Goal 14:** Create an equitable and diverse suicide prevention workforce that is equipped and supported to address the needs of the communities they serve.
- **Goal 15:** Improve and expand effective suicide prevention programs for populations disproportionately impacted by suicide across the life span through improved data, research, and evaluation.

For the first time, the *National Strategy* includes a *Federal Action Plan*. This plan is designed to improve accountability for suicide prevention efforts and to maximize federal infrastructure. Federal agencies committed to specific, short-term actions related to the goals and objectives included in the Strategy that they will carry out over the next three years. Following the release of the *National Strategy*, a plan will be developed to monitor and evaluate the *Federal Action Plan* and the *National Strategy*, overall. The federal government and the Action Alliance will serve as joint stewards, monitoring progress, identifying successes and barriers, and providing solutions for improvement.

This 2024 *National Strategy*, with its "whole of government" and comprehensive approach alongside the *Federal Action Plan* provides a path forward that together, with communities and partners, can make a difference and help address our national challenge to prevent suicide.

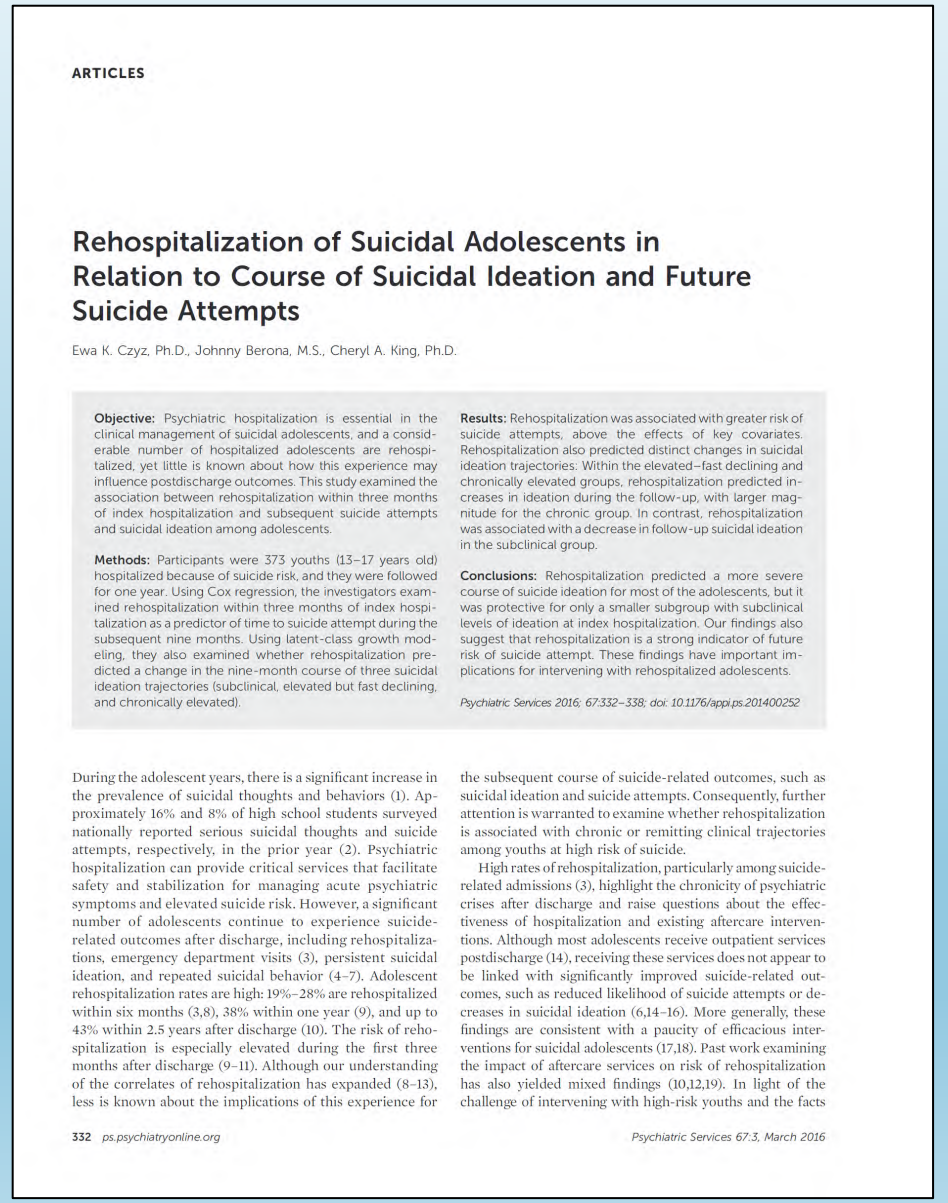
Released April 23, 2024

A fixed mindset about hospitalization…

- Hospital suicides: 49-65/year (Joint Commission, 2018)
- Highly critical views of Drs. Marsha Linehan and Matthew Large—i.e.,"Nosocomial suicides" which are suicides that are *caused* by hospitalization!
- Czyz, Berona, and King (2016)—readmission for teens who are suicidal significantly associated with more severe suicidal trajectory and suicide attempts
- Typical inpatient stay: Rx and some brief group work (NAMI, 2014)
- Hospitalization is associated with hundreds times greater risk for deaths by suicide than general population (Qin & Nordentoft, 2005; Large et al., 2011).
- 5% of post-discharge suicides occur within a week (Pirkota et al., 2005); 20% of post-discharge suicides occur within one year (Desai et al., 2005)
- Patients avoid talking about suicide due to hospitalization (Blanchard & Farber, 2018)
- We must enhance the hospitalization experience and make it more suicide-focused

Re-Hospitalization for Teens who are Suicidal

- Want to challenge the general value of inpatient care
- What suicide-focused treatment is actually provided?
- University of Michigan research team found a much more severe suicidal trajectory was associated with rehospitalization
- A second hospitalization was significantly associated with increased suicide attempts
- Five iterations of this manuscript was needed before it was accepted



ARTICLES

Rehospitalization of Suicidal Adolescents in Relation to Course of Suicidal Ideation and Future Suicide Attempts

Ewa K. Czyz, Ph.D., Johnny Berona, M.S., Cheryl A. King, Ph.D.

Objective: Psychiatric hospitalization is essential in the clinical management of suicidal adolescents, and a considerable number of hospitalized adolescents are rehospitalized, yet little is known about how this experience may influence postdischarge outcomes. This study examined the association between rehospitalization within three months of index hospitalization and subsequent suicide attempts and suicidal ideation among adolescents.

Methods: Participants were 373 youths (13–17 years old) hospitalized because of suicide risk, and they were followed for one year. Using Cox regression, the investigators examined rehospitalization within three months of index hospitalization as a predictor of time to suicide attempt during the subsequent nine months. Using latent-class growth modeling, they also examined whether rehospitalization predicted a change in the nine-month course of three suicidal ideation trajectories (subclinical, elevated but fast declining, and chronically elevated).

Results: Rehospitalization was associated with greater risk of suicide attempts, above the effects of key covariates. Rehospitalization also predicted distinct changes in suicidal ideation trajectories: Within the elevated–fast declining and chronically elevated groups, rehospitalization predicted increases in ideation during the follow-up, with larger magnitude for the chronic group. In contrast, rehospitalization was associated with a decrease in follow-up suicidal ideation in the subclinical group.

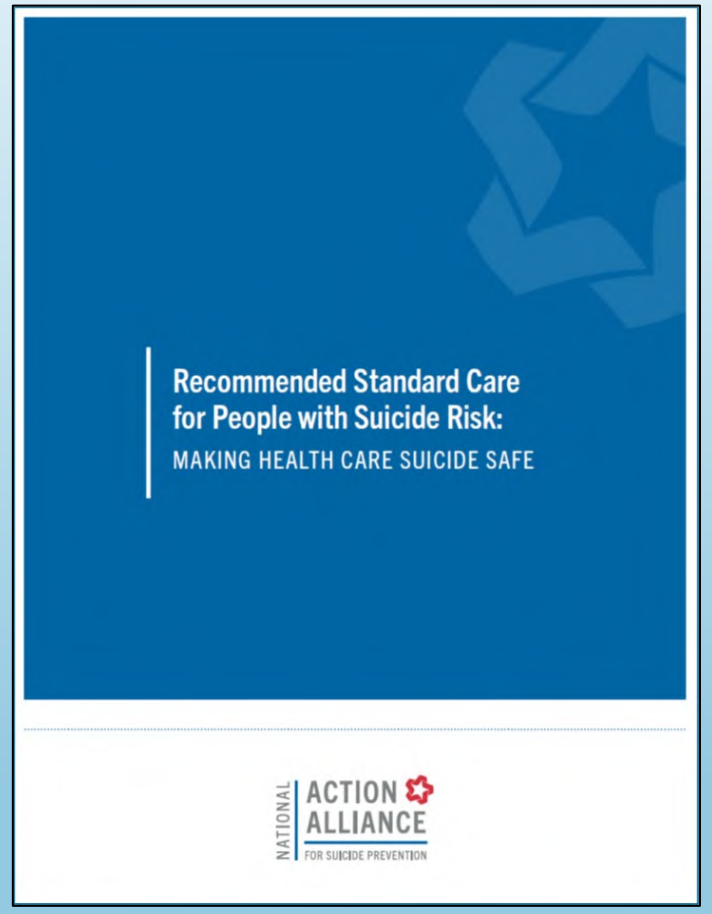
Conclusions: Rehospitalization predicted a more severe course of suicide ideation for most of the adolescents, but it was protective for only a smaller subgroup with subclinical levels of ideation at index hospitalization. Our findings also suggest that rehospitalization is a strong indicator of future risk of suicide attempt. These findings have important implications for intervening with rehospitalized adolescents.

Psychiatric Services 2016; 67:332–338; doi: 10.1176/appi.ps.201400252

During the adolescent years, there is a significant increase in the prevalence of suicidal thoughts and behaviors (1). Approximately 16% and 8% of high school students surveyed nationally reported serious suicidal thoughts and suicide attempts, respectively, in the prior year (2). Psychiatric hospitalization can provide critical services that facilitate safety and stabilization for managing acute psychiatric symptoms and elevated suicide risk. However, a significant number of adolescents continue to experience suicide-related outcomes after discharge, including rehospitalizations, emergency department visits (3), persistent suicidal ideation, and repeated suicidal behavior (4–7). Adolescent rehospitalization rates are high: 19%–28% are rehospitalized within six months (3,8), 38% within one year (9), and up to 43% within 2.5 years after discharge (10). The risk of rehospitalization is especially elevated during the first three months after discharge (9–11). Although our understanding of the correlates of rehospitalization has expanded (8–13), less is known about the implications of this experience for the subsequent course of suicide-related outcomes, such as suicidal ideation and suicide attempts. Consequently, further attention is warranted to examine whether rehospitalization is associated with chronic or remitting clinical trajectories among youths at high risk of suicide.

High rates of rehospitalization, particularly among suicide-related admissions (3), highlight the chronicity of psychiatric crises after discharge and raise questions about the effectiveness of hospitalization and existing aftercare interventions. Although most adolescents receive outpatient services postdischarge (14), receiving these services does not appear to be linked with significantly improved suicide-related outcomes, such as reduced likelihood of suicide attempts or decreases in suicidal ideation (6,14–16). More generally, these findings are consistent with a paucity of efficacious interventions for suicidal adolescents (17,18). Past work examining the impact of aftercare services on risk of rehospitalization has also yielded mixed findings (10,12,19). In light of the challenge of intervening with high-risk youths and the facts

A Commonsense Approach to Clinical Suicidology



1) Screening for suicidal ideation

2) Assessment of suicide risk

3) Management of acute risk
   - Safety planning
   - Lethal means safety
   - Crisis hotlines/text lines

4) Treating the causes of suicide

5) Clinical follow through

6) Possible caring contact

Commonsense Recommendations for Standard Care of Suicidal Risk

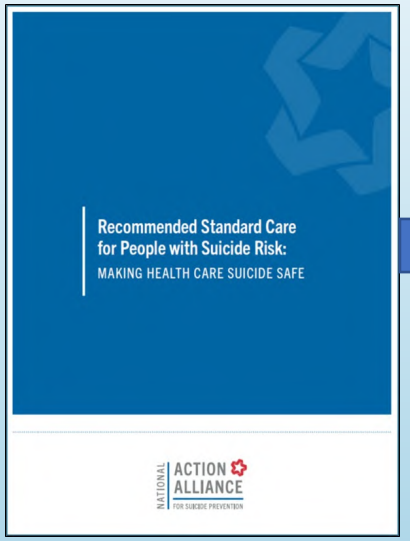
David A. Jobes

Abstract

Vignettes

The Clinical Challenge of Suicide Risk

The Joint Commissions/PEW Survey (2024)



- Four recommended practices:
  - Safety Planning
  - Warm handoff to outpatient care
  - Caring contact follow-up post-discharge
  - Lethal Means Safety Planning

The Joint Commission Journal on Quality and Patient Safety 2024; 000:1–11

Evaluating the Prevalence of Four Recommended Practices for Suicide Prevention Following Hospital Discharge

Salome O. Chiaze, PhD; Jamie Pietrantoni, PhD; Scott C. Williams, PsyD; Stephen P. Schmaltz, PhD, MPH, MS; Brian K. Ahmedani, PhD, LMSW; Kimberly Beaton, PhD, ABPP; Edwin D. Boudreaux, PhD; Gregory K. Brown, PhD

- Findings from the survey:
  - Safety Planning = 61%
  - Warm handoff to outpatient care = 37%
  - Caring contact follow-up post-discharge = 30%
  - Lethal Means Safety Planning = 28%
- Only 8% of TJC accredited hospitals use all four interventions!

Review of "Evidence-Based" Approaches

1. Gate keeper training (e.g., QPR, ASSIST, SOS)

2. Screening for suicide risk (e.g., ASQ and C-SSRS)

3. Assessment of suicide risk (use of assessment tools and interviews)

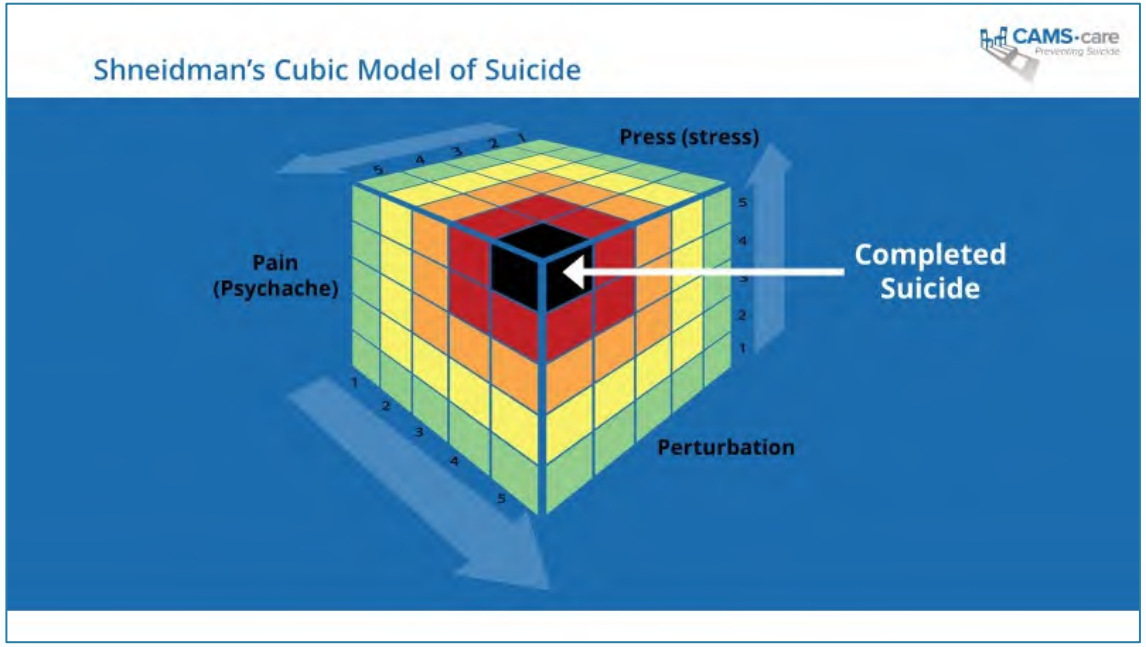
4. Interventions for acute crisis and stabilization (safety plan type interventions, lethal means safety, digital interventions, caring contacts) but is not treatment

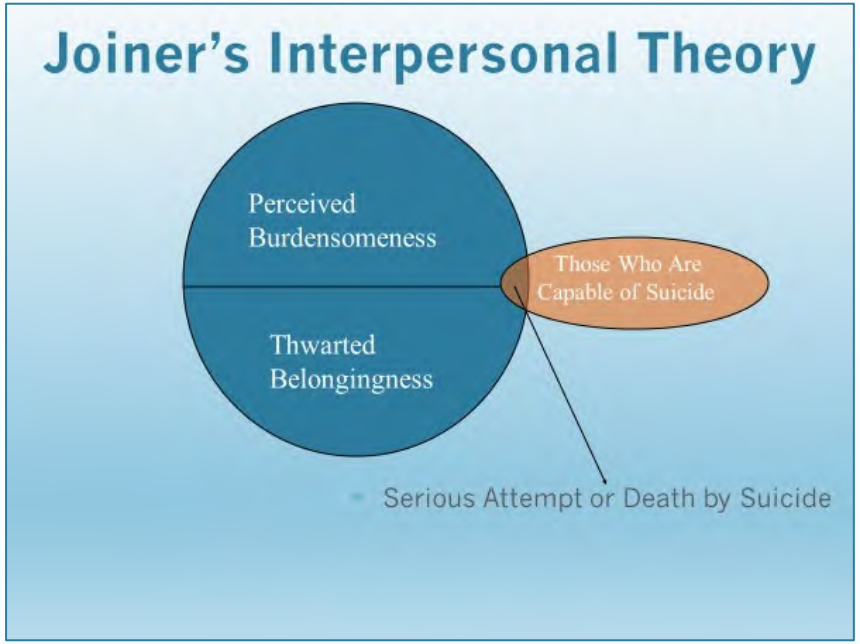
5. Clinical treatments of what causes someone to be suicidal (DBT, CT-SP, BCBT, and CAMS)

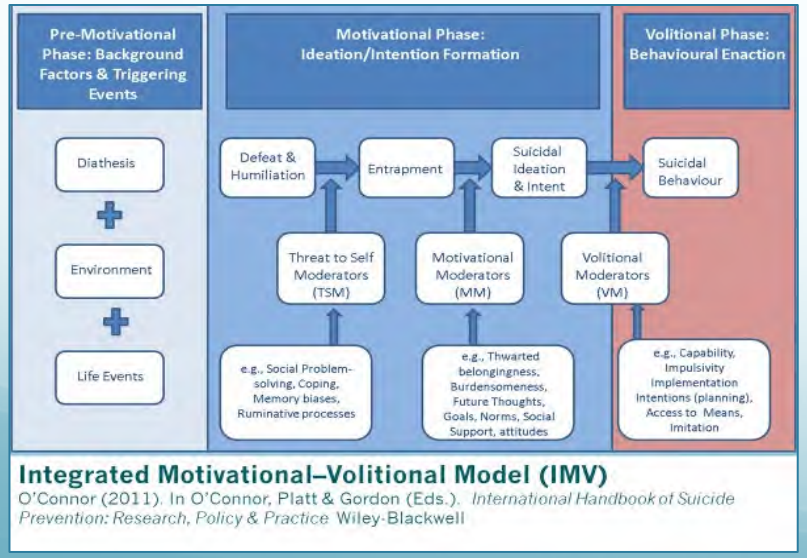
Challenges to a growth mindset:

- Status quo—despite the lack of evidence it is just too hard to change our mindset about hospitalization and medication (magical/wishful thinking)
- Health plans *insufficiently* cover effective suicide care (no suicide diagnosis)
- Clinician fears about losing patients and particularly the fear of malpractice litigation paralyzes providers and fosters a "better safe than sorry" defensive practice attitude
- Training issues (implementation/dissemination)—actually getting clinicians to use proven and effective treatments
- The pervasive clinical care bias being the *only* approach that will work
- The vast majority of people who are suicidal reject mental health care
- The public relations battle—the general public and the media are still insufficiently concerned about the magnitude of this major public health issue

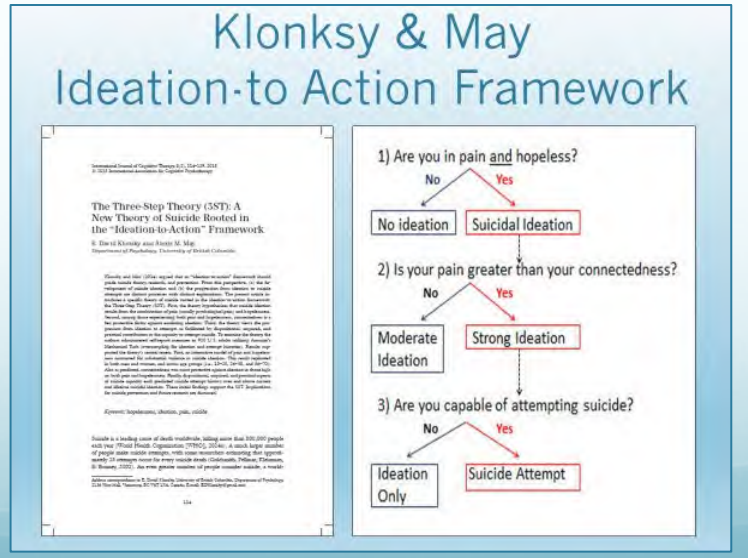
Theories and Models Driving Innovation

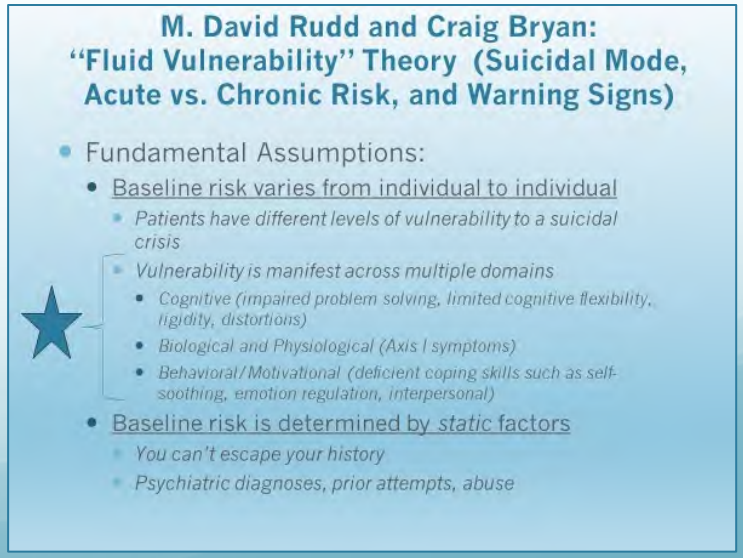




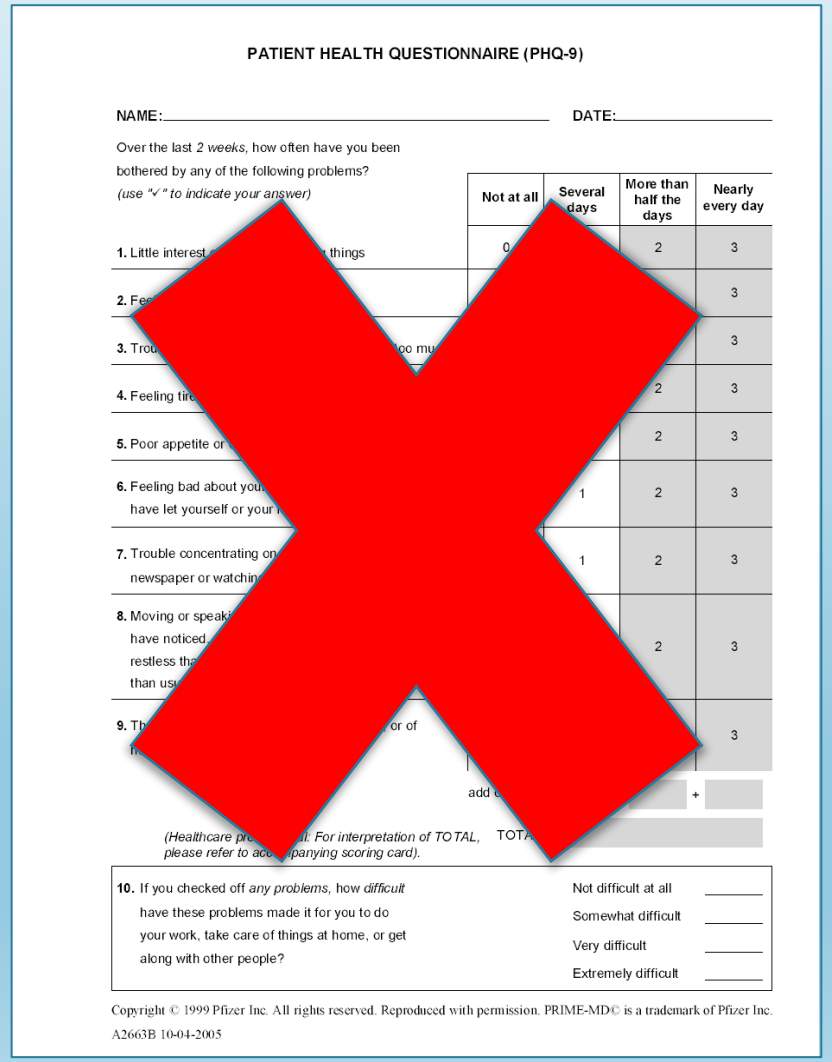


Integrated Motivational–Volitional Model (IMV)
O'Connor (2011). In O'Connor, Platt & Gordon (Eds.). *International Handbook of Suicide Prevention: Research, Policy & Practice* Wiley-Blackwell





Screening & Assessment for Suicidal Risk



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest … things	0		2	3
2. Fe…				3
3. Trou… …oo mu…				3
4. Feeling tir…			2	3
5. Poor appetite or …			2	3
6. Feeling bad about you… have let yourself or your …		1	2	3
7. Trouble concentrating on … newspaper or watchin…		1	2	3
8. Moving or speaki… have noticed … restless th… than us…			2	3
9. Th… …or of …				3
		add …		+

(Healthcare pro… …l: For interpretation of TOTAL, please refer to acc… …panying scoring card). TOTA…

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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A2663B 10-04-2005

COLUMBIA SUICIDE-SEVERITY RATING SCALE (C-SSRS)

Baseline

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended for use by trained clinicians. The questions contained in the Columbia Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidality depends on clinical judgment.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M.A., Halberstam B. & Mann J. J, Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries contact posnerk@childpsych.columbia.edu

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   When? _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 6/13/2017

Suicide-Specific Assessment Measures

- 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...

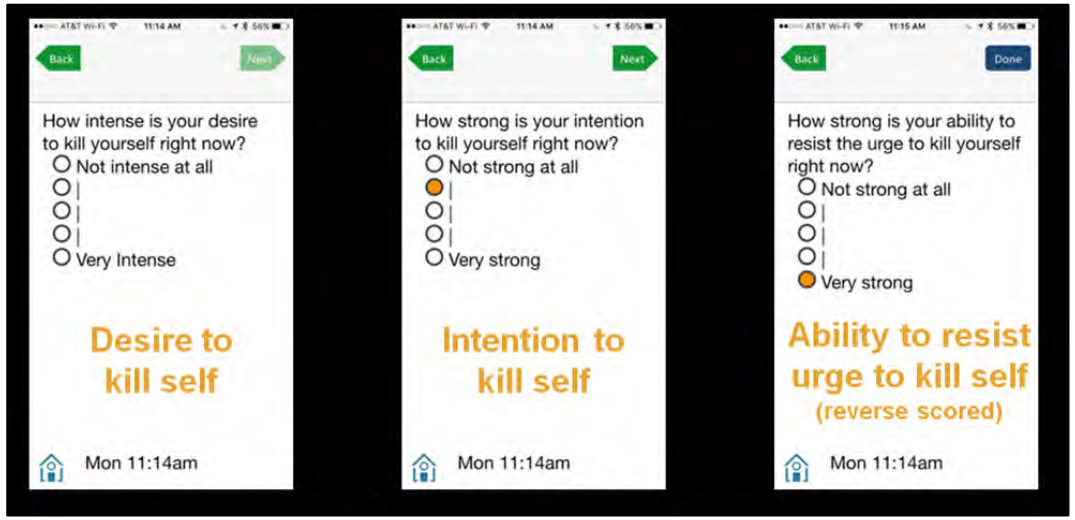
And hundreds more!

Actuarial assessments always beat clinical judgement!

Professor Paul Meehl

Digital Monitoring of Suicidal Thinking

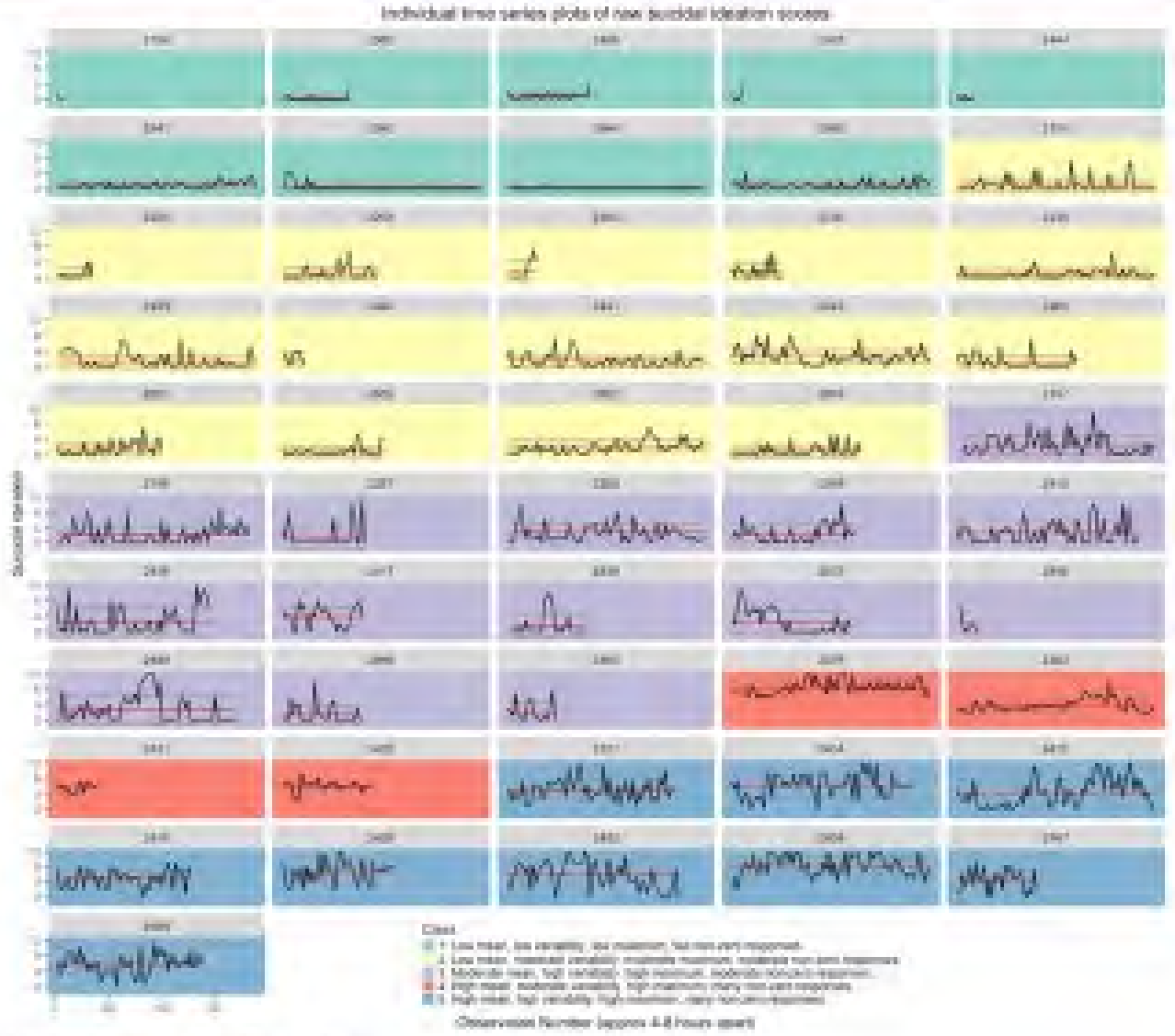
- Palm pilot 2x/day monitoring of adolescent NSSI/SI for 2 weeks



Nock et al. (2009). Journal of Abnormal Psychology.

- Smartphone monitoring 4-6x/day of adults with suicide ideation for 1 month

Subtypes of Suicidal Thoughts(?)



Kleiman et al. (2018). Depression & Anxiety.

A big idea that has been brewing for 30 years…

The Challenge and the Promise of Clinical Suicidology

David A. Jobes, PhD

The existing research in clinical assessment and treatment of suicidal patients is reviewed. Data concerning the "life course" of suicidality among outpatient samples of suicidal university students are then presented. These data suggest different subtypes of suicidality, which are further considered using a conceptual model that differentiates intrapsychic versus interpsychic suicidality. The implications of these data and this model are discussed in relation to current changes in mental health care with an emphasis on differential assessment and prescriptive treatments. Future developments in clinical suicidology and ideas for additional research are discussed.

As many mental health practitioners will attest, clinical work with suicidal patients can be quite challenging, sometimes even perilous. Suicide is the most commonly encountered clinical emergency for mental health professionals (Schein, 1976) and may account for an estimated 5000 patient-deaths per year (Berman, 1986). It has been further estimated that one in six completed suicides are patients in ongoing psychotherapy, and that about half of all people that complete suicide have been involved in psychotherapy sometime in the course of their lives (Berman, 1986). Survey data suggest that psychologists have a one-in-five chance, and that psychiatrists have a one-in-two chance, of losing a patient to suicide during their career (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988). Not surprisingly, perhaps, no other patient behavior generates more stress and fear among clinicians than suicide and suicide-related behaviors (Deutsch, 1984; Farber, 1983; Pope & Tabachnick, 1993). Moreover, in our contemporary litigious society, clinicians must be wary of the potential of malpractice liability for "wrongful death" when a patient commits suicide (Jobes & Berman, 1993).

Given that suicidal presentations are fairly common, that clinicians are clearly stressed by these patients, and that fears related to malpractice liability are reality based, it is remarkable to note that most practicing clinicians (across disciplines) typically receive little, if any, formalized training in clinical suicidology (Bongar, 1991). Indeed, it is probably fair to say that most clinicians learn about working with a suicidal patient by being faced with a suicidal patient and perforce learning in the moment. Then, after the initial clinical contact, the clinician may scramble to gather some supervisory input or collect relevant literature to quickly bolster a limited knowledge base in suicide.

When a naive clinician turns to the literature on suicide assessment and treatment, what is largely found are references written not from empirical data, but rather from the perspective of clinical experience. Simply put, scant data exist about what actually works in terms of assessing and treating suicidal patients. Let us briefly consider some of what is empirically known about assessment and treatment of suicidal patients.

ASSESSMENT OF SUICIDAL PATIENTS

Until relatively recently, we had many unanswered questions about the clinical

David A. Jobes is with the Catholic University of America. Address correspondence to the author at the Department of Psychology, Catholic University of America, Washington, DC 20064.

Shneidman Award Address to the 28th annual convention of the American Association of Suicidologists, May 1995, Arizona Biltmore, Phoenix, AZ.

Suicide and Life-Threatening Behavior, Vol. 25(4), Winter 1995
© 1995 The American Association of Suicidology

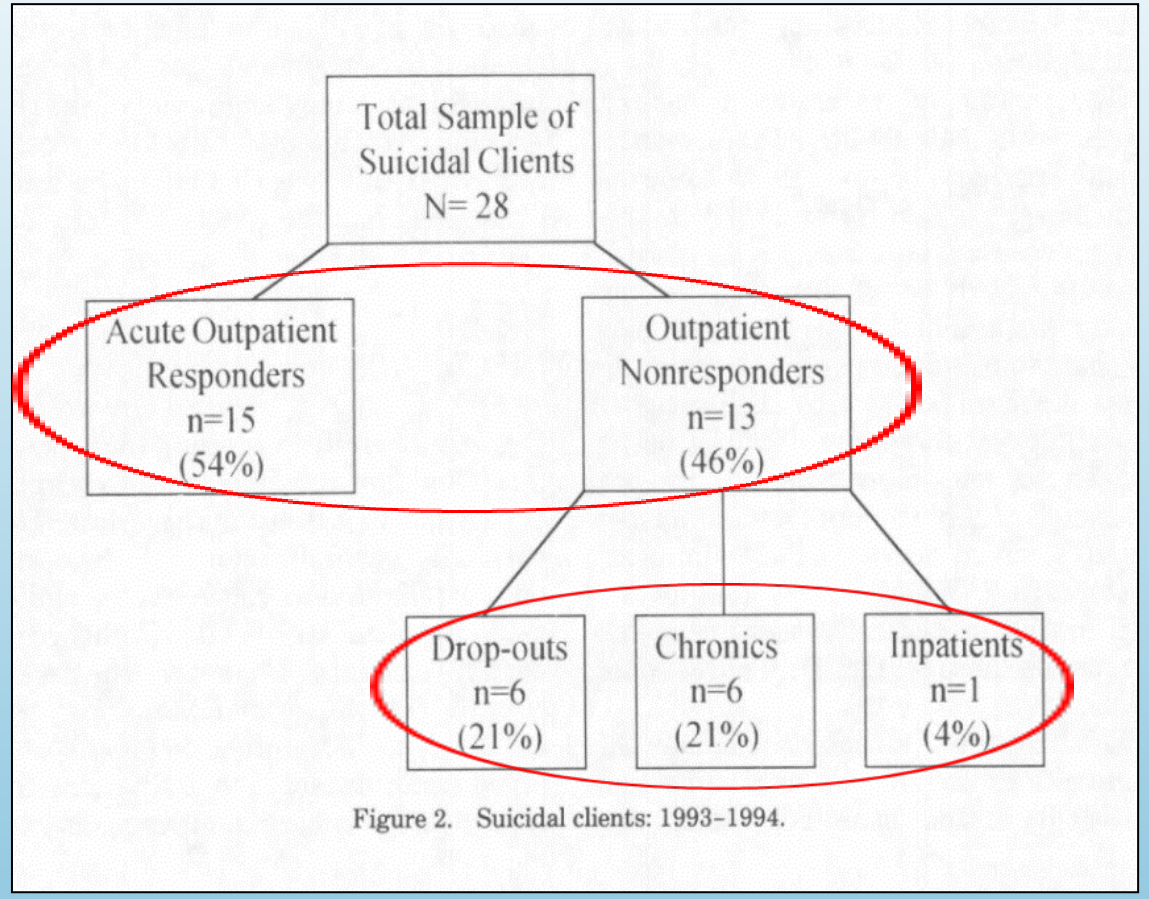


Figure 2. Suicidal clients: 1993–1994.

and interpsychic worlds. According to Bonanno and Castonguay (1994), this approach can be used to create *prescriptive* dimensions of differential treatments for different patients who are on any point of the continuum (see Figure 4).

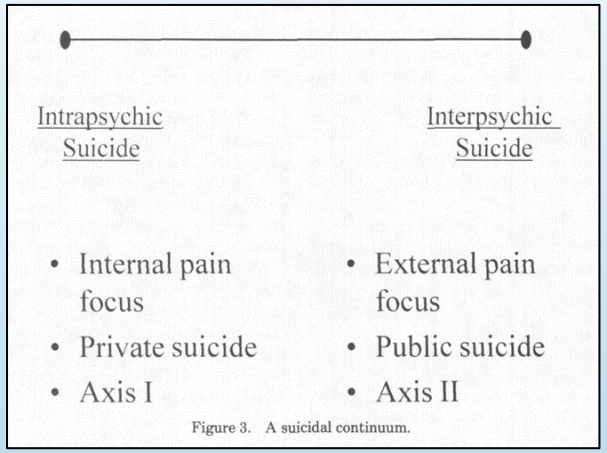


Figure 3. A suicidal continuum.

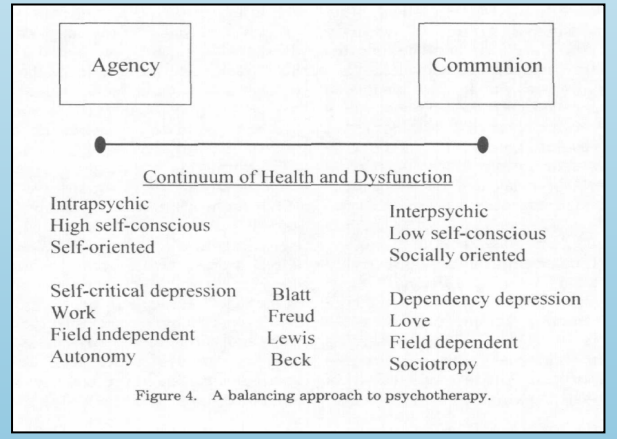
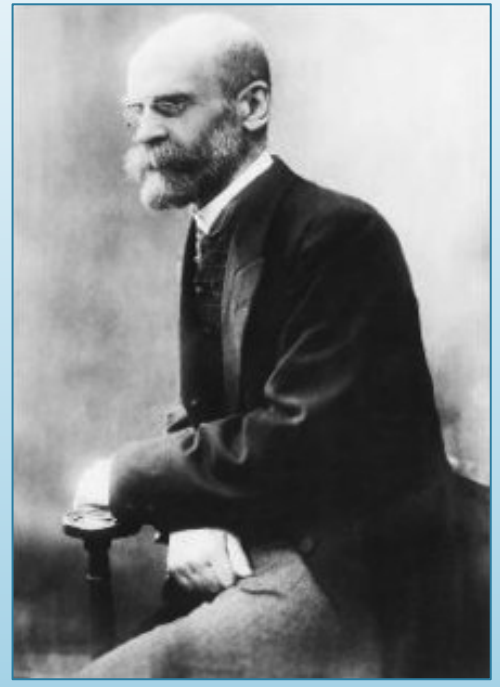


Figure 4. A balancing approach to psychotherapy.

Could differential assessments of different suicidal states lead to different "prescriptive" treatments?

Suicidal Typologies: Different Suicidal States



Durkeim (1897)

Egoistic
Altruistic
Anomic
Fatalistic

Jobes (1995)
Intra-psychic vs. Inter-psychic
Agentic vs. Communal

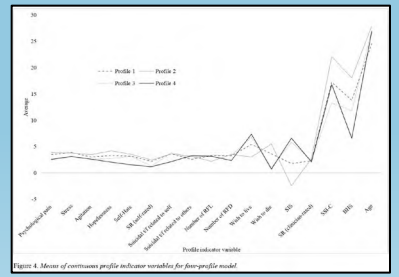
Conrad et al (2009)
Acute vs. Chronic

TABLE 2
Factor Analysis Results: Spearman Promax Rotated Factor Pattern

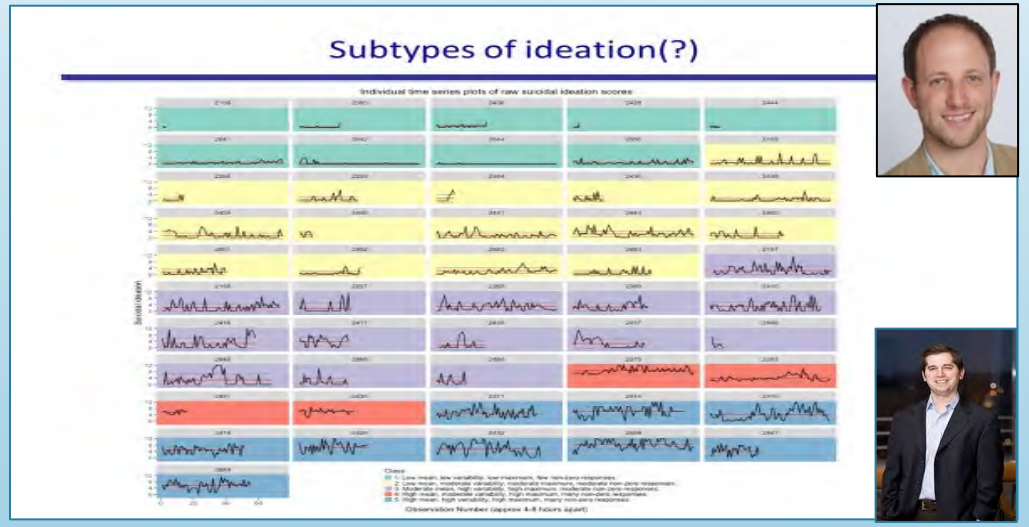
SSF-II Item	Factor 1	Factor 2
Self-hate	.88***	−.09
Hopelessness	.85***	.05
Pain	.74***	.10
Agitation	−.07	.92***
Stress	.12	.78***

Note. ***Value is greater than 0.4

Josephine Au's Latent Profile Analysis CUA dissertation...



Kleiman & Nock, 2017
Ecological Momentary Assessment (EMA)



Possible DSM-6 Diagnosis?

Rogers & Joiner (2017)
Acute Suicidal Affective Disturbance

Galynker (2017)
Suicide Crisis Syndrome

Safety Planning Type Interventions

SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

Warning Signs: pacing
feeling irritable
thinking "it'll never get better"

- go for a walk 10 mins
- watch Friends episodes
- play with my dog
- think about my kids
  - vacation to beach in Florida
  - Christmas Day 2012
- call/text my Mom or Jennifer
- call Dr. Brown: 555-555-5555
  - leave msg w/ name, time, phone #
- 1-800-273-TALK
- go to hospital
- call 911

CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION (page 3 of 4)

CAMS STABILIZATION PLAN

Ways to reduce access to lethal means:

1. Conversation with girlfriend about knife
2. Remove the knife
3. _____

Things I can do to cope differently when I am in a suicide crisis:

1. Exercise
2. Watching "Breaking Bad"
3. Write in journal
4. Read "Choosing to Live"
5. Walk to local Best Buy
6. **Life or death emergency contact number:** Lifeline 988, Crisis Text Line, text HOME to 741741

People I can call for help or to decrease my isolation:

TBD
1. _____
2. _____
3. _____

Attending treatment as scheduled:

Potential barrier	Solutions I will try:
1. N/A	
2. _____	

The Stanley-Brown Safety Plan, the Crisis Response Plan, and the CAMS Stabilizations Plan are similar to each other and have different types and levels of empirical support...

2020 Meta-Analysis on Safety Planning-Type Interventions

BJPsych The British Journal of Psychiatry (2021)
Page 1 of 8. doi: 10.1192/bjp.2021.50

Review

Safety planning-type interventions for suicide prevention: meta-analysis

Chani Nuij, Wouter van Ballegooijen, Derek de Beurs, Dilfa Juniar, Annette Erlangsen, Gwendolyn Portzky, Rory C. O'Connor, Johannes H. Smit, Ad Kerkhof and Heleen Riper

Background
Safety planning-type interventions (SPTIs) for patients at risk of suicide are often used in clinical practice, but it is unclear whether these interventions are effective.

Aims
This article reports on a meta-analysis of studies that have evaluated the effectiveness of SPTIs in reducing suicidal behaviour and ideation.

Method
We searched Medline, EMBASE, PsycINFO, Web of Science and Scopus from their inception to 9 December 2019, for studies that compared an SPTI with a control condition and had suicidal behaviour or ideation as outcomes. Two researchers independently extracted the data. To assess suicidal behaviour, we used a random-effects model of relative risk based on a pooled measure of suicidal behaviour. For suicidal ideation, we calculated effect sizes with Hedges' *g*. The study was registered at PROSPERO (registration number CRD42020129185).

Results
Of 1816 unique abstracts screened, 6 studies with 3536 participants were eligible for analysis. The relative risk of suicidal behaviour among patients who received an SPTI compared with control was 0.570 (95% CI 0.408–0.795, $P = 0.001$; number needed to treat, 16). No significant effect was found for suicidal ideation.

Conclusions
To our knowledge, this is the first study to report a meta-analysis on SPTIs for suicide prevention. Results support the use of SPTIs to help preventing suicidal behaviour and the inclusion of SPTIs in clinical guidelines for suicide prevention. We found no evidence for an effect of SPTIs on suicidal ideation, and other interventions may be needed for this purpose.

Keywords
Suicide; suicide prevention; safety planning; meta-analysis.

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Background

Suicidal behaviour is a significant public health issue worldwide, resulting in an estimated 16 million suicide attempts and 800 000 suicides per year.[1] For every person who dies by suicide, more than 20 others make a non-fatal attempt,[2] and many more have serious thoughts about ending their life.[3] Suicidal ideation and suicidal behaviour (including both fatal and non-fatal suicide attempts) thus constitute a substantial disease burden. This underlines the importance of suicide prevention.[4]

There is an increasing body of evidence in support of several psychological treatments for suicide prevention, including cognitive–behavioural therapy and dialectical behaviour therapy.[5,6] In recent years, brief interventions, defined as up to three encounters between a patient and (para-)professional, have also been linked to reduced risks of suicidal behaviour.[7,8]

Safety planning-type interventions

One group of brief interventions consists of safety planning-type interventions (SPTIs). The technique in SPTIs is called safety planning, and is derived from cognitive therapy and cognitive-behavioural therapy for suicide prevention.[9,10] The goal of safety planning is to reduce the imminent risk of suicidal behaviour by constructing a predetermined set of coping strategies and sources of support in a plan.[10,11] During a crisis, an individual may use these strategies to avert their thoughts about suicide and manage their suicidal urges.[11] Since its introduction, safety planning has become an integral part of standard clinical care for people at risk of suicide, and it is being used as a brief standalone intervention.[11]

The plan that is constructed in safety planning has been referred to in a number of ways, including 'safety plan',[9,11] 'crisis response plan'[12] and 'coping card',[13] but in essence they all cover the same psychological technique. The current review uses the term SPTIs to summarise the entire range of brief interventions in which safety planning is applied. The strategies and sources of support are embedded in what we will call a safety plan.

Interventions of the safety planning type are recommended as best practice by the National Institute for Health and Care Excellence (https://www.nice.org.uk/guidance/cg133) in the UK, and the Suicide Prevention Resource Center (www.sprc.org) in the USA. Historically, the use of safety plans in clinical practice seems to be based on clinicians' beliefs about their effectiveness,[14,15] rather than on empirical evidence.[16] Individual trials on the effectiveness of SPTIs have yielded conflicting results,[17,18] whereas meta-analyses of studies that included SPTIs have focused on brief interventions more broadly.[7,8] Although the latter have made an important contribution to the literature, they did not include all published trials on SPTIs, and did not report on the effectiveness of SPTIs specifically.[7,8]

Aims

The purpose of this study was to conduct a meta-analysis to assess whether SPTIs for suicide prevention are linked to reductions in first, suicidal behaviour (fatal and non-fatal suicide attempts), and second, suicidal ideation.

Method

Before study commencement, the study protocol was registered in the international Prospective Register of Systematic Reviews at the University of York (PROSPERO; registration number CRD42020129185). We modified the protocol in two respects. First, to more accurately reflect the focus of the study, we chose to use the term 'safety planning-type' instead of 'crisis management'.

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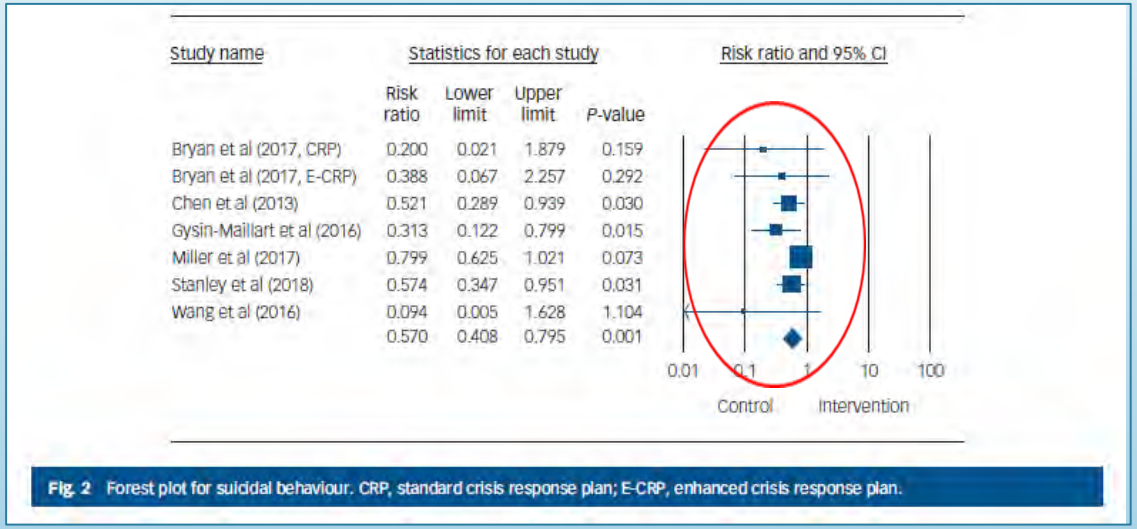


Fig. 2 Forest plot for suicidal behaviour. CRP, standard crisis response plan; E-CRP, enhanced crisis response plan.

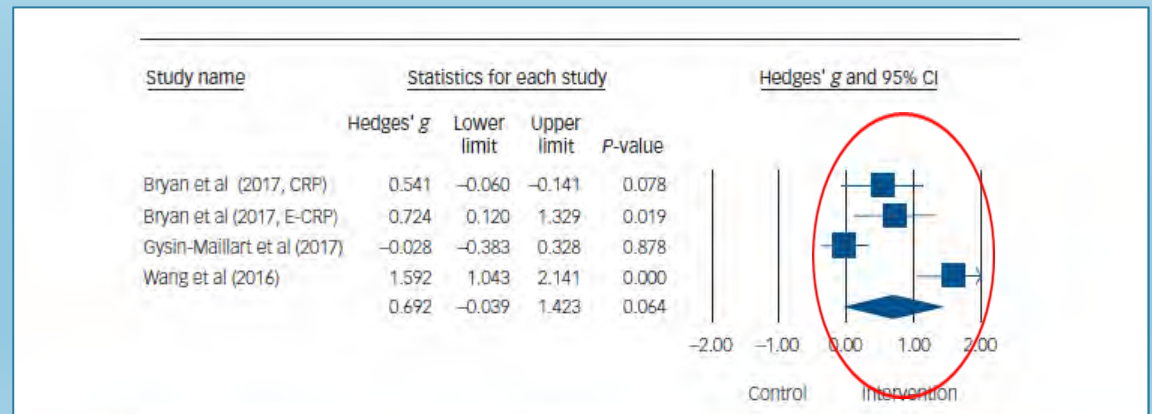
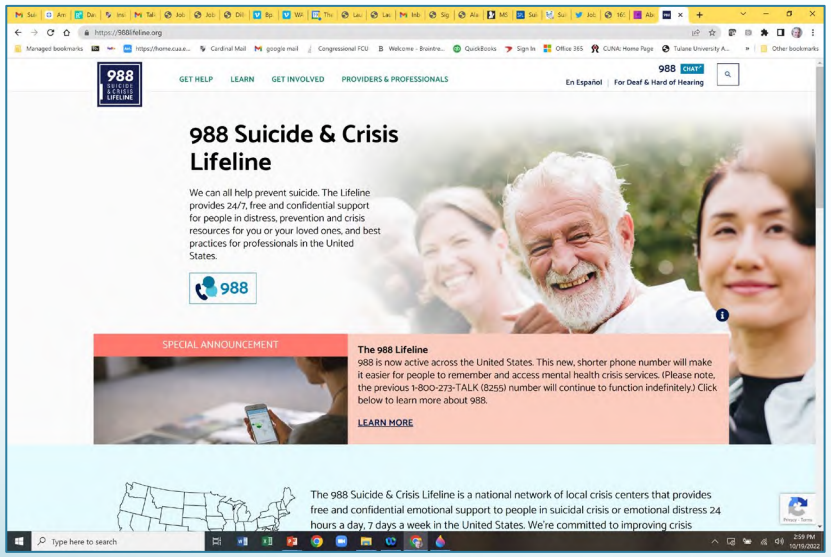
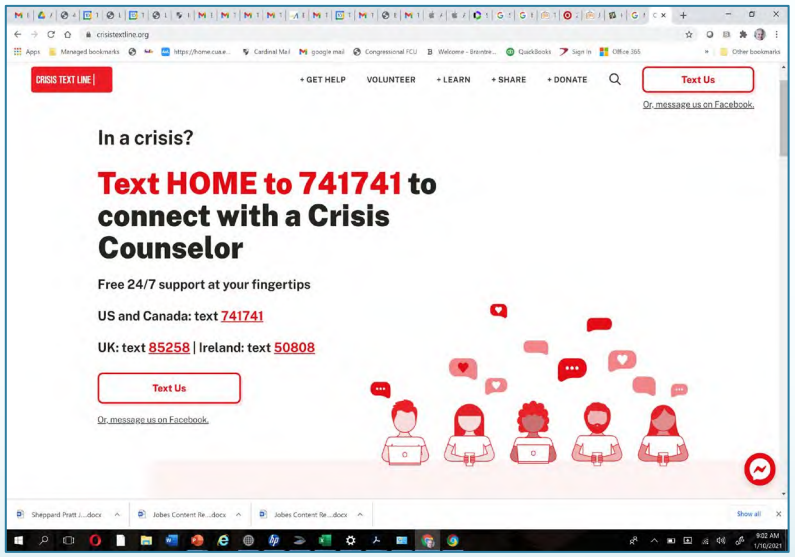


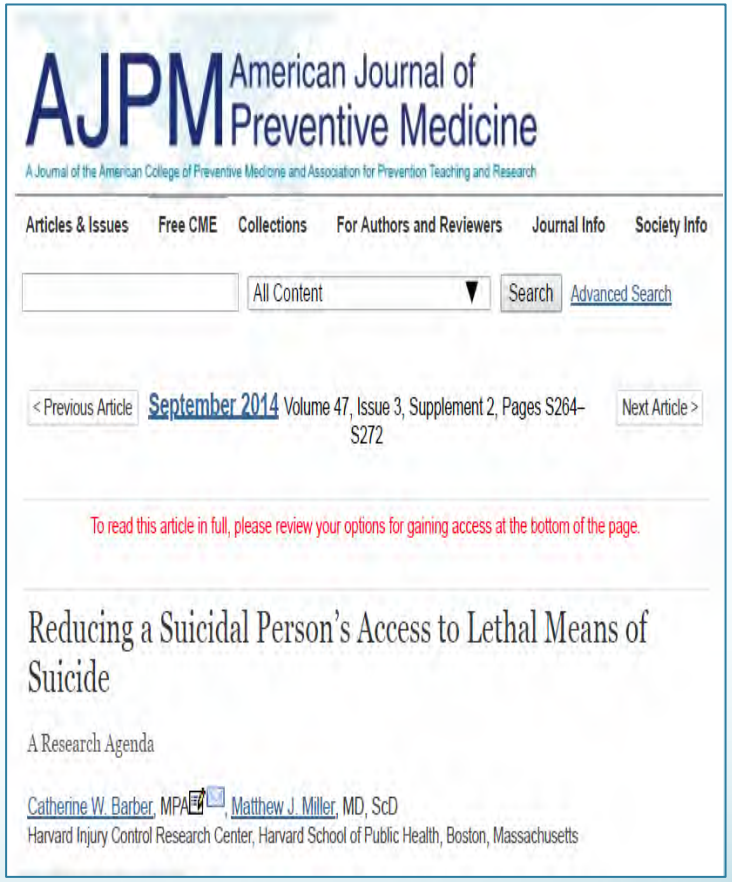
Fig. 3 Forest plot for suicidal ideation. CRP, standard crisis response plan; E-CRP, enhanced crisis response plan.

Managing Acute Suicidal Risk:
988 Suicide & Crisis Lifeline; Crisis Text Line; lethal means safety

1) Always provide 988 Lifeline/Crisis Text Line numbers
2) Always discuss reducing access to lethal means
3) Then verify that means have been secured







Discussing and trying to remove or decrease access to any lethal means is a clinical must to help save lives!

Evidence-Based **Treatments** to Reduce Suicidal Ideation and Behaviors

Curr Treat Options Psych
DOI 10.1007/s40501-015-0064-3

Suicide (MS Goodman, Section Editor)

Psychological Approaches to Suicide Treatment and Prevention

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This article is part of the Topical Collection on Suicide

Keywords Suicide treatment · Dialectical Behavior Therapy · Cognitive Therapy for suicide prevention · The collaborative assessment and management of suicidality · Brief interventions

Opinion statement

In recent decades, the sub-specialization of "clinical suicidology" emphasizing suicide risk assessment, treatment, training, and the management of suicide-related liability has grown exponentially. This line of thinking had led to the development of suicide-specific treatments that target suicide as the focus of care (vs. a primary focus on treating mental disorders). These treatments are being extensively investigated using randomized controlled clinical trials to prove their efficacy and effectiveness. This article features the three main replicated treatments for suicide: Dialectical Behavior Therapy, Cognitive Therapy for Suicide Prevention, and the Collaborative Assessment and Management of Suicidality. In addition, there is a recent surge of brief suicide-focused interventions (1–4 sessions) that include variations of stabilization planning and close examination of suicide attempts as an opportunity to learn about suicidal risk with coping-oriented guidance and support. Within a rapidly evolving contemporary mental health care reality, these suicide-related treatments and interventions hold great promise for the prospect of providing more effective (and potentially life-saving care) for suicidal patients.

Introduction

In the wake of health care reform and dramatic changes in mental health and psychiatric care over recent decades, there has been an increasing focus on the topic of suicide risk within clinical practice and the professional literature [1•, 2]. This article will examine recent developments in psychological approaches to treating

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International Journal of *Environmental Research and Public Health*

MDPI

Review

One Size Does Not Fit All: A Comprehensive Clinical Approach to Reducing Suicidal Ideation, Attempts, and Deaths

David A. Jobes * and Samantha A. Chalker

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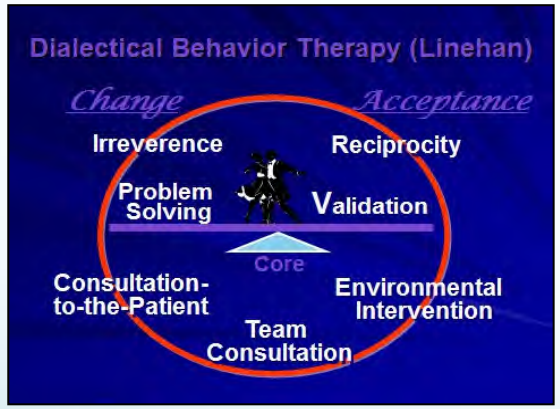
Received: 29 August 2019; Accepted: 25 September 2019; Published: 26 September 2019

check for updates

Abstract: While the existence of mental illness has been documented for centuries, the understanding and treatment of such illnesses has evolved considerably over time. Ritual exorcisms and locking mentally ill patients in asylums have been fundamentally replaced by the use of psychotropic medications and evidence-based psychological practices. Yet the historic roots of mental health management and care has left a certain legacy. With regard to suicidal risk, the authors argue that suicidal patients are by definition seen as mentally ill and out of control, which demands hospitalization and the treatment of the mental disorder (often using a medication-only approach). Notably, however, the evidence for inpatient care and a medication-only approach for suicidal risk is either limited or totally lacking. Thus, a "one-size-fits-all" approach to treating suicidal risk needs to be re-considered in lieu of the evolving evidence base. To this end, the authors highlight a series of evidence-based considerations for suicide-focused clinical care, culminating in a stepped care public health model for optimal clinical care of suicidal risk that is cost-effective, least-restrictive, and evidence-based.

Dialectical Behavior Therapy (DBT)



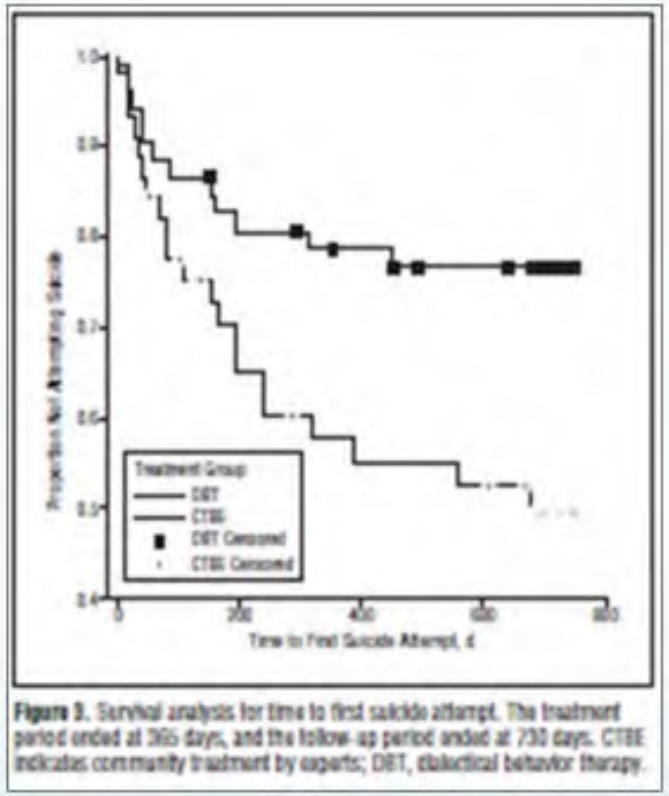


Figure 3. Survival analysis for time to first suicide attempt. The treatment period ended at 365 days, and the follow-up period ended at 730 days. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

DBT's Impact on Suicide Attempt Behavior

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

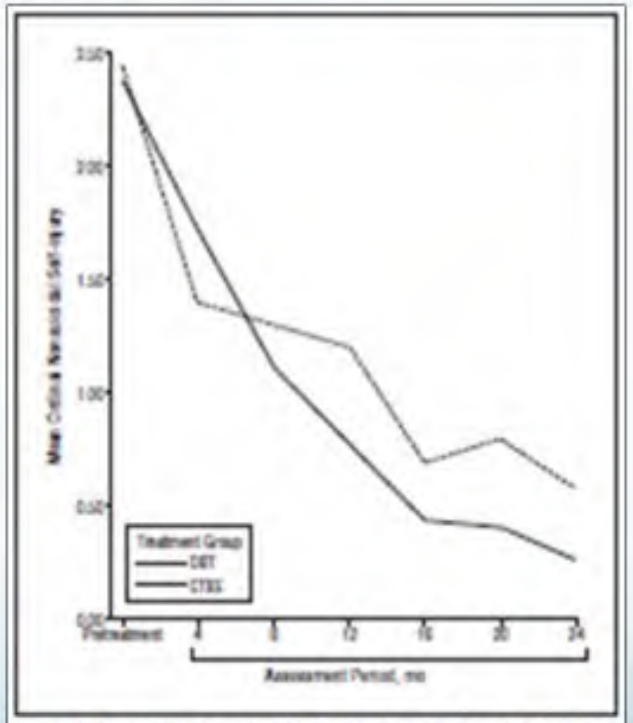


Figure 4. Mean ordinal nonsuicidal self-injury during the 2-year study.[1] The treatment period ended at 12 months, and the follow-up period ended at 24 months. The 5-level ordinal categories per assessment period were 0, 0.01 to 1, 1.01 to 2, 2.01 to 4, and 4.01 and higher. CTBE indicates community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

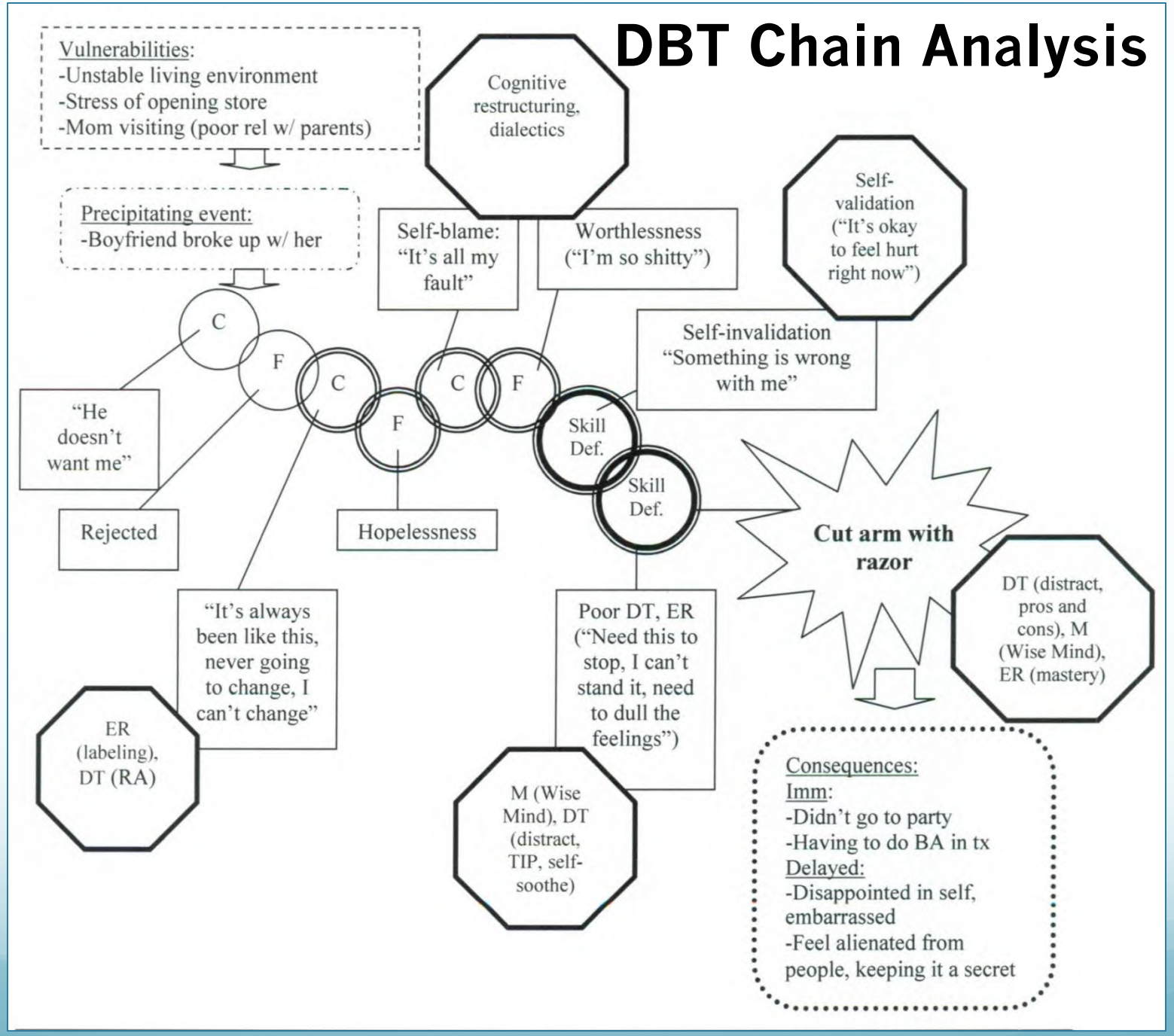
Dialectical Behavior Therapy (DBT)

DBT is an Outpatient Treatment with Four Modalities:

1. Group Skills Training
2. Individual Psychotherapy
3. Out-of-session Phone Coaching
4. Therapist Consultation Team Meeting

Source: DeCou, C.R., Comtois, K.A., Landes, S.J. (2019) Dialectical Behavior Therapy is effective for the treatment of suicidal behavior: A meta-analysis *Behavior Therapy.* 50(2019) 60-72

DBT Chain Analysis



Dialectical Behavior Therapy (DBT)

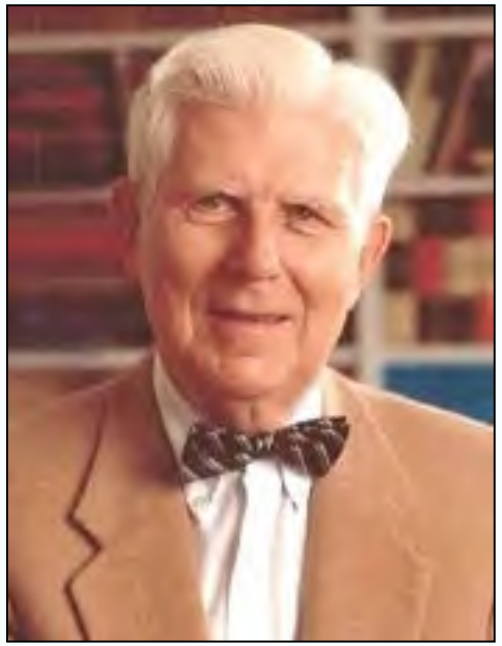
Meta-analysis of 18 controlled trials of DBT

DBT Reduced
Self-Directed Violence

DBT Reduced
Frequency of Psychiatric Crisis Services

*Suicidal Ideation was **not** significantly impacted by DBT in most of the studies*

Source: DeCou, C.R., Comtois, K.A., Landes, S.J. (2019) Dialectical Behavior Therapy is effective for the treatment of suicidal behavior: A meta-analysis *Behavior Therapy.* 50(2019) 60-72



Cognitive Therapy for Suicide Prevention (CT-SP)

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

Center for the Treatment and Prevention of Suicide (2007)

124

ORIGINAL CONTRIBUTION

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 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.

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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).
Corresponding Author: Gregory K. Brown, PhD, Department of Psychiatry, University of Pennsylvania, 3535 Market St, Room 3320, Philadelphia, PA 19104 (gregbrow@mail.med.upenn.edu).

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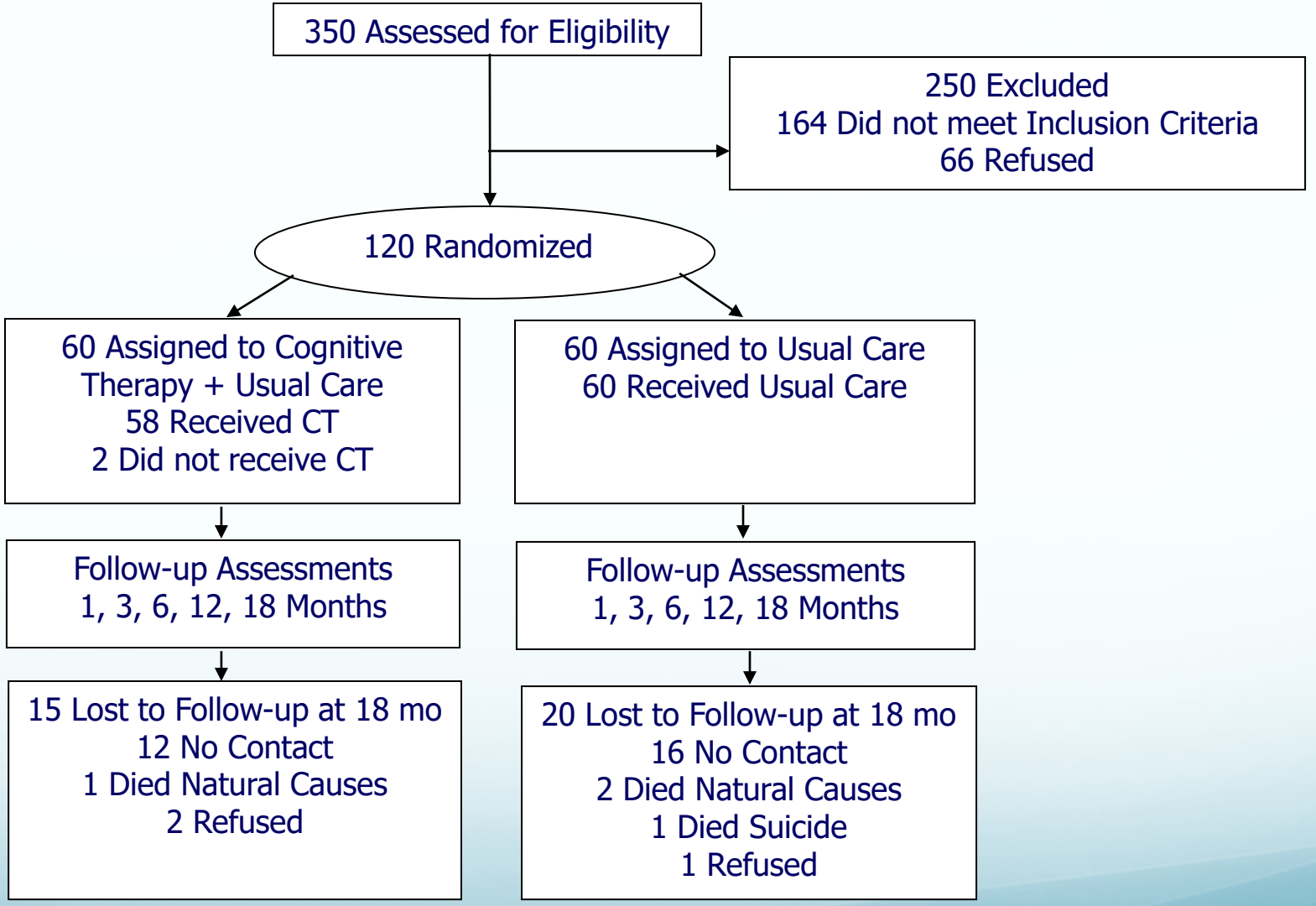
CT-SP RCT Participant Flow



Cognitive Therapy for Suicide Prevention (CT-SP)

Methods:

- Identifying thoughts, images, core beliefs
- Emphasis on “suicidal mode”
- Develop adaptive ways of coping with stressors
- Relapse prevention task

Source: Brown, G.K., Ten Have, T., Henriques, G.R., Xie, S.X., Hollander, J.E., Beck, A.T. (2005) Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *JAMA, 294*, 563-370

Cognitive Therapy for Suicide Prevention (CT-SP)

Results of Study

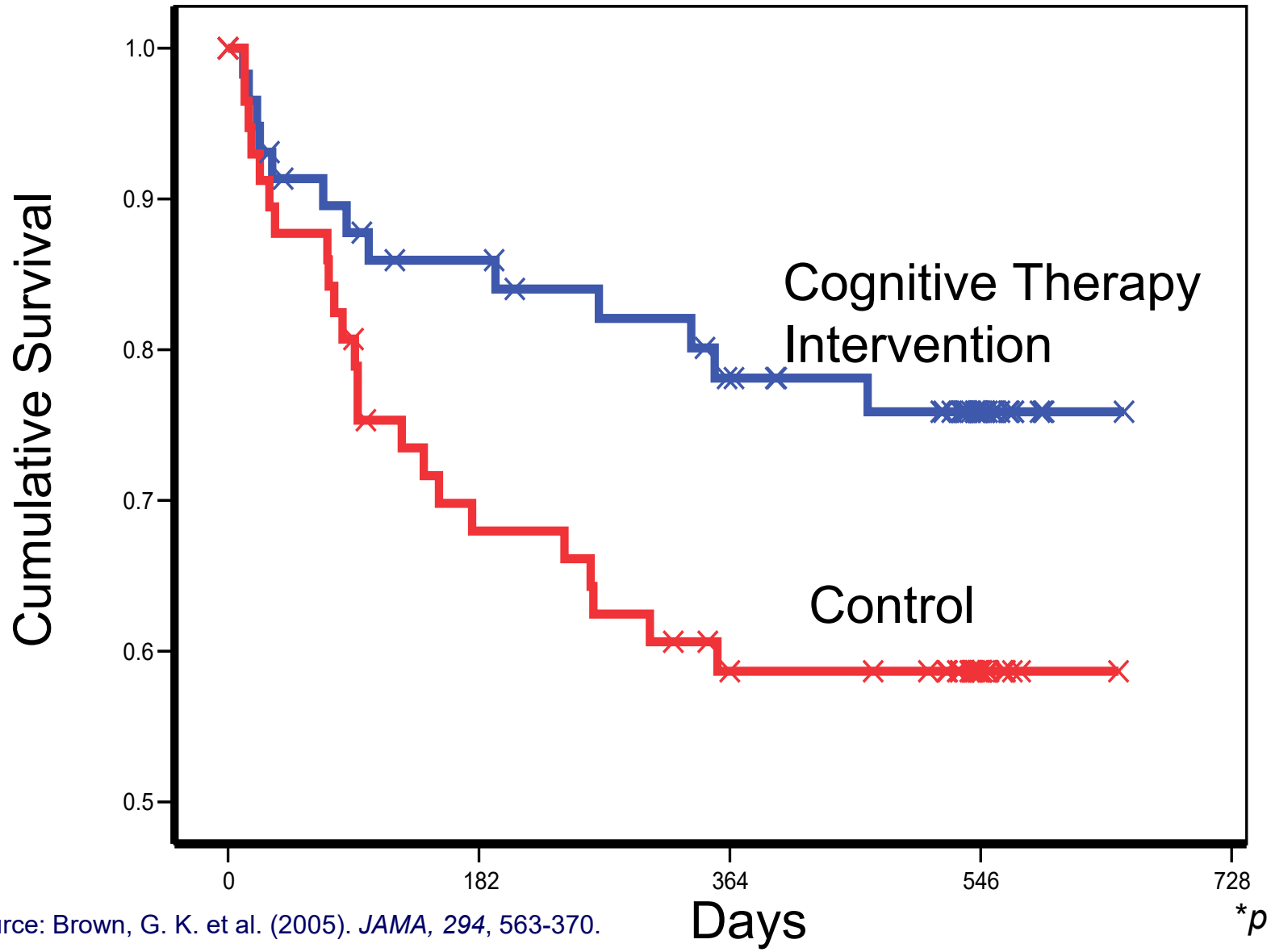
CT-SP was **twice as effective** as usual care in reducing suicide attempts

Patients in CT-SP treatment had significantly **lower scores** on Beck Depression Inventory (BDI)

Patients in CBT-SP treatment had significantly **lower levels** of hopelessness

Source: Brown, G.K., Ten Have, T., Henriques, G.R., Xie, S.X., Hollander, J.E., Beck, A.T. (2005) Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *JAMA, 294*, 563-370

Survival Functions for Repeat Suicide Attempt by Study Condition

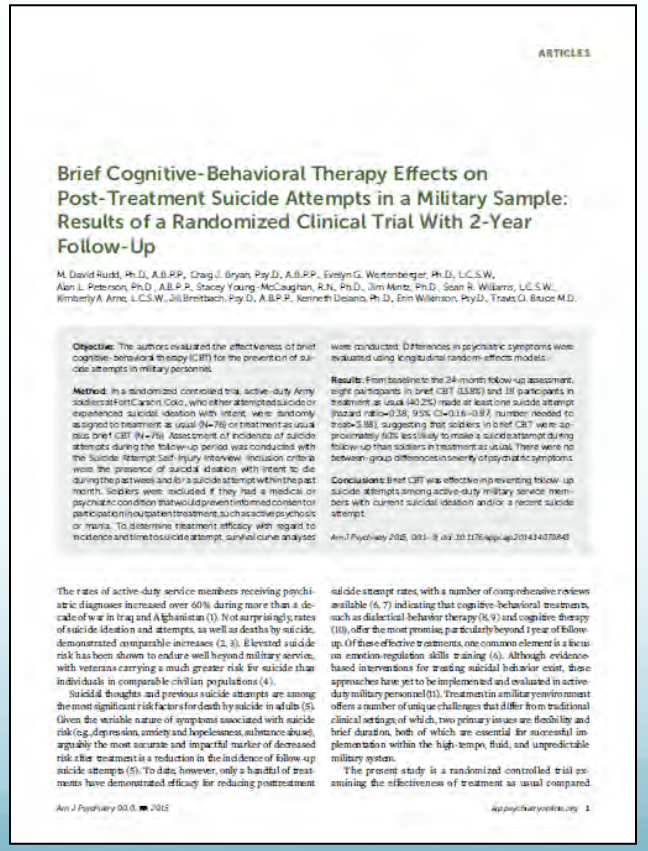


Source: Brown, G. K. et al. (2005). *JAMA, 294*, 563-370.

*$p < .05$

Brief Cognitive Behavior Therapy (BCBT)

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



ARTICLES

Brief Cognitive-Behavioral Therapy Effects on Post-Treatment Suicide Attempts in a Military Sample: Results of a Randomized Clinical Trial With 2-Year Follow-Up

M. David Rudd, Ph.D., A.B.P.P., Craig J. Bryan, Psy.D., A.B.P.P., Evelyn G. Wertenberger, Ph.D., L.C.S.W., Alan L. Peterson, Ph.D., A.B.P.P., Stacey Young-McCaughan, R.N., Ph.D., Jim Mintz, Ph.D., Sean R. Williams, L.C.S.W., Kimberly A. Arne, L.C.S.W., Jill Breitbach, Psy.D., A.B.P.P., Kenneth Delano, Ph.D., Erin Wilkinson, Psy.D., Travis O. Bruce M.D.

Objective: The authors evaluated the effectiveness of brief cognitive-behavioral therapy (CBT) for the prevention of suicide attempts in military personnel.

Method: In a randomized controlled trial, active-duty Army soldiers at Fort Carson, Colo., who either attempted suicide or experienced suicidal ideation with intent, were randomly assigned to treatment as usual (N=76) or treatment as usual plus brief CBT (N=76). Assessment of incidence of suicide attempts during the follow-up period was conducted with the Suicide Attempt Self-Injury Interview. Inclusion criteria were the presence of suicidal ideation with intent to die during the past week and/or a suicide attempt within the past month. Soldiers were excluded if they had a medical or psychiatric condition that would prevent informed consent or participation in outpatient treatment, such as active psychosis or mania. To determine treatment efficacy with regard to incidence and time to suicide attempt, survival curve analyses were conducted. Differences in psychiatric symptoms were evaluated using longitudinal random-effects models.

Results: From baseline to the 24-month follow-up assessment, eight participants in brief CBT (13.8%) and 18 participants in treatment as usual (40.2%) made at least one suicide attempt (hazard ratio=0.38, 95% CI=0.16–0.87; number needed to treat=3.88), suggesting that soldiers in brief CBT were approximately 62% less likely to make a suicidal attempt during follow-up than soldiers in treatment as usual. There were no between-group differences in severity of psychiatric symptoms.

Conclusions: Brief CBT was effective in preventing follow-up suicide attempts among active-duty military service members with current suicidal ideation and/or a recent suicide attempt.

Am J Psychiatry 2015; 001–9; doi: 10.1176/appi.ajp.20143470848

The rates of active-duty service members receiving psychiatric diagnoses increased over 60% during more than a decade of war in Iraq and Afghanistan (1). Not surprisingly, rates of suicide ideation and attempts, as well as deaths by suicide, demonstrated comparable increases (2, 3). Elevated suicide risk has been shown to endure well beyond military service, with veterans carrying a much greater risk for suicide than individuals in comparable civilian populations (4).

Suicidal thoughts and previous suicide attempts are among the most significant risk factors for death by suicide in adults (5). Given the variable nature of symptoms associated with suicide risk (e.g., depression, anxiety and hopelessness, substance abuse), arguably the most accurate and impactful marker of decreased risk after treatment is a reduction in the incidence of follow-up suicide attempts (5). To date, however, only a handful of treatments have demonstrated efficacy for reducing posttreatment suicide attempt rates, with a number of comprehensive reviews available (6, 7) indicating that cognitive-behavioral treatments, such as dialectical-behavior therapy (8, 9) and cognitive therapy (10), offer the most promise, particularly beyond 1 year of follow-up. Of these effective treatments, one common element is a focus on emotion-regulation skills training (6). Although evidence-based interventions for treating suicidal behavior exist, these approaches have yet to be implemented and evaluated in active-duty military personnel (11). Treatment in a military environment offers a number of unique challenges that differ from traditional clinical settings, of which, two primary issues are flexibility and brief duration, both of which are essential for successful implementation within the high-tempo, fluid, and unpredictable military system.

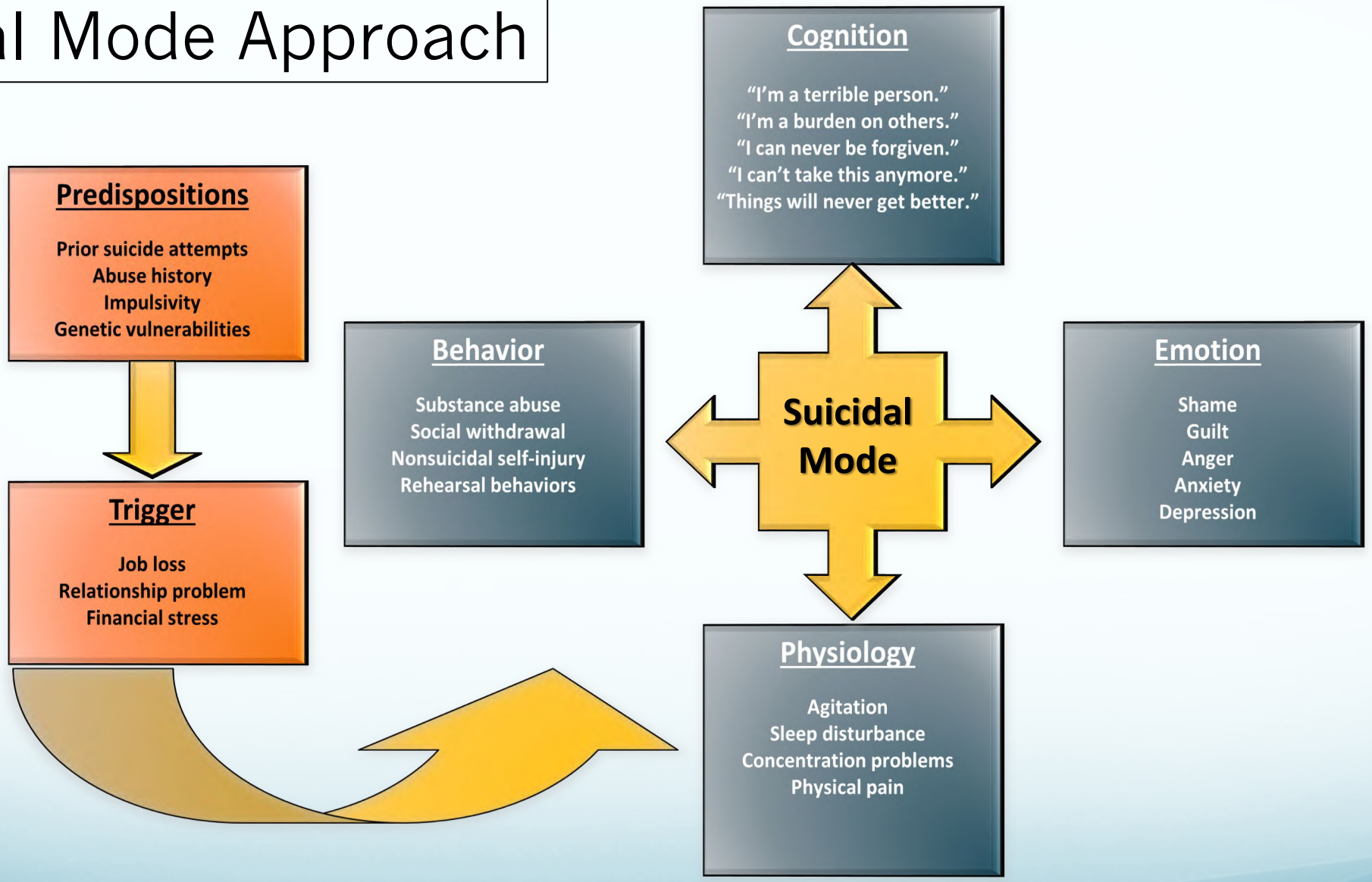
The present study is a randomized controlled trial examining the effectiveness of treatment as usual compared

JAMA Psychiatry | Original Investigation

Brief Cognitive Behavioral Therapy for Suicidal Inpatients
A Randomized Clinical Trial

60% between-group reduction in suicide attempts (*American Journal of Psychiatry*, 2015)

Suicidal Mode Approach



Brief Cognitive Behavior Therapy (BCBT)

Treatment of Suicidal States

Methods

Phase I: Brief Cognitive Behavioral Therapy

Phase II: Assessment of suicidal behaviors and develop strategies

Phase III: Apply strategies to reduce vulnerability to using suicide to cope

Phase IV: Relapse prevention task conducted

Source: Rudd, D.M., Bryan, C.J. et al (2015) Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. Am J Psychiatry. 2015 May;172(5):441-9

Brief Cognitive Behavior Therapy (BCBT) Treatment of Suicidal States

Results of Study

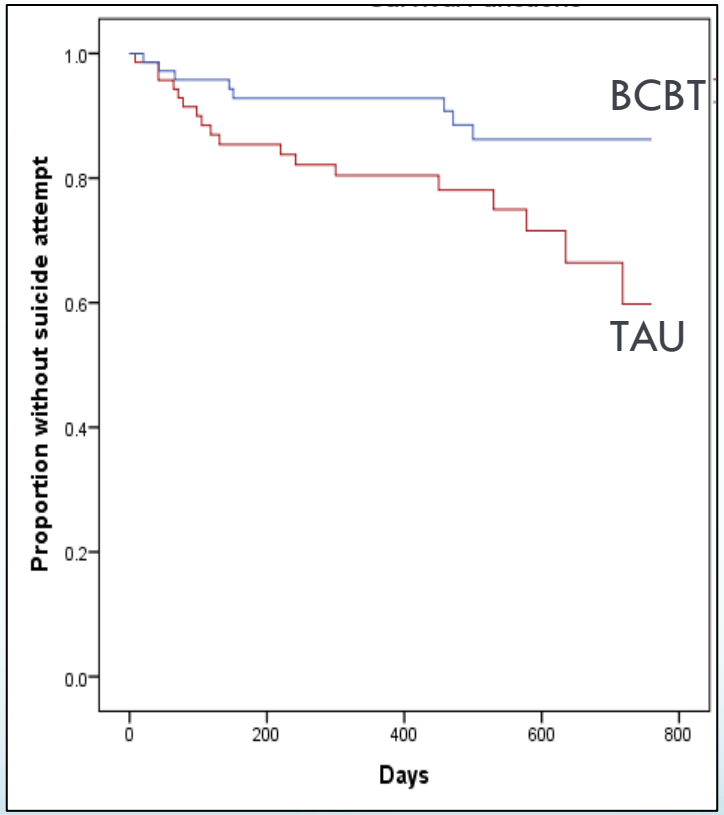
Soldiers in BCBT **60% less likely** than soldiers in treatment to make a suicide attempt during the 2 year follow up period

Soldiers in BCBT **slightly less likely** to be medically retired than soldiers in treatment

Source: Rudd, D.M., Bryan, C.J. et al (2015) Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: results of a randomized clinical trial with 2-year follow-up. Am J Psychiatry. 2015 May;172(5):441-9

Brief Cognitive Behavioral Therapy (BCBT)

Time to First Suicide Attempt by Study Condition



Source: Rudd MD et al. (2015). *Am J Psychiatry, 172*, 441-449.

log-rank $\chi^2(1) = 5.28$, $p = .022$

Slide courtesy of Craig Bryan

Manage troubling thoughts with Aviva

Aviva is built on science shown to help people manage troubling thoughts. It's a directed and personalized program.

Aviva includes a chatbot designed to engage with you

Aviva has a chatbot that goes back and forth with users to gather specific issues and develop a course of exercises and information tailored for individual needs.

Mentalization-Based Therapy

Effectiveness of Partial Hospitalization in the Treatment of Borderline Personality Disorder: A Randomized Controlled Trial

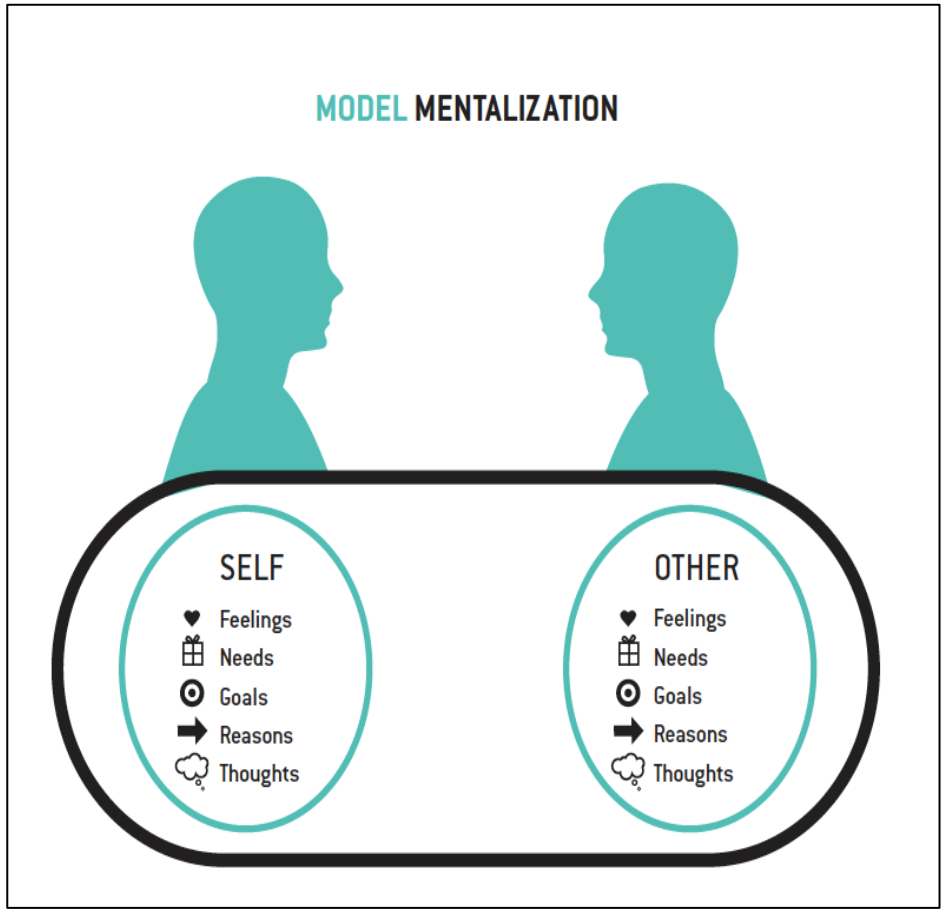
Anthony Bateman, M.A., F.R.C.Psych., and Peter Fonagy, Ph.D., F.B.A.

Objective: This study compared the effectiveness of psychoanalytically oriented partial hospitalization with standard psychiatric care for patients with borderline personality disorder. **Method:** Thirty-eight patients with borderline personality disorder, diagnosed according to standardized criteria, were allocated either to a partially hospitalized group or to a standard psychiatric care (control) group in a randomized controlled design. Treatment, which included individual and group psychoanalytic psychotherapy, was for a maximum of 18 months. Outcome measures included the frequency of suicide attempts and acts of self-harm, the number and duration of inpatient admissions, the use of psychotropic medication, and self-report measures of depression, anxiety, general symptom distress, interpersonal function, and social adjustment. Data analysis used repeated measures analysis of covariance and nonparametric tests of trend. **Results:** Patients who were partially hospitalized showed a statistically significant decrease on all measures in contrast to the control group, which showed limited change or deterioration over the same period. An improvement in depressive symptoms, a decrease in suicidal and self-mutilatory acts, reduced inpatient days, and better social and interpersonal function began at 6 months and continued until the end of treatment at 18 months. **Conclusions:** Psychoanalytically oriented partial hospitalization is superior to standard psychiatric care for patients with borderline personality disorder. Replication is needed with larger groups, but these results suggest that partial hospitalization may offer an alternative to inpatient treatment.
(Am J Psychiatry 1999; 156:1563–1569)

Most patients with borderline personality disorder are treated with nonspecialist standard psychiatric services by using inpatient treatment, partial hospitalization, and outpatient services as necessary. However, more specific psychological interventions have been developed. These include individual psychoanalytic psychotherapy (1, 2), dialectical behavior therapy (3), group psychotherapy (4), family therapy (5), and supportive psychotherapy (6). While a number of naturalistic outcome studies have been done, particularly of inpatient treatment, randomized controlled trials of outpatient treatment and partial hospitalization are rare (7, 8).

Received June 16, 1998; revisions received Nov. 12, 1998, and March 5, 1999; accepted March 17, 1999. From the Halliwick Day Unit, St. Ann's Hospital. Address reprint requests to Dr. Bateman, Consultant Psychiatrist in Psychotherapy, Haringey Healthcare NHS Trust, Halliwick Day Unit, St. Ann's Hospital, St. Ann's Road, London N15 3TH; anthony@mullins.demon.co.uk (e-mail).
The authors thank Dr. Ilan Diamant for conducting research interviews and the day hospital staff for patient care.

In one of the few controlled studies of intensive outpatient treatment of individuals with borderline personality disorder, Linehan and colleagues (3) showed that dialectical behavior therapy was partially effective. Dialectical behavior therapy (9) is a treatment incorporating cognitive, behavioral, and supportive psychotherapies. Skilled practitioners in an intensive outpatient program use a combination of individual and group approaches centered on a patient-therapist relationship. Treatment with dialectical behavior therapy for 1 year compared with standard treatment led to a reduction in the number and severity of suicide attempts and decreased the frequency and length of inpatient admissions. However, there were no between-group differences on measures of depression, hopelessness, or reasons for living and, although patients receiving dialectical behavior therapy continued to show less parasuicidal behavior at the 6-month follow-up examination, there was no difference in measures of self-destructive acts between groups at the 1-year follow-up (10).



NEW RESEARCH

Mentalization-Based Treatment for Self-Harm in Adolescents: A Randomized Controlled Trial

Trudie I. Rossouw, M.R.C.Psych., AND Peter Fonagy, Ph.D., F.B.A.

Objective: We examined whether mentalization-based treatment for adolescents (MBT-A) is more effective than treatment as usual (TAU) for adolescents who self-harm. **Method:** A total of 80 adolescents (85% female) consecutively presenting to mental health services with self-harm and comorbid depression were randomly allocated to either MBT-A or TAU. Adolescents were assessed for self-harm, risk-taking and mood at baseline and at 3-monthly intervals until 12 months. Their attachment style, mentalization ability and borderline personality disorder (BPD) features were also assessed at baseline and at the end of the 12-month treatment. **Results:** MBT-A was more effective than TAU in reducing self-harm and depression. This superiority was explained by improved mentalization and reduced attachment avoidance and reflected improvement in emergent BPD symptoms and traits. **Conclusions:** MBT-A may be an effective intervention to reduce self-harm in adolescents. **Clinical trial registration information**—The emergence of personality disorder traits in adolescents who deliberately self harm and the potential for using a mentalisation based treatment approach as an early intervention for such individuals: a randomised controlled trial; http://www.controlled-trials.com; ISRCTN95266816. J. Am. Acad. Child Adolesc. Psychiatry, 2012; 51(12):1304-1313. **Key Words:** self-harm, treatment, borderline, RCT.

Self-harm can be defined as any act of deliberate harm to oneself, regardless of whether it is accompanied by suicidal thoughts.[1] It is common in community samples,[2] and the incidence of self-harm without suicidal intent is increasing.[3] Self-harm in clinical groups is associated with negative outcomes.[1] Self-harm is common among young people with treatment-resistant depression, and is a significant predictor of future suicide.[4] In a population-based US sample, the prevalence of self-harm in youths was 17%.[5] Of young people with self-harm behaviors, 30% continue to harm themselves into adulthood.[6] When adolescents present with self-harm and depression, the close association of self-harm with suicide is of particular clinical concern.[1,4]

There are few evidence-based treatments for adolescents who harm themselves.[7] A promising group program evaluated in a small randomized clinical trial (RCT) showed a reduction of self-harming behavior in adolescents over 12 months of treatment compared to with treatment as usual (TAU) (either family work or supportive therapy).[8] However, two large-scale replications failed to demonstrate benefit.[9,10] In their study of multisystemic therapy, Huey et al[11] reported that multisystemic therapy, conducted over 6 months, appeared to be more effective than hospitalization on a single-item measure of suicidality but no more effective than TAU in reducing suicidal ideation, depression, or hopelessness. An RCT of cognitive analytic therapy for adolescents with borderline personality disorder (BPD), 91% of whom presented with self-harm,[12] found that cognitive analytic therapy was no more effective than TAU in reducing self-harm, depression, and changes in BPD symptoms. Two open trials with dialectical behavior therapy (DBT) reported

This article is discussed in an editorial by Dr. Davis J. Miklowitz on page 1238.
CG Clinical guidance is available at the end of this article.
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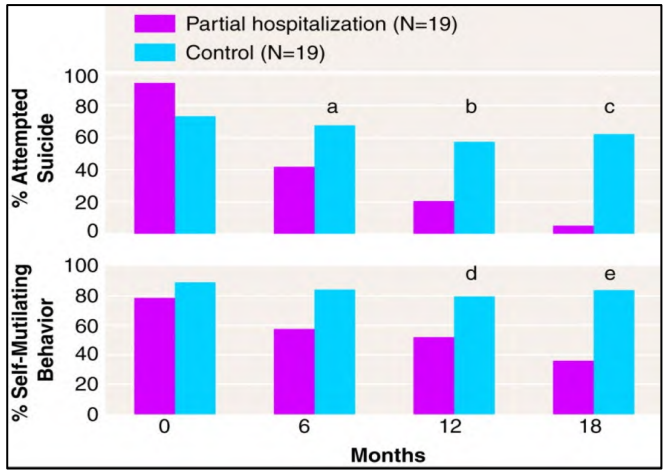
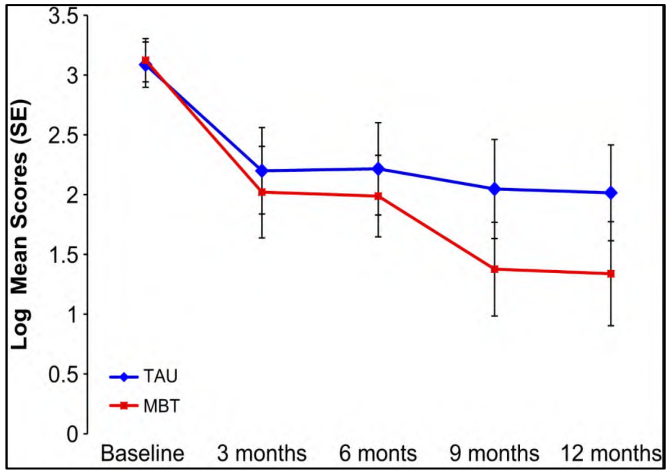
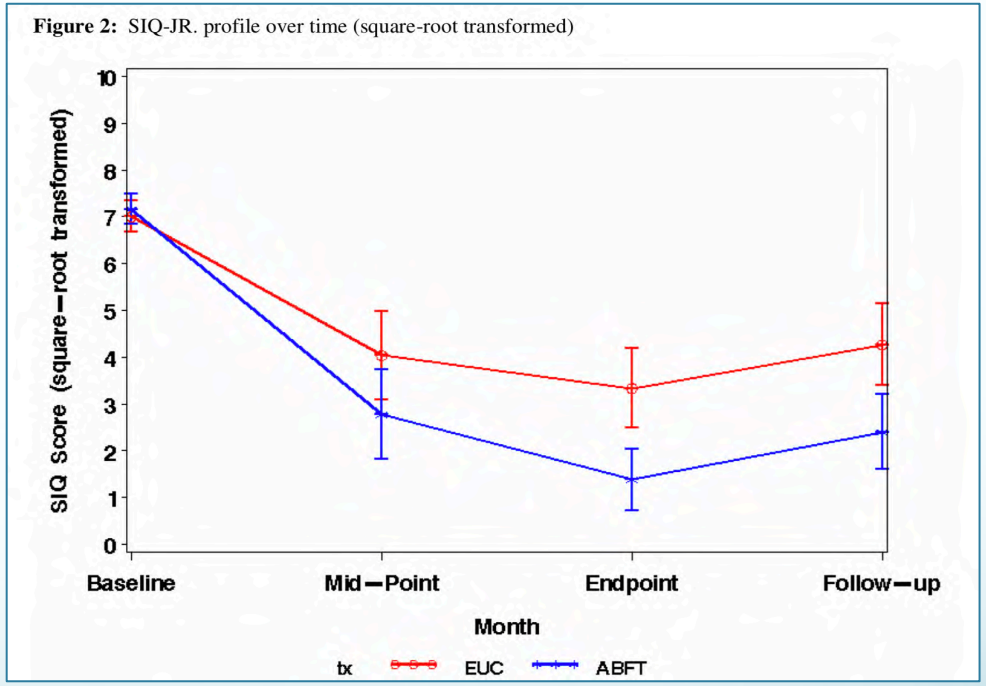


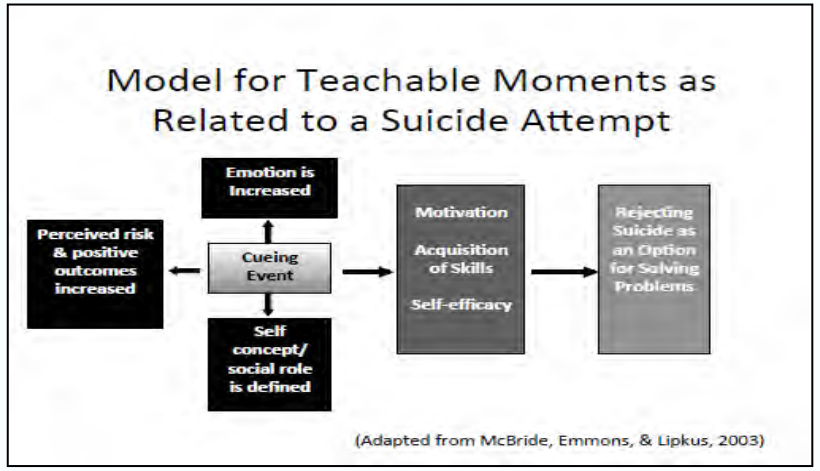


Attachment-Based Family Therapy (ABFT)

- Improving family relationships
  - Parent-child attachment
- Weekly individual, parent, and family sessions (3 months)
- 2 RCTs found reduction in suicide ideation
  - Rapid reduction at post-treatment (vs. Waitlist control condition)
  - Maintained at 6-month follow-up (vs. E-Usual Care)
- Limitations
  - Comparison groups had low treatment completion
  - Suicide behaviors not assessed



Diamond et al., 2010; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002

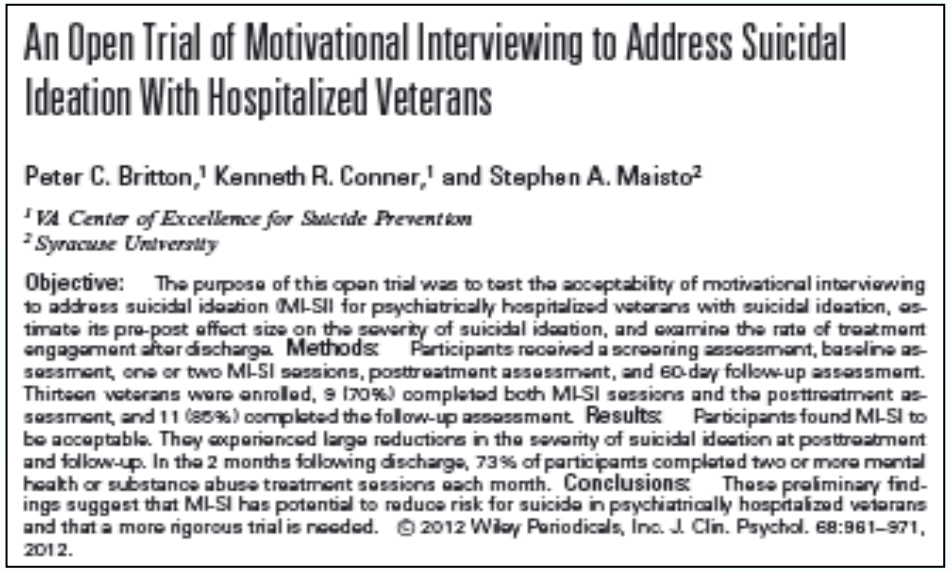


Stephen O'Connor, Ph.D.

A one-time psychological intervention on medical-surgical unit for attempters…

Peter Britton, Ph.D.

1-2 sessions of Motivational Interviewing With veterans following a suicide attempt…

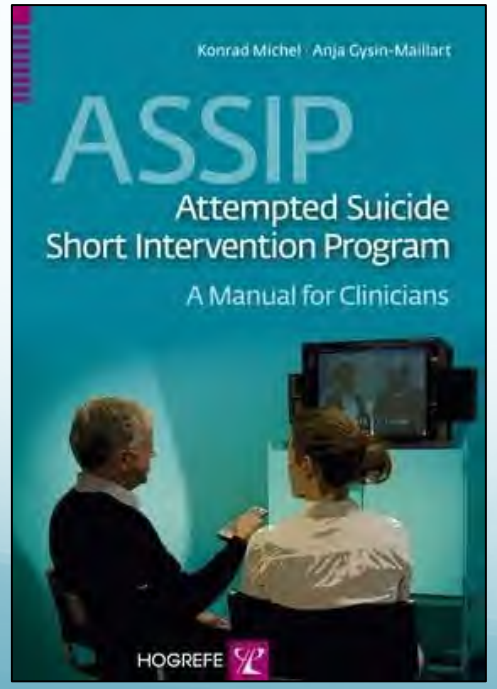


An Open Trial of Motivational Interviewing to Address Suicidal Ideation With Hospitalized Veterans

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.

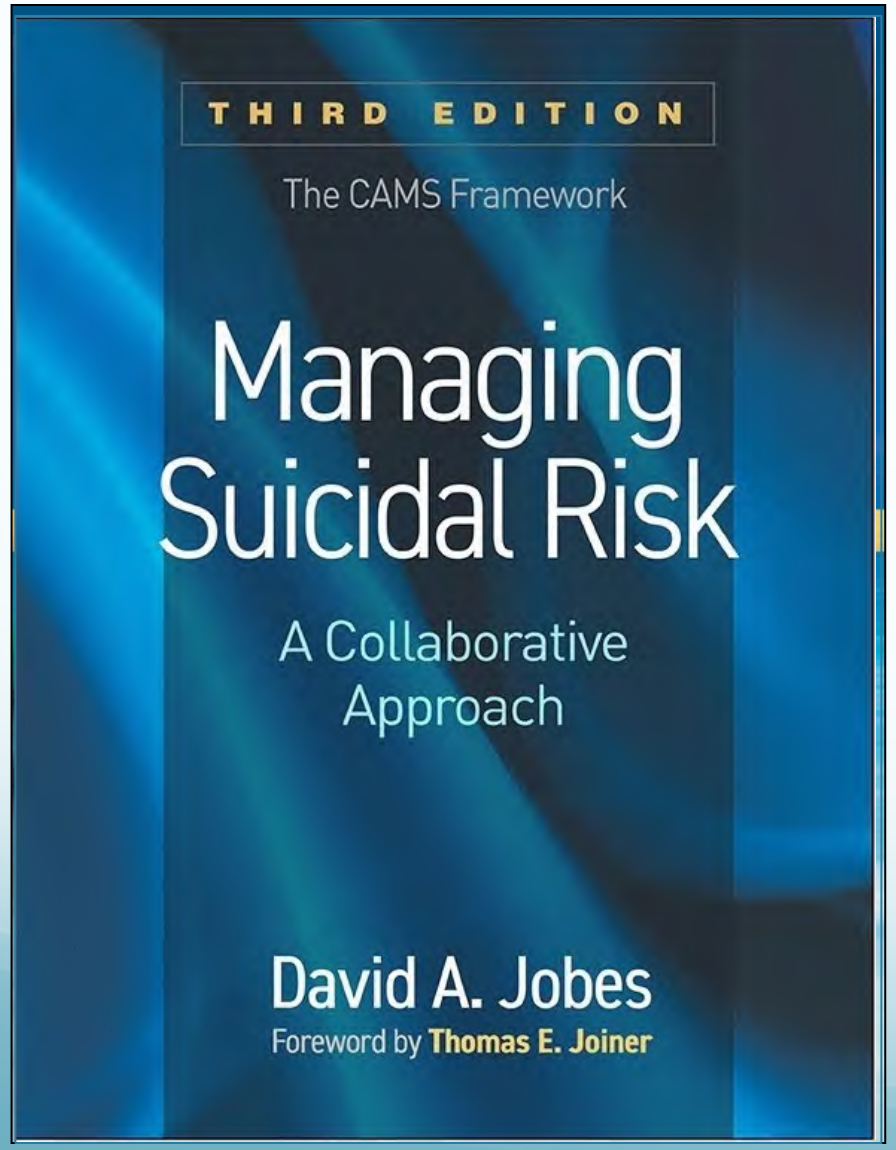


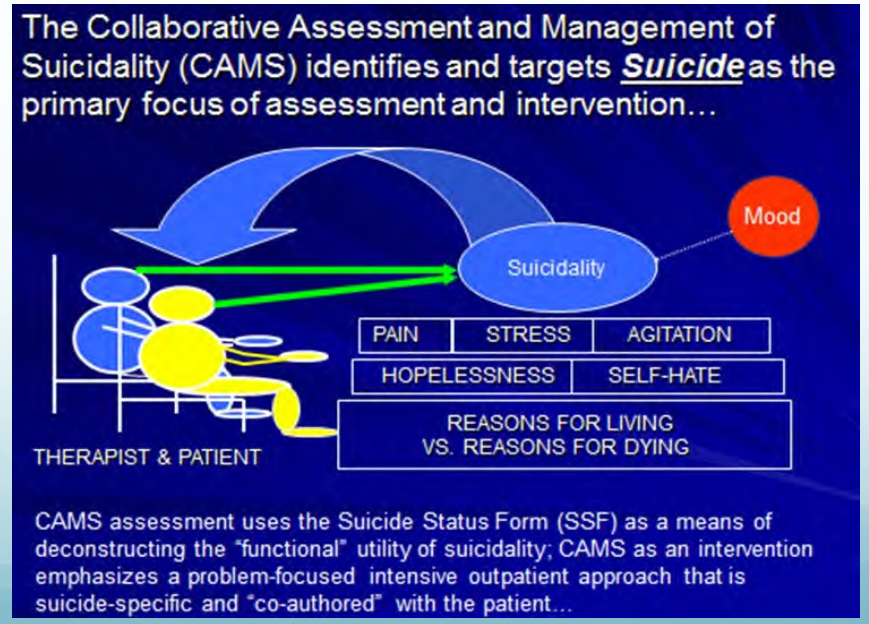
BRIEF SUICIDE-SPECIFIC INTERVENTIONS…

Anja Gysin-Maillart, Ph.D. & Konrad Michel, M.D.

3 session intervention focused on narrative interview, self-confrontation, safety plan, and follow up…

The Collaborative Assessment and Management of Suicidality (CAMS)





The four pillars of the CAMS framework:

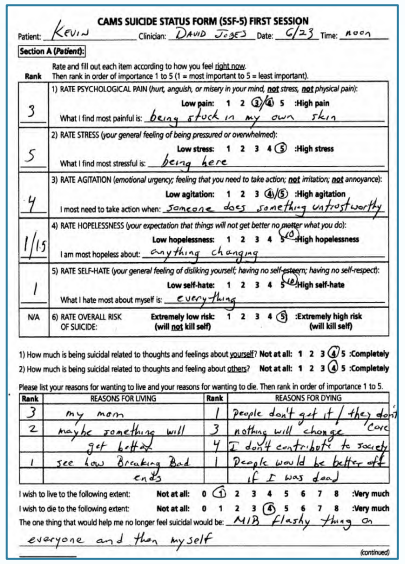
1) Empathy

2) Collaboration

3) Honesty

4) Suicide-focused

Goal: Build a strong therapeutic alliance that increases patient-motivation; CAMS targets and treats *patient-defined* suicidal "drivers"


CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION

Patient: Kevin Clinician: David Jobes Date: 6/23 Time: noon

Section A (Patient):

Rate and fill out each item according to how you feel right now.

Rank — Then rank in order of importance 1 to 5 (1 = most important to 5 = least important).

Rank	
3	1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain): Low pain: 1 2 (3) 4 5 :High pain. What I find most painful is: being stuck in my own skin
5	2) RATE STRESS (your general feeling of being pressured or overwhelmed): Low stress: 1 2 3 4 (5) :High stress. What I find most stressful is: being here
4	3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance): Low agitation: 1 2 3 (4) (5) :High agitation. I most need to take action when: someone does something untrustworthy
1/15	4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do): Low hopelessness: 1 2 3 4 (5) :High hopelessness. I am most hopeless about: anything changing
1	5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect): Low self-hate: 1 2 3 4 (5) :High self-hate. What I hate most about myself is: everything
N/A	6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 (5) :Extremely high risk (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 (4) 5 :Completely

2) How much is being suicidal related to thoughts and feeling about others? Not at all: 1 2 3 (4) 5 :Completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

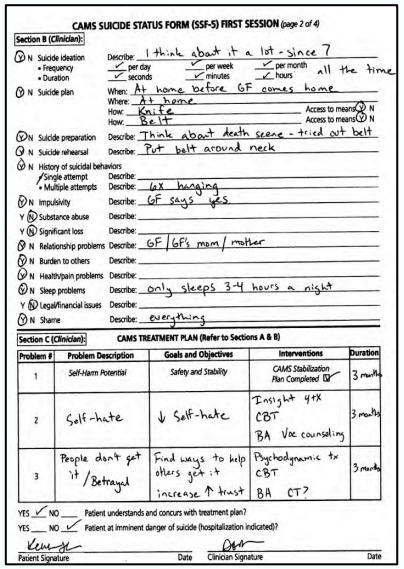
Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
3	my mom	1	People don't get it / they don't Care
2	maybe something will change / get better	3	nothing will change
		4	I don't contribute to society
1	see Law Breaking Bad ends	1	People would be better off if I was dead

I wish to live to the following extent: Not at all: 0 (1) 2 3 4 5 6 7 8 :Very much

I wish to die to the following extent: Not at all: 0 1 2 3 (4) 5 6 7 8 :Very much

The one thing that would help me no longer feel suicidal would be: MIB Flashy thing on everyone and then myself

(continued)


CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION (page 2 of 4)

Section B (Clinician):

(Y) N	Suicide ideation • Frequency • Duration	Describe: I think about it a lot - since 7 / per day / per week / per month / seconds / minutes / hours all the time
(Y) N	Suicide plan	When: At home / Where: At home / How: Knife / How: Belt / Access to means: (Y) N / Access to means: (Y) N
(Y) N	Suicide preparation	Describe: Think about death scene - tried out belt
(Y) N	Suicide rehearsal	Describe: Put belt around neck
(Y) N	History of suicidal behaviors / Single attempt / • Multiple attempts	Describe: Describe: 6x hanging
(Y) N	Impulsivity	Describe: GF says yes
Y (N)	Substance abuse	Describe:
Y (N)	Significant loss	Describe:
(Y) N	Relationship problems	Describe: GF / GF's mom / mother
(Y) N	Burden to others	Describe:
(Y) N	Health/pain problems	Describe:
(Y) N	Sleep problems	Describe: only sleeps 3-4 hours a night
Y (N)	Legal/financial issues	Describe:
(Y) N	Shame	Describe: everything

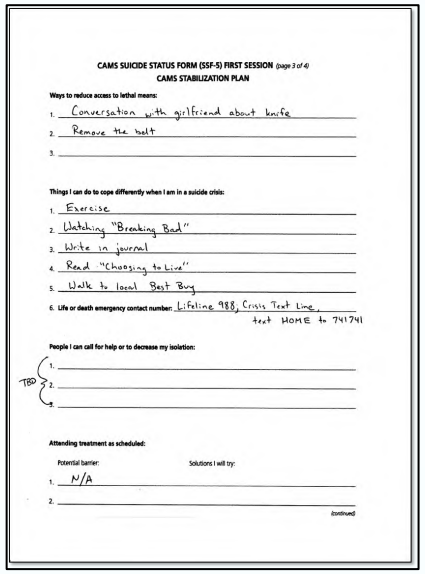
Section C (Clinician): CAMS TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-Harm Potential	Safety and Stability	CAMS Stabilization Plan Completed (X)	3 months
2	Self-hate	↓ Self-hate	Insight 4 tx CBT BA Vac counseling	3 months
3	People don't get it / Betrayed	Find ways to help others get it increase ↑ trust	Psychodynamic tx CBT BA CT?	3 months

YES (✓) NO ( ) Patient understands and concurs with treatment plan?

YES ( ) NO (✓) Patient at imminent danger of suicide (hospitalization indicated)?

Kevin — Date — Clinician Signature — Date


CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION (page 3 of 4)

CAMS STABILIZATION PLAN

Ways to reduce access to lethal means:

1. Conversation with girlfriend about knife
2. Remove the belt
3.

Things I can do to cope differently when I am in a suicide crisis:

1. Exercise
2. Watching "Breaking Bad"
3. Write in journal
4. Read "Choosing to Live"
5. Walk to local Best Buy
6. Life or death emergency contact number: Lifeline 988, Crisis Text Line, text HOME to 741741

People I can call for help or to decrease my isolation:

TBD
1.
2.
3.

Attending treatment as scheduled:

Potential barrier:	Solutions I will try:
1. N/A	
2.	

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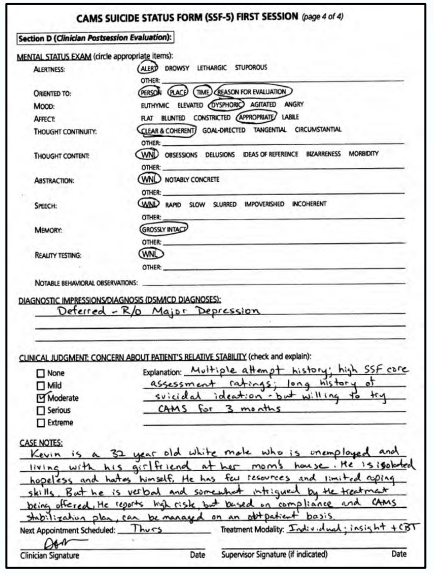

CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION (page 4 of 4)

Section D (Clinician Postsession Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS OTHER:

ORIENTED TO: (PERSON) PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED (DYSPHORIC) AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE

THOUGHT CONTINUITY: (CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL

THOUGHT CONTENT: (WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY

ABSTRACTION: (WNL) NOTABLY CONCRETE

SPEECH: (WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT

MEMORY: (GROSSLY INTACT)

REALITY TESTING: (WNL)

NOTABLE BEHAVIORAL OBSERVATIONS:

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/CD DIAGNOSES):
Deferred - R/O Major Depression

CLINICAL JUDGMENT: CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check and explain):

( ) None ( ) Mild (✓) Moderate ( ) Serious ( ) Extreme

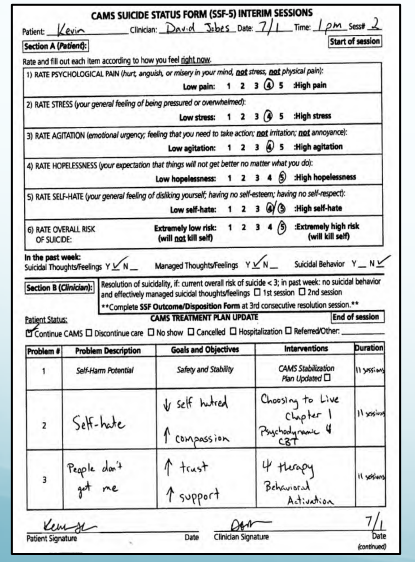
Explanation: Multiple attempt history; high SSF core assessment ratings; long history of suicidal ideation - but willing to try CAMS for 3 months

CASE NOTES:
Kevin is a 32 year old white male who is unemployed and living with his girlfriend at her mom's house. He is isolated hopeless and hates himself. He has few resources and limited coping skills. But he is verbal and somewhat intrigued by the treatment being offered. He reports high risk but based on compliance and CAMS stabilization plan, can be managed on an outpatient basis.

Next Appointment Scheduled: Thurs Treatment Modality: Individual; insight + CBT

Clinician Signature — Date — Supervisor Signature (if indicated) — Date

First session of CAMS—SSF-5 Assessment, Stabilization Planning, Driver-Focused Treatment Planning, and HIPAA Documentation


CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS

Patient: Kevin Clinician: David Jobes Date: 7/1 Time: 1pm Sess# 2

Section A (Patient): Start of session

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain):	Low pain: 1 2 3 (4) 5 :High pain
2) RATE STRESS (your general feeling of being pressured or overwhelmed):	Low stress: 1 2 3 (4) 5 :High stress
3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):	Low agitation: 1 2 3 (4) 5 :High agitation
4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):	Low hopelessness: 1 2 3 4 (5) :High hopelessness
5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):	Low self-hate: 1 2 3 (4) (5) :High self-hate
6) RATE OVERALL RISK OF SUICIDE:	Extremely low risk: (will not kill self) 1 2 3 4 (5) :Extremely high risk (will kill self)

In the past week:
Suicidal Thoughts/Feelings Y (✓) N ( ) Managed Thoughts/Feelings Y (✓) N ( ) Suicidal Behavior Y ( ) N (✓)

Section B (Clinician): Resolution of suicidality, if: current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session
Complete SSF Outcome/Disposition Form at 3rd consecutive resolution session.

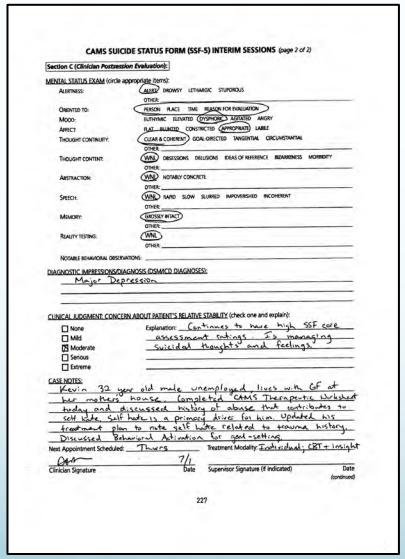
Patient Status: End of session

CAMS TREATMENT PLAN UPDATE

(✓) Continue CAMS ☐ Discontinue care ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other:

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-Harm Potential	Safety and Stability	CAMS Stabilization Plan Updated ☐	11 sessions
2	Self-hate	↓ self hatred ↑ compassion	Choosing to Live Chapter 1 Psychodynamic & CBT	11 sessions
3	People don't get me	↑ trust ↑ support	↓ therapy Behavioral Activation	11 sessions

Kevin — Date — Clinician Signature — 7/1 Date (continued)


CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS (page 2 of 2)

Section C (Clinician Postsession Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS OTHER:

ORIENTED TO: (PERSON) PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED (DYSPHORIC) AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE

THOUGHT CONTINUITY: (CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL

THOUGHT CONTENT: (WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY

ABSTRACTION: (WNL) NOTABLY CONCRETE

SPEECH: (WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT

MEMORY: (GROSSLY INTACT)

REALITY TESTING: (WNL)

NOTABLE BEHAVIORAL OBSERVATIONS:

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/CD DIAGNOSES):
Major Depression

CLINICAL JUDGMENT: CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check one and explain):

( ) None ( ) Mild (✓) Moderate ( ) Serious ( ) Extreme

Explanation: Continues to have high SSF core assessment ratings; is managing suicidal thoughts and feelings

CASE NOTES:
Kevin 32 year old male unemployed, lives with GF at her mothers house. Completed CAMS Therapeutic Worksheet today and discussed making use of these tools to cope with suicidality. Self-hate is a primary driver for him. Updated his treatment plan to note self hate related to trauma history. Discussed Behavioral Activation for next meeting.

Next Appointment Scheduled: Thurs Treatment Modality: Individual, CBT + insight

Clinician Signature — 7/1 Date — Supervisor Signature (if indicated) — Date (continued)

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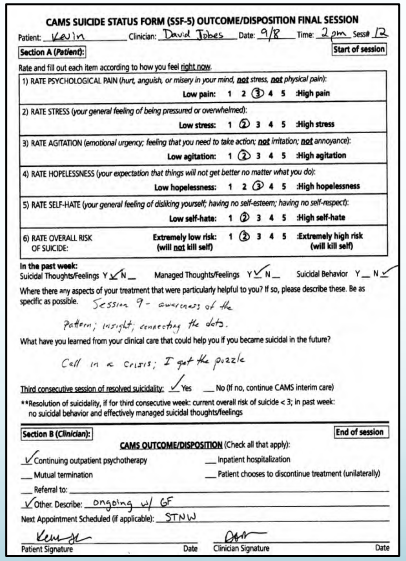

CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION

Patient: Kevin Clinician: David Jobes Date: 9/8 Time: 2pm Sess# 12

Section A (Patient): Start of session

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain):	Low pain: 1 2 (3) 4 5 :High pain
2) RATE STRESS (your general feeling of being pressured or overwhelmed):	Low stress: 1 (2) 3 4 5 :High stress
3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):	Low agitation: 1 (2) 3 4 5 :High agitation
4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):	Low hopelessness: 1 2 (3) 4 5 :High hopelessness
5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):	Low self-hate: 1 (2) 3 4 5 :High self-hate
6) RATE OVERALL RISK OF SUICIDE:	Extremely low risk: (will not kill self) 1 (2) 3 4 5 :Extremely high risk (will kill self)

In the past week:
Suicidal Thoughts/Feelings Y (✓) N ( ) Managed Thoughts/Feelings Y (✓) N ( ) Suicidal Behavior Y ( ) N (✓)

Where there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible. Session 9 - awareness of the pattern; insight; connecting the dots.

What have you learned from your clinical care that could help you if you became suicidal in the future? Call in a crisis; I got the puzzle

Third consecutive session of resolved suicidality: (✓) Yes ( ) No (If no, continue CAMS interim care)

**Resolution of suicidality, if for third consecutive week: current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings

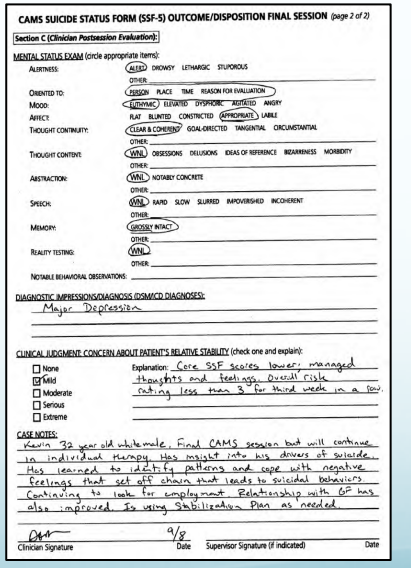
Section B (Clinician): End of session

CAMS OUTCOME/DISPOSITION (Check all that apply):

(✓) Continuing outpatient psychotherapy
( ) Inpatient hospitalization
( ) Mutual termination
( ) Patient chooses to discontinue treatment (unilaterally)
( ) Referral to:
(✓) Other. Describe: ongoing w/ GF

Next Appointment Scheduled (if applicable): STNW

Kevin — Date — Clinician Signature — Date


CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION (page 2 of 2)

Section C (Clinician Postsession Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS OTHER:

ORIENTED TO: (PERSON) PLACE TIME REASON FOR EVALUATION

MOOD: (EUTHYMIC) ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE

THOUGHT CONTINUITY: (CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL

THOUGHT CONTENT: (WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY

ABSTRACTION: (WNL) NOTABLY CONCRETE

SPEECH: (WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT

MEMORY: (GROSSLY INTACT)

REALITY TESTING: (WNL)

NOTABLE BEHAVIORAL OBSERVATIONS:

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/CD DIAGNOSES):
Major Depression

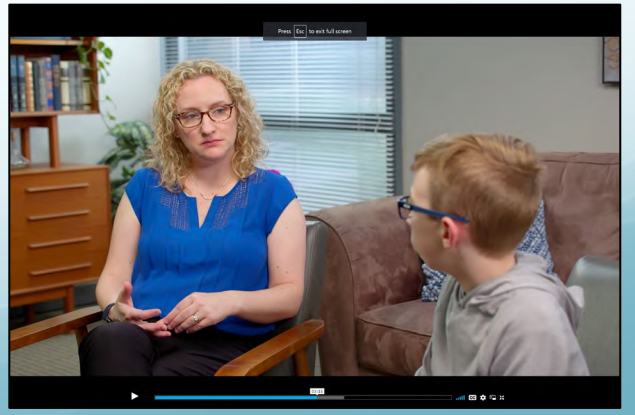
CLINICAL JUDGMENT: CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check one and explain):

( ) None (✓) Mild ( ) Moderate ( ) Serious ( ) Extreme

Explanation: Core SSF scores lower; managed thoughts and feelings. Overall risk rating less than 3 for third week in a row.

CASE NOTES:
Kevin 32 year old white male. Final CAMS session but will continue in individual therapy. Has insight into his drivers of suicide. Has learned to identify patterns and cope with negative feelings that set off chain that leads to suicidal behaviors. Continuing to look for employment. Relationship with GF has also improved. Is using Stabilization Plan as needed.

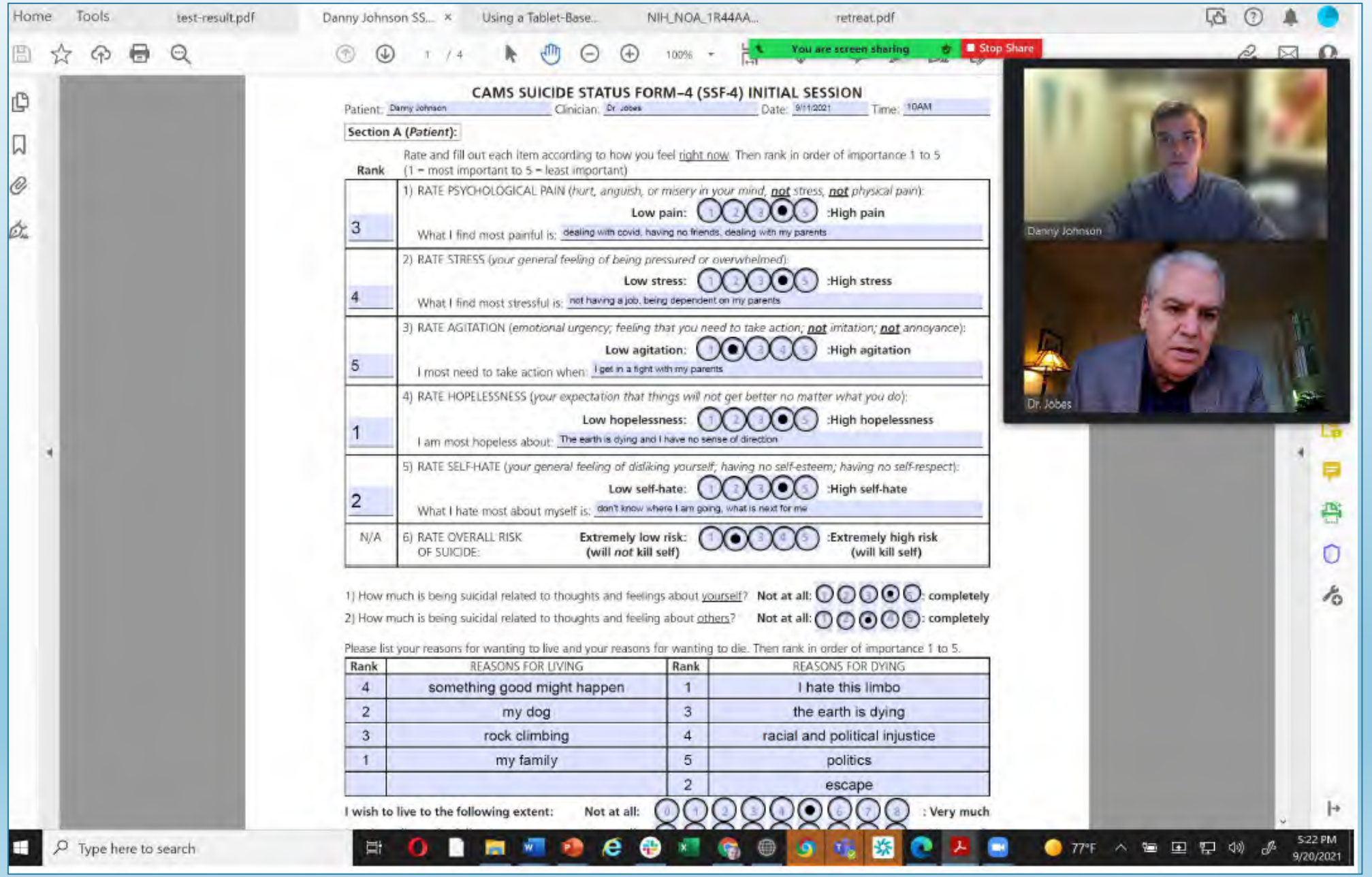
Clinician Signature — 9/8 Date — Supervisor Signature (if indicated) — Date



CAMS Interim Sessions

CAMS Outcome/Disposition Final Session

Form-fillable PDF of the SSF for telehealth CAMS sessions



CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: Danny Johnson Clinician: Dr. Jobes Date: 9/11/2021 Time: 10AM

Section A (*Patient*):

Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)

Rank		
3	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, not stress, not physical pain*): Low pain: 1 2 3 ● 5 :High pain What I find most painful is: dealing with covid, having no friends, dealing with my parents	
4	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): Low stress: 1 2 3 ● 5 :High stress What I find most stressful is: not having a job, being dependent on my parents	
5	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; not irritation; not annoyance*): Low agitation: 1 ● 3 4 5 :High agitation I most need to take action when: I get in a fight with my parents	
1	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): Low hopelessness: 1 2 3 ● 5 :High hopelessness I am most hopeless about: The earth is dying and I have no sense of direction	
2	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): Low self-hate: 1 2 3 ● 5 :High self-hate What I hate most about myself is: don't know where I am going, what is next for me	
N/A	6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will *not* kill self) 1 ● 3 4 5 :Extremely high risk (will kill self)	

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 ● 5 : completely

2) How much is being suicidal related to thoughts and feeling about others? Not at all: 1 2 ● 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
4	something good might happen	1	I hate this limbo
2	my dog	3	the earth is dying
3	rock climbing	4	racial and political injustice
1	my family	5	politics
		2	escape

I wish to live to the following extent: Not at all: 0 1 2 3 4 ● 6 7 8 : Very much

Guilford Press has authorized CAMS-care LLC to negotiate licenses with electronic medical record companies to install the SSF on their default EMR platforms

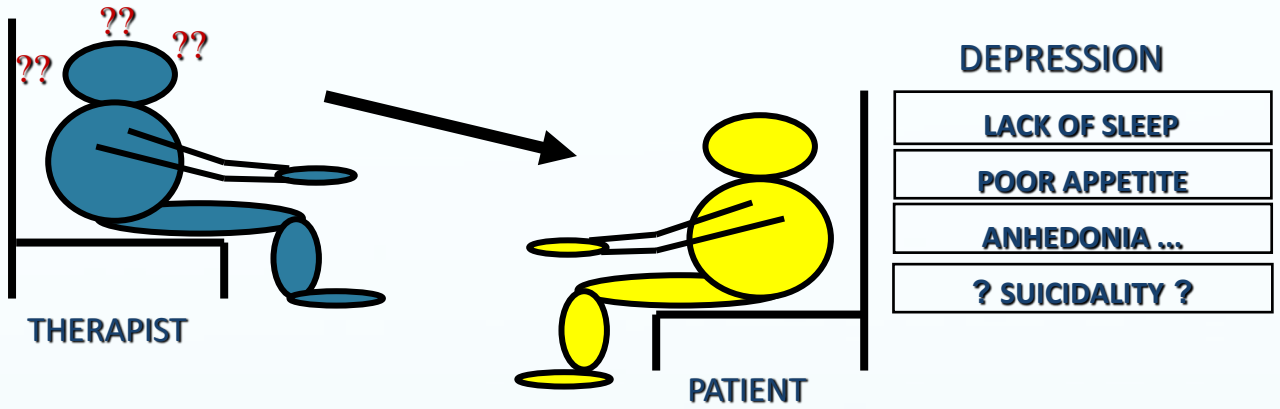
Epic

Cerner

NEUROFLOW

Netsmart

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 Drivers* as the primary focus of assessment and intervention

ARCHIVES OF SUICIDE RESEARCH
https://doi.org/10.1080/13811118.2022.2151958

Routledge
Taylor & Francis Group

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The Content of Patient-Identified Suicidal Drivers within CAMS Treatment Planning

Thomas Lynch, Victoria Colborn Bathe, and David A. Jobes

ABSTRACT

The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based, suicide-focused, clinical framework that effectively treats people who are suicidal across clinical settings. A central tool within CAMS is the Suicide Status Form (SSF) which is a multipurpose assessment, treatment planning, tracking, to clinical outcome tool that guides suicide-focused care from the start of CAMS treatment to completion. Previous SSF assessment research investigated the content of patient-written qualitative responses to SSF assessment prompts which were reliably coded into twelve content categories. Four coding categories captured 70% of written responses revealing the content of patients' suicidal ideation which centered on: relationships, vocation, the self, and unpleasant internal states. While qualitative SSF assessment research has thus revealed key information about suicidal ideation content, patient-identified "drivers" of suicide within CAMS treatment planning have not yet been examined qualitatively. "Drivers" of suicide are the issues that compel one to consider suicide, and ultimately become the focus of CAMS treatment; thus, it is important to examine their qualitative content. The present exploratory study investigated suicide driver content collected in the context of two randomized controlled trials of CAMS. Reliably coded qualitative content of patient-articulated drivers were comparable to previously noted SSF content assessment results, emphasizing the following driver issues: (1) Relationships, (2) Unpleasant Internal States (e.g., suffering and anxiety), (3) Role Responsibility (vocational concerns), and (4) the Self (e.g., self-hatred or esteem issues). These four coding themes captured 70% of 332 total treatment planning drivers obtained from 166 patients who were suicidal and seeking treatment. Implications of these findings are discussed.

KEYWORDS
CAMS; drivers; suicidal ideation; treatment planning

Central to effective assessment and treatment of suicide risk is the need to understand the suicidal mind. Jobes and Joiner (2019) have argued that despite an understandable preoccupation with suicide behaviors, we should consider the importance of suicidal ideation, in and of itself. Research has shown us that suicidal ideation is much more complex when we seek to understand the words of those who have suicidal thoughts. Jobes et al. (2004) studied the written responses of 119 college students and 33 U.S. Air Force Airmen who were suicidal analyzing patient-written responses to open-ended prompts on the Suicide Status Form (SSF) in a first session of the Collaborative Assessment and Management of Suicidality (CAMS—Jobes, 2016). CAMS is a suicide-focused clinical intervention with

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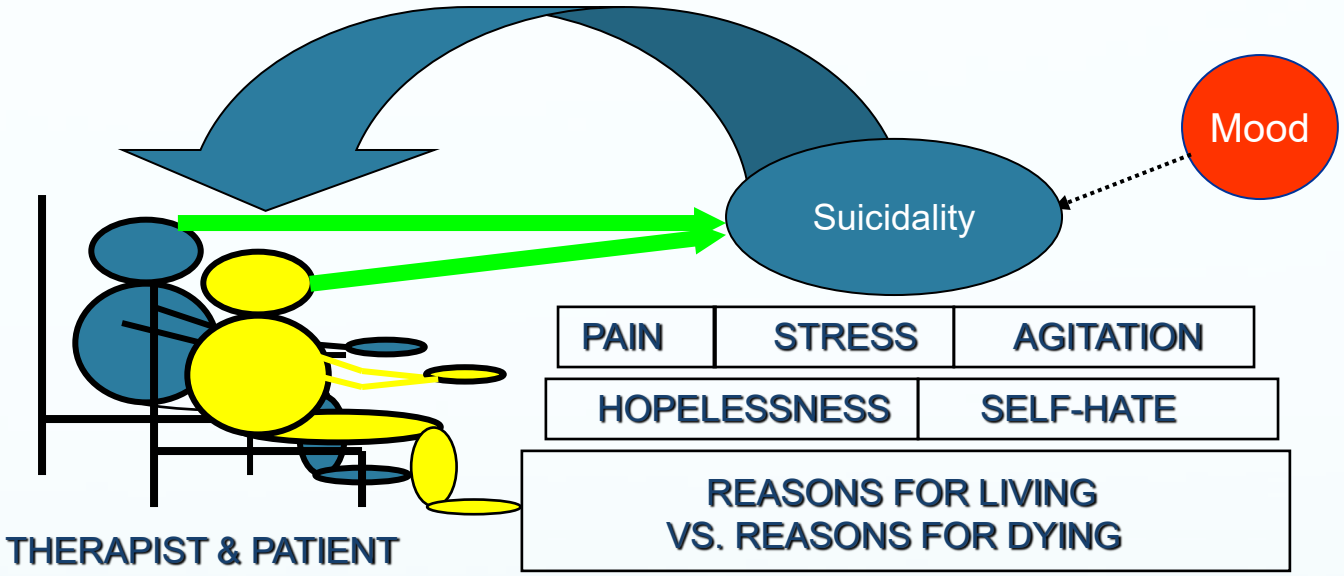
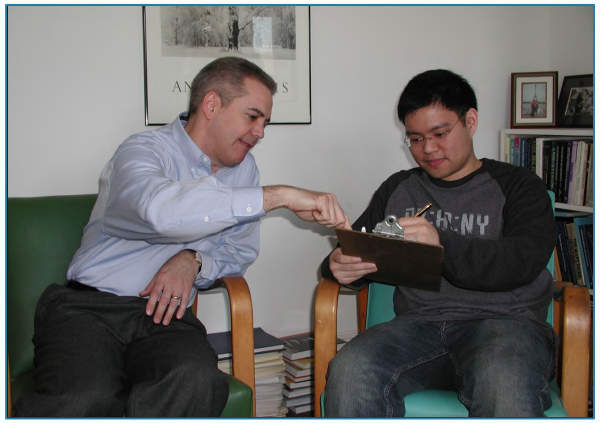




Approximately 72% of n=166 from two CAMS RCTs (with inter-rater Kappa's = .78+) content of treatment planning drivers were reliably captured by four domains:

1. Relational concerns (25%)
2. Misery and distress (22%)
3. Vocational issues (12%)
4. Self-related issues (12%)

(Lynch et al., 2022)

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

Adherence to the CAMS Framework

CAMS is a therapeutic framework, that is used to *manage* suicidal thoughts and feelings and establish behavioral stability. Adherence to CAMS requires a thorough suicide-focused assessment and treatment of patient-identified suicidal "drivers" and the pursuit of life worth living with purpose and meaning.

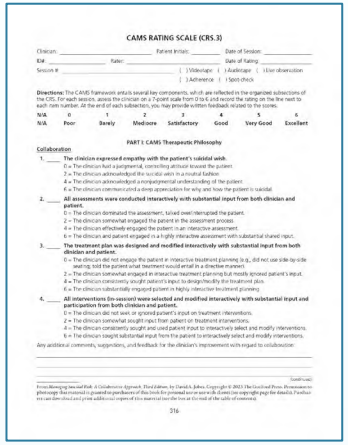
CAMS Philosophy

- Empathy for suicidal states—no shame, no blame
- Collaboration with the patient in all aspects of care
- Honesty and transparency throughout clinical care

CAMS as Therapeutic Framework

- Focus on Suicide—from the beginning, to the middle, and to the end
- Outpatient Oriented—goal of stability and using outpatient care
- Flexible and "Nondenominational"—across theories and techniques

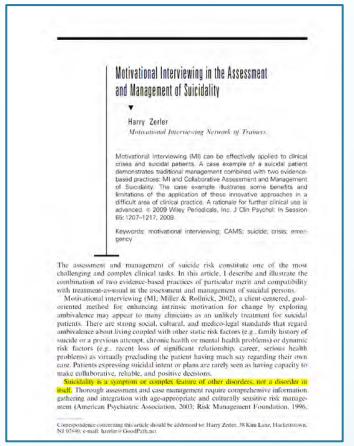
CAMS Rating Scale


CAMS RATING SCALE (CRS.3)

PART I: CAMS Therapeutic Philosophy

CAMS ideas are catching on


Self-determination theory and the collaborative assessment and management of suicidality


Motivational Interviewing in the Assessment and Management of Suicidality


Personal View

Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management

What is *DRIVING* *this person's* suicide risk?
(Jobes et al., 2011; Tucker et al., 2015)

- ***Direct Drivers***: Internal experiences, behaviors, and external situations that are associated with ***this person's own*** acute suicidal crises (what is the "straw that breaks the camel's back?" to trigger any suicidal behavior).

- ***Indirect Drivers***: Factors that make ***this person*** feel vulnerable to their direct drivers being activated
  - Examples include negative life events, psychosocial stressors, psychiatric illnesses, isolating, not sleeping enough
  - These may be profoundly painful, but they ***do not necessarily trigger acute crises but increase vulnerability***

Beyond Stability: Treating the Drivers

- DBT chain analysis to identify triggers and points of intervention
- Teach 4-step problem solving
- Teach mindfulness and mentalization
- Various covert sensitization techniques
- Assertiveness training/role plays
- Najavits (2002) “Seeking Safety Treatment”
  - Safe coping skills (Part I)
  - Safe coping skills (Part 2)
  - Detaching from emotional pain (grounding)
    - Mental grounding
    - Physical grounding
  - Taking Good Care of Yourself

CAMS-Guided Care and a Life Worth Living

- There should be an overt emphasis on developing and consolidating coping and problem-solving skills and techniques.

- There should be an overt emphasis on actively developing Reasons for Living and systematically eliminating existing Reasons for Dying.

- There should be an emphasis on future thinking/planning (protective factors) including:

  - The development of short and long term plans and goals.
  - The development of hope for the future.
  - The development or further consolidation of guiding beliefs.
  - Developing a life worth living.

Resolution and Clinical Outcomes

Over three month of CAMS-guided care, we are seeking:

Completion of Sections A-B of the SSF Outcome/Disposition

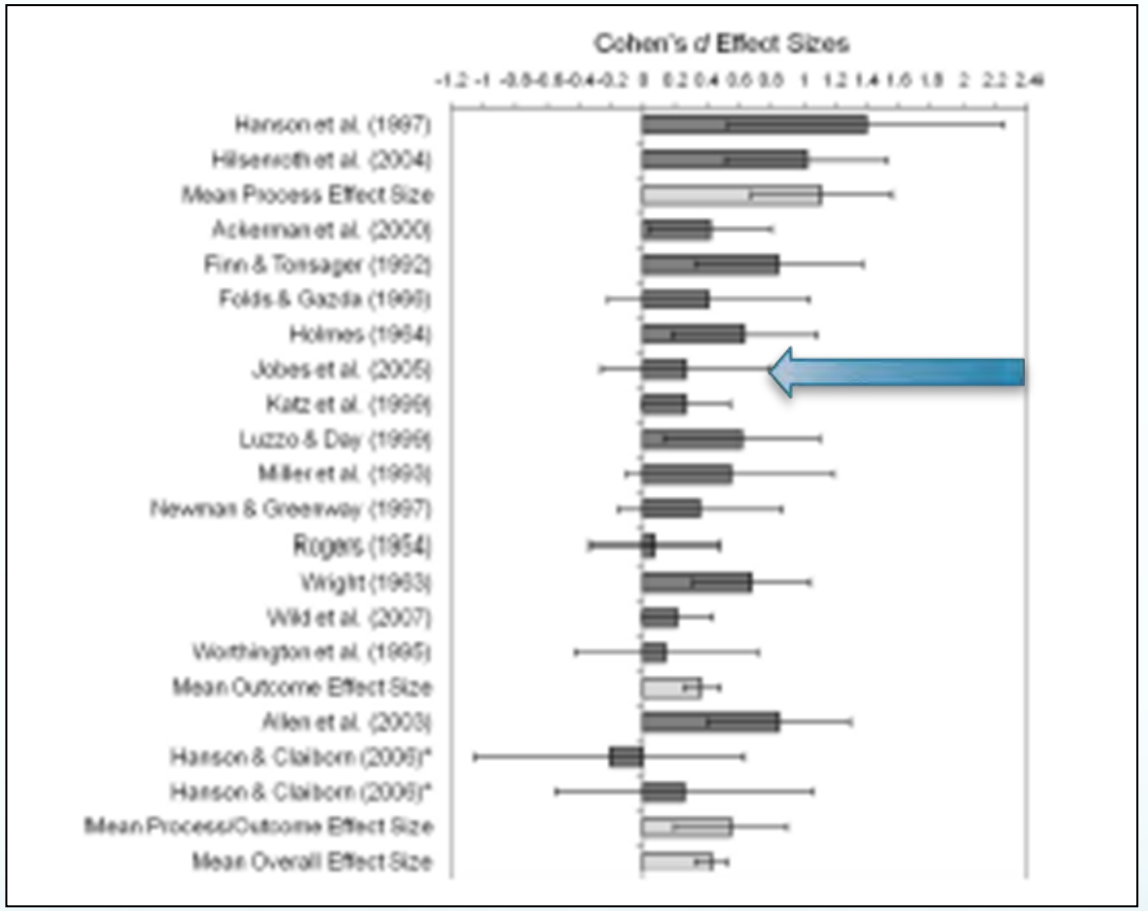
- Resolution of suicidality if:
- 1) current overall risk of suicide <3;
- 2) in past week, no suicidal behavior and
- 3) effectively managed suicidal thoughts/feelings

- ❑ Patient's CAMS-guided care comes to an end; the patient is appropriately debriefed and referred to further care if indicated.
- ❑ SSF Outcome Form HIPAA page is completed after final CAMS session (Section C).

CAMS/SSF as a "Therapeutic Assessment"

Meta-Analysis of Psychological Assessment as a Therapeutic Intervention

John M. Poston and William E. Hanson
Purdue University

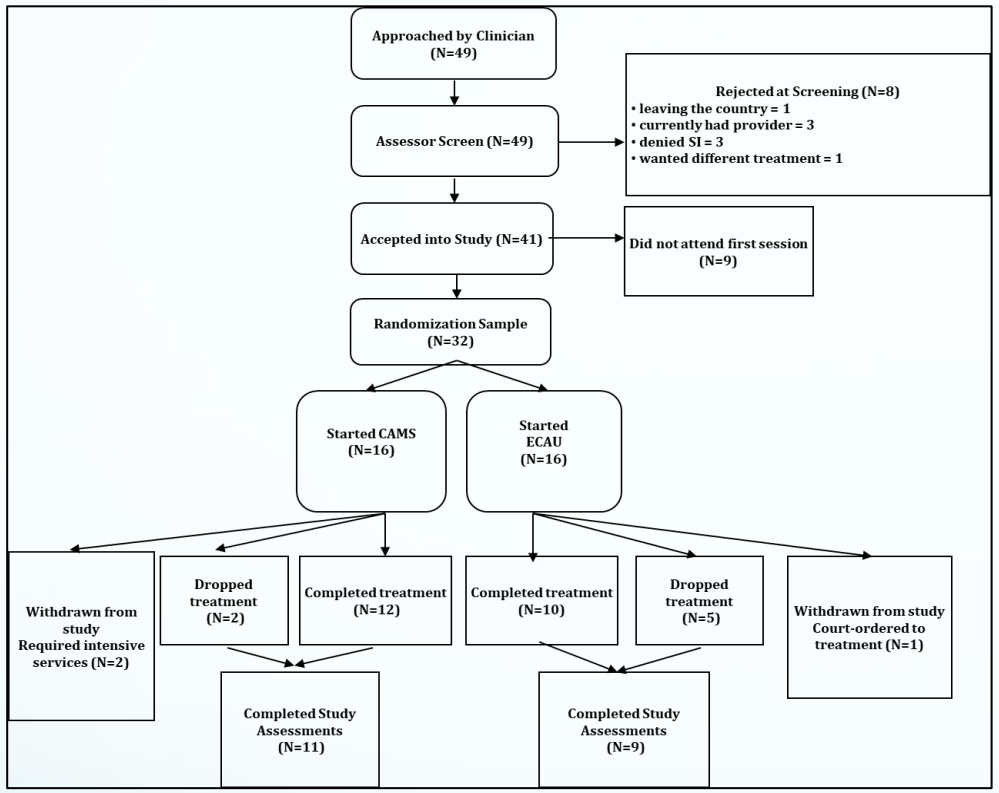


Meta-Analysis Results: *"Taken together, they suggest that psychological assessment procedures—when combined with personalized, collaborative, and highly involving test feedback—have positive, clinically meaningful effects on treatment, especially regarding treatment processes."*

Twelve Correlational/Open Trial Support for SSF/CAMS

Authors	Sample/Setting	n =	Significant Results
Jobes et al., 1997	College Students	106	Pre/Post SSF Core Assessment and symptom distress
Jobes et al., 2005	USAF Outpatients	56	Between-group suicidal ideation; ED/PC appts reductions
Arkov et al., 2008	Danish CMC Outpatients	27	Pre/Post SSF Core Assessment and qualitative findings
Jobes et al., 2009	College Students	55	Linear reductions in suicidal ideation and distress
Nielsen et al., 2011	Danish CMH Outpatients	42	Pre/Post SSF Core Assessment reductions
Ellis et al., 2012	Psychiatric Inpatients	20	Pre/Post SSF Core Assessment; reduced suicidal ideation, depression, hopelessness
Ellis et al., 2015	Psychiatric Inpatients	52	Reduced suicide ideation; changes in SI cognitions
Ellis et al., 2017	Inpatients (& post-discharge)	104	Impacts suicidal ideation, depression, hopelessness, functional impairment, well-being, psychological flexibility
Graure et al., 2021	Outpatients—CMH/SME	61	Pre/post SSF Core Assessment reductions
Adrian et al., 2021	Teenage outpatients	22	Pre/post suicidal ideation reductions; benchmark results
O'Neill et al., 2023	Telehealth outpatients	130	Pre/post reductions anxiety, depression, suicidal ideation

AFSP-funded NDA CAMS RCT (Comtois et al., 2011)

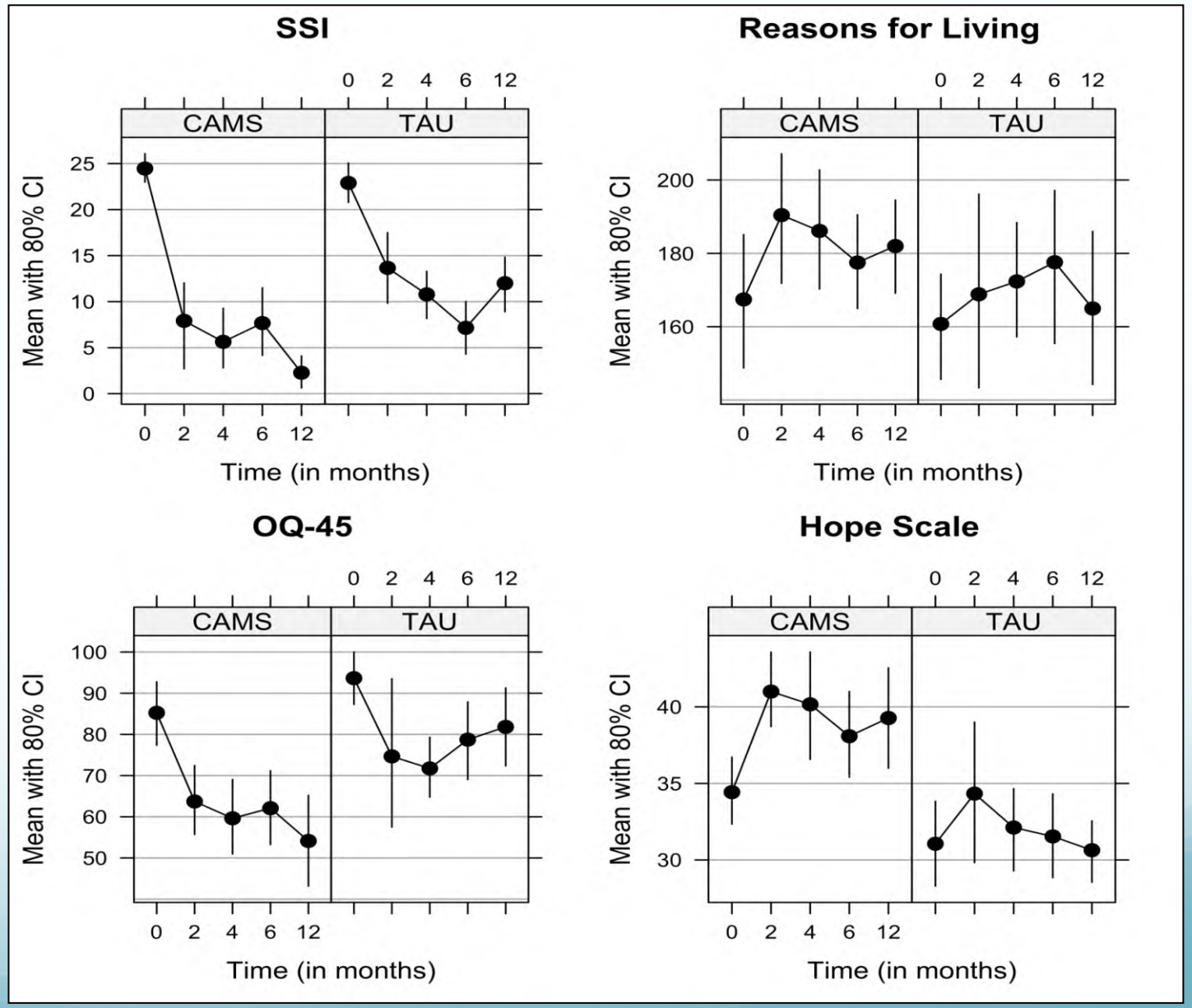


Research Article

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

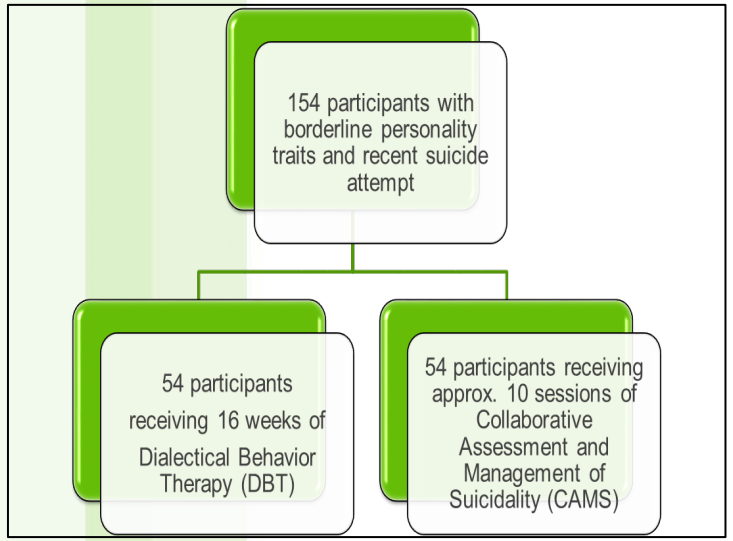
INTRODUCTION

CAMS was feasible; there were significant reductions in suicide ideation, symptom distress, increased hope, higher patient satisfaction



Mental Health Services

Andreasson et al (2014; 2016) DBT vs. CAMS Superiority RCT Copenhagen, Denmark



(n=108)

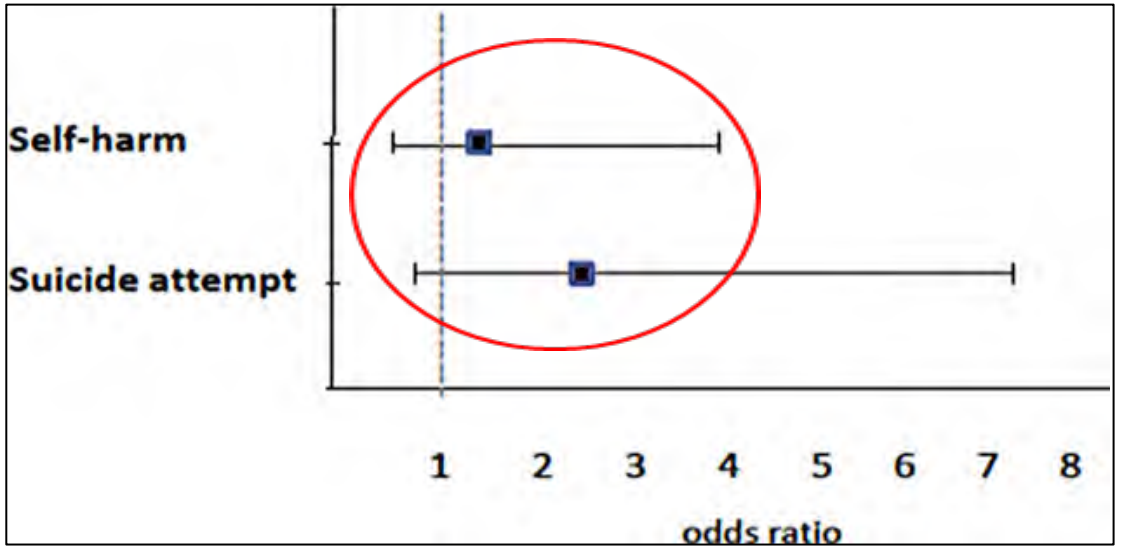


Figure 1. Odds ratio with 95% confidence intervals for NSSI and suicide attempts, favoring CAMS

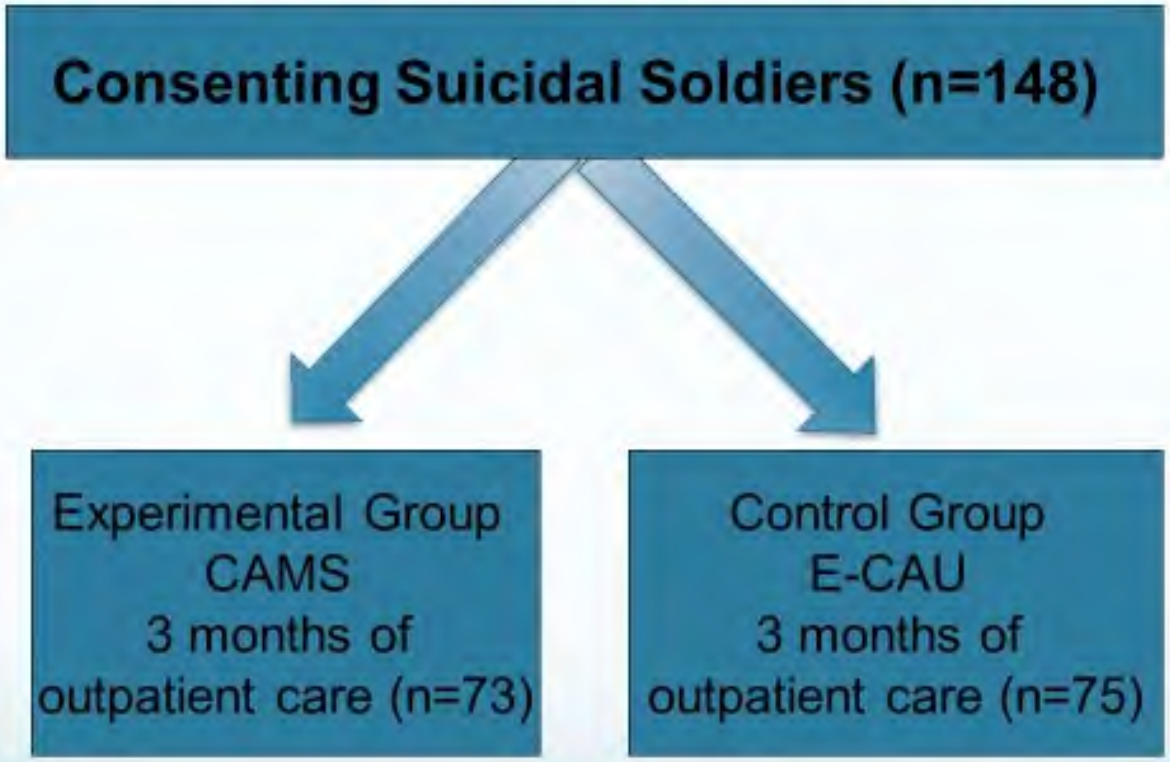
Research Article

EFFECTIVENESS OF DIALECTICAL BEHAVIOR THERAPY VERSUS COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY TREATMENT FOR REDUCTION OF SELF-HARM IN ADULTS WITH BORDERLINE PERSONALITY TRAITS AND DISORDER—A RANDOMIZED OBSERVER-BLINDED CLINICAL TRIAL

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

DiaS RCT

Operation Worth Living (OWL)



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

Measures: SSI, OQ-45, SASI-Count, CDRISC, PCL-M, SF-36, NSI, THI…(at 1, 3, 6, 12 months)

Psychiatry, 80:339–356, 2017
© Washington School of Psychiatry
ISSN: 0033-2747 print / 1943-281X online
DOI: https://doi.org/10.1080/00332747.2017.1354607

Check for updates

A Randomized Controlled Trial of the Collaborative Assessment and Management of Suicidality versus Enhanced Care as Usual With Suicidal Soldiers

David A. Jobes, Katherine Anne Comtois, Peter M. Gutierrez, Lisa A. Brenner, David Huh, Samantha A. Chalker, Gretchen Ruhe, Amanda H. Kerbrat, David C. Atkins, Keith Jennings, Jennifer Crumlish, Christopher D. Corona, Stephen O' Connor, Karin E. Hendricks, Blaire Schembari, Bradley Singer, and Bruce Crow

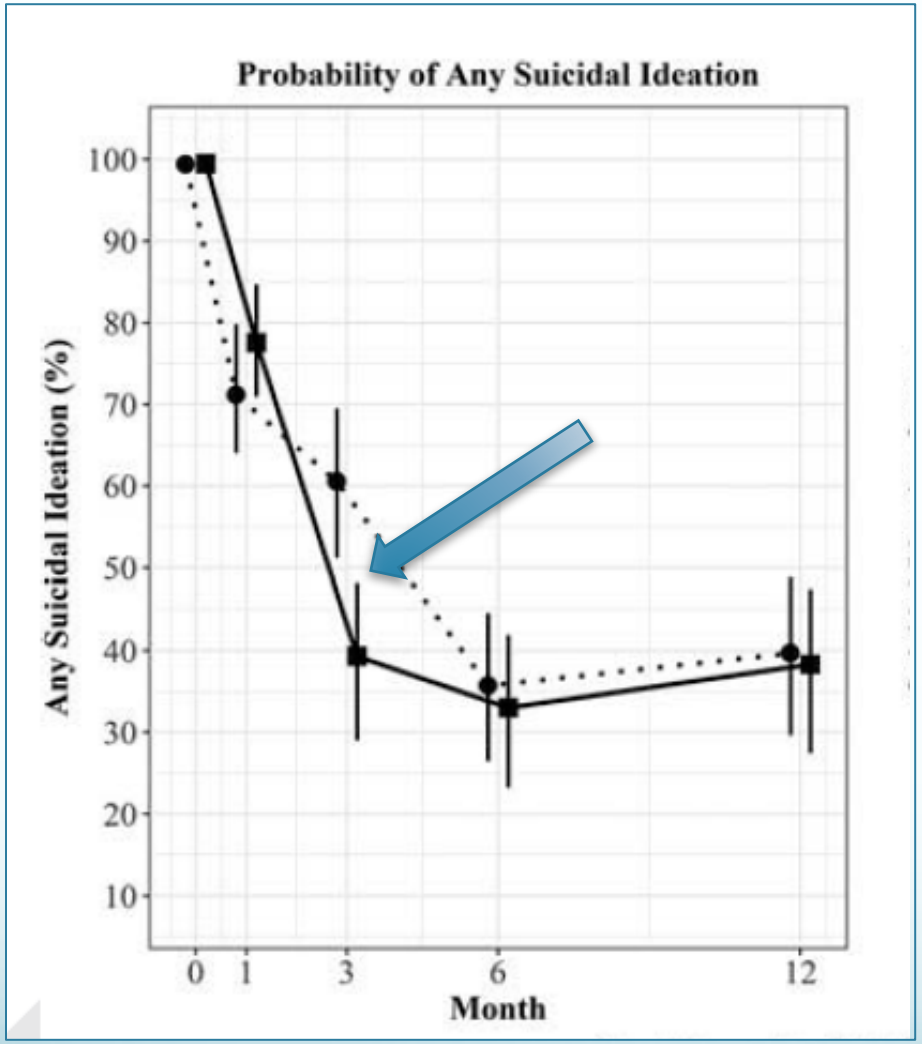
Objective: This study describes a randomized controlled trial called "Operation Worth Living" (OWL) which compared the use of the Collaborative Assessment and Management of Suicidality (CAMS) to enhanced care as usual (E-CAU). We hypothesized that CAMS would be more effective than E-CAU for reducing suicidal ideation (SI) and suicide attempts (SA), along with secondary behavioral health and health care utilization markers for U.S. Army Soldier outpatients with significant SI (i.e., > 13 on Beck's Scale for Suicide Ideation). *Method*: Study participants were 148 Soldiers who presented to a military outpatient behavioral health clinic. There were 73 Soldiers in the experimental arm of the trial who received adherent CAMS; 75 Soldiers received E-CAU. Nine a-priori treatment outcomes (SI, past year SA, suicide-related emergency department (ED) admits, behavioral health-related ED admits, suicide-related inpatient psychiatric unit

David A. Jobes, PhD, is affiliated with The Catholic University of America, Washington, DC. *Katherine Anne Comtois, PhD, MPH*, is affiliated with the University of Washington, Seattle. *Peter M. Gutierrez, PhD*, and *Lisa A. Brenner, PhD*, are affiliated with the Denver Veterans Health Administration, Rocky Mountain Mental Illness Research Education and Clinical Center, and the University of Colorado School of Medicine, Denver. *David Huh, PhD*, is affiliated with the University of Washington, Seattle. *Samantha A. Chalker, BA*, is affiliated with The Catholic University of America, Washington, DC. *Gretchen Ruhe, BS*, is affiliated with Fort Stewart, Georgia. *Amanda H. Kærbrat, LICSW*, and *David C. Atkins, PhD*, are affiliated with the University of Washington, Seattle. *Keith Jennings, PhD, Jennifer Crumlish, PhD*, and *Christopher D. Corona, MA*, are affiliated with The Catholic University of America, Washington, DC. *Stephen O'Connor, PhD*, is affiliated with the University of Louisville, Kentucky. *Karin E. Hendricks, MA*, is affiliated with the University of Washington, Seattle. *Blaire Schembari, MA*, is affiliated with The Catholic University of America, Washington, DC. *Bradley Singer, LCSW*, is affiliated with Fort Stewart, Georgia. *Bruce Crow, PsyD*, is affiliated with the Warrior Resiliency Program, Fort Sam Houston, Texas

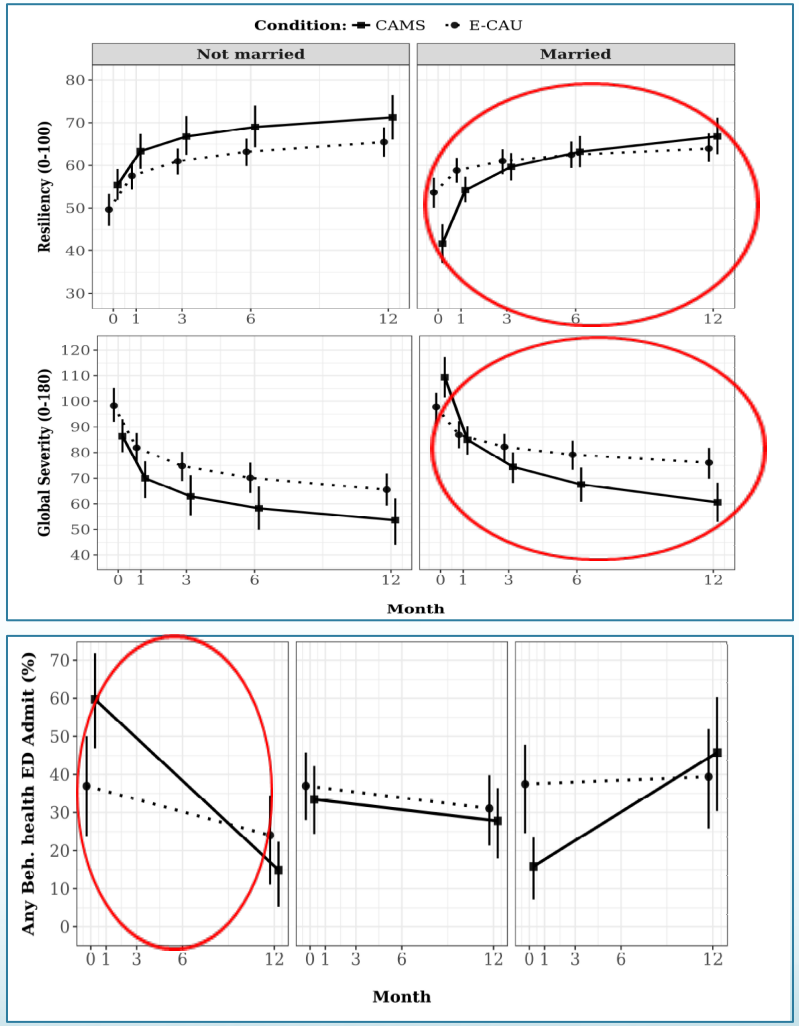
Clinicaltrials.gov identifier: NCT01300169. This work was supported by the Department of the Army through federal grant W81XWH-11-1-0164, awarded and administered by the Military Operational Medicine Research Program (MOMRP). The views expressed in this manuscript are those of the authors and do not necessarily reflect the official policy of the Department of Defense, the Department of the Army, the U.S. Army Medical Department, the Department of Veterans Affairs, or the U.S. government.

Address correspondence to David A. Jobes, The Catholic University of America, Department of Psychology, 314 O'Boyle Hall, Washington, DC 20064. E-mail: jobes@cua.edu

Operation Worth Living RCT Outcome and Moderator Results



CAMS significantly eliminated suicidal ideation in 6-8 sessions

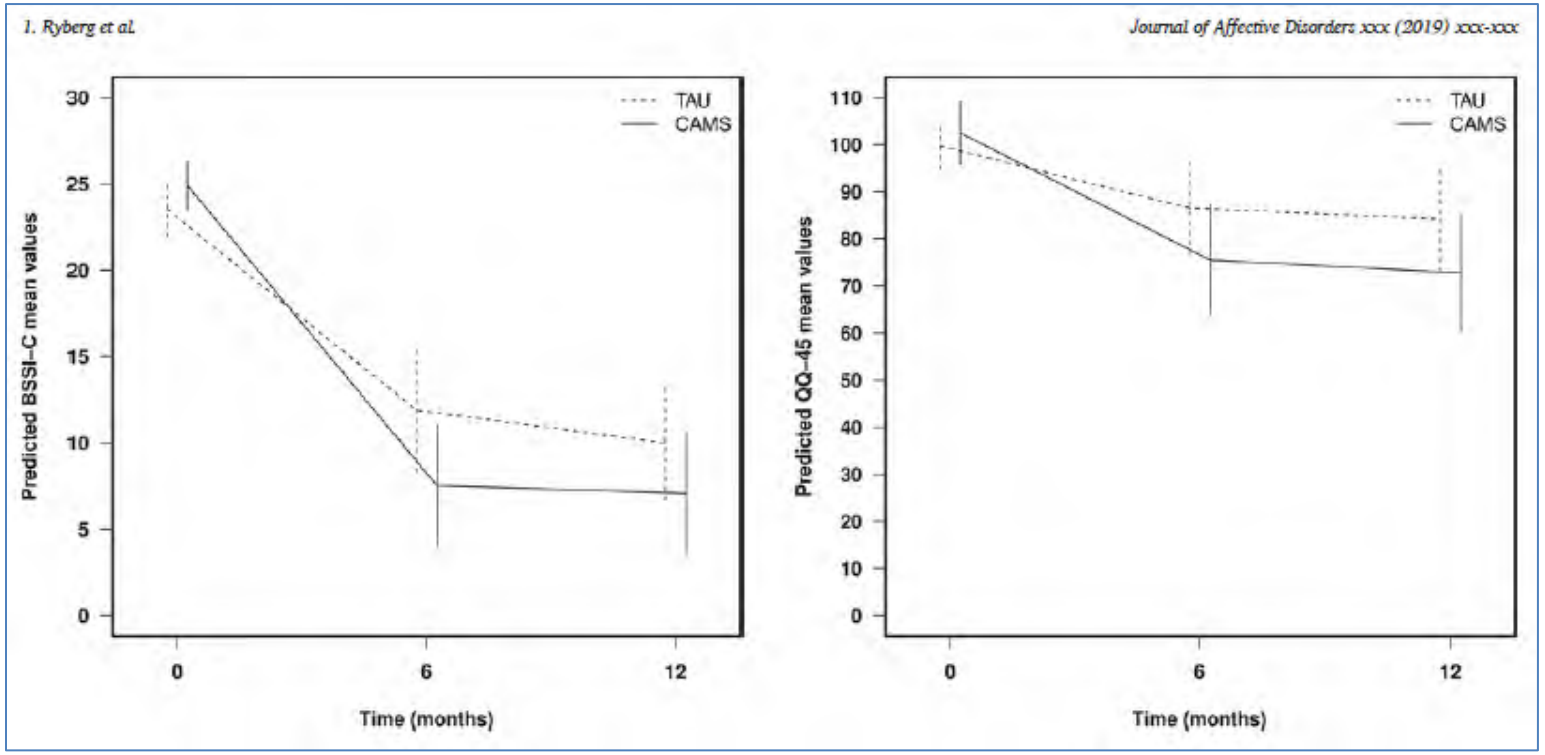


CAMS significantly increased resiliency, decreased global severity and ED visits

VESTRE VIKEN

Oslo Norway

CAMS significantly reduced suicidal ideation and overall symptom distress



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journal homepage: www.elsevier.com/locate/jad

Research paper

Managing suicidality within specialized care: A randomized controlled trial

Wenche Ryberg[a,d,*], Per-Henrik Zahl[b], Lien My Diep[c], Nils Inge Landrø[d], Roar Fosse[a]

[a] Department of Research and Development, Mental Health and Addiction, Vestre Viken Hospital Trust, Drammen, Norway
[b] Norwegian Institute of Public Health, Oslo, Norway
[c] Oslo University Hospital, Oslo, Norway
[d] University of Oslo, Oslo, Norway

ARTICLE INFO

Keywords:
Suicidal ideation
Self-harm
Collaboration
Psychotherapy
Randomized controlled trial
Suicide specific treatment model

ABSTRACT

Background: Suicide prevention is a core task in mental health services. Our objective was to determine whether Collaborative Assessment and Management of Suicidality (CAMS) reduced suicidal thoughts and behaviors and mental health distress more effectively than treatment as usual (TAU) in a heterogeneous patient population within specialized mental health care services.

Methods: In this observer-blinded pragmatic randomized controlled trial participants who scored 13 or above on Beck's Scale for Suicide Ideation-Current (BSSI-C) were included from seven in- and outpatient units. Primary outcome was suicidal ideation (BSSI-C). Secondary outcomes were mental health distress measured by the Outcome Questionnaire–45, and suicidal behaviors measured by the Suicide Attempt Self-Injury Count. Patients were assessed at baseline and after 6 and 12 months.

Results: The final intent-to-treat analyses included 78 participants (mean age 35.9 years, SD = 14.5, 41 females). The majority were depressed (65%), had a secondary diagnosis (73%) and 32% suffered from borderline personality disorder or borderline traits. After 6 months, CAMS participants reported lower levels of suicidal ideation compared to TAU ($\beta = -4.29$, 95% CI = −8.32 to −0.27, $p = .036$). Larger changes in mental health distress were observed for CAMS participants after 6 months ($\beta = -11.87$, 95% CI = −22.99 to −0.76, $p = .036$) and 12 months ($\beta = -13.70$, 95% CI = −24.88 to −2.51, $p = .017$).

Limitations: The modest sample size rendered the trial unable to detect small between-group differences.

Conclusions: CAMS reduced suicidal ideation and mental health distress more efficiently than TAU in a heterogeneous patient population within specialized care.

1. Introduction

Traditionally, suicidal thoughts and behaviors have been understood as symptoms and indicators of an underlying mental disorder (cf. Jobes, 2006; Pompili, 2010), most typically depression (Chesney et al., 2014). However, leading researchers have questioned whether treatment of the mental health disorder alone is an effective way to reduce the risk of suicide (De Leo, 2004; Linehan, 2008; Jobes, 2006; Pompili, 2010). Suicide specific treatment models may be effective in reducing suicide risk and suicidal behaviors (Meerwijk et al., 2016). It has been suggested, that opposed to focusing on the mental health disorder per se, treatment should target the pain and underlying reasons of why a person considers suicide (Pompili, 2018). Suicide specific treatment models explicitly address suicidal thoughts and behaviors. Phenomena such as mental pain and hopelessness trancend diagnostic categories and are tightly assosiated with suicidal thoughts and behaviors, both independent from and in the context of a specific mental health disorder as e.g. depression (Ducasse et al., 2017; Verrocchio et al., 2016; Cuijpers et al., 2013). Together with listening to the patients' communications about suicide (Pompili et al., 2016), exploring these phenomenological factors in treatment might be a promising approach in suicide prevention.

In a metaanalysis of 32 RCTs, Calati and Courtet (2016) found that those adult patients who received psychotherapy were less likely to attempt suicide during follow-up compared to those who received pharmacological interventions, supportive interventions, telephone interviews or treatment as usual. In another systematic review and meta-analyses, Meerwijk et al. (2016) reported that psychotherapeutic interventions for people at risk for suicide that directly targeted suicidal thoughts and behaviors were more effective in reducing suicide attempts and suicide compared to interventions that only adressed these factors indirectly. In a recent systematic review, Zalsman et al. (2016)

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Vestre Viken Hospital Trust, Mental Health and Addiction
Department of Research and Development

NIMH-Funded R-34; PI: Jacque Pistorello, Ph.D.; Co-I: David Jobes, Ph.D. (n=62)

Figure 1. College Student Client Flow through the SMART

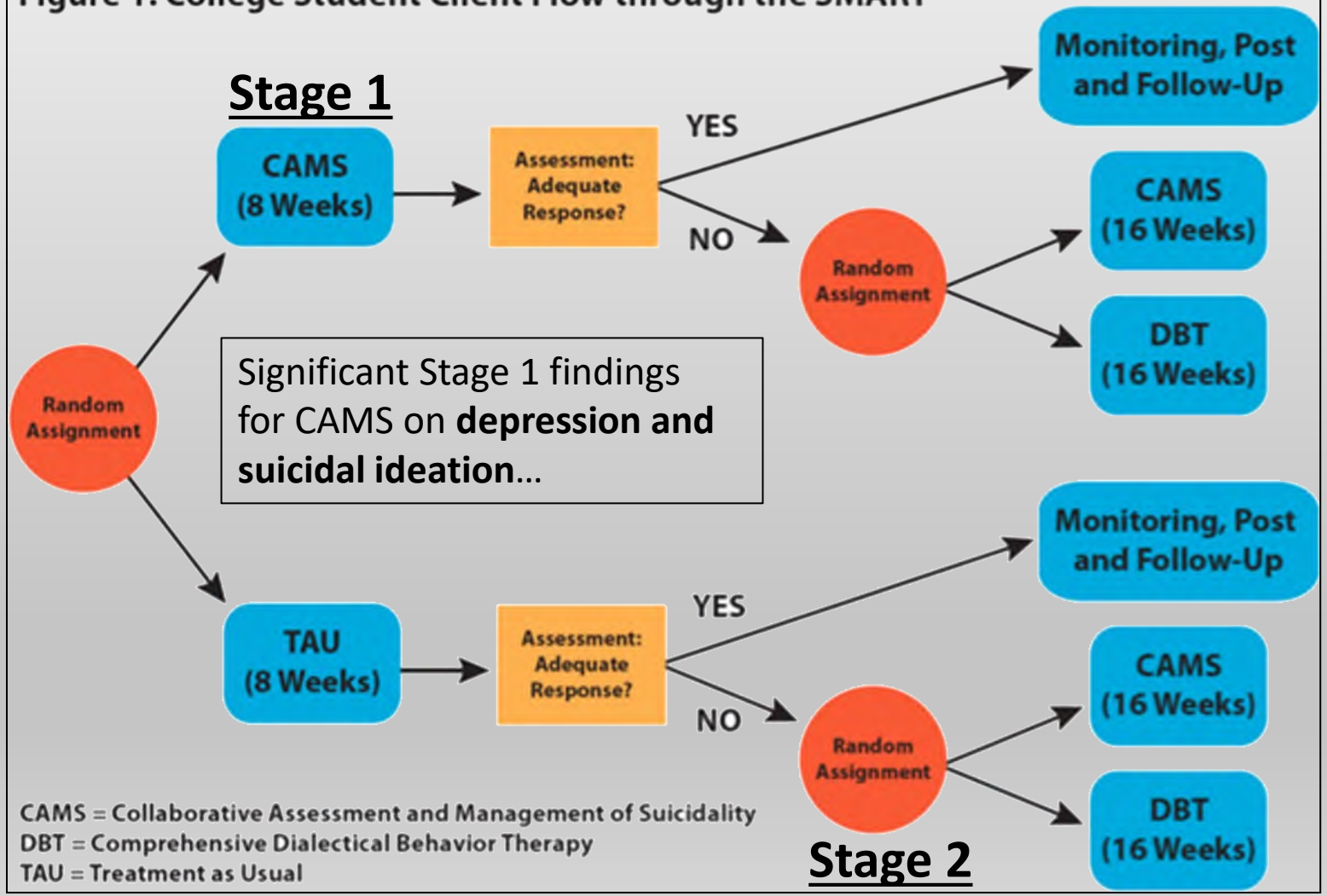


Figure 1. CCAPS Depression

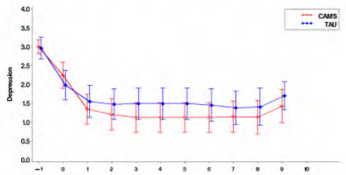


Figure 2. CCAPS Suicidal Ideation Question

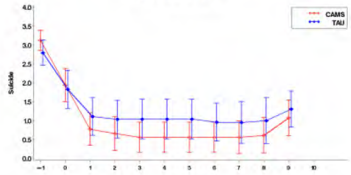
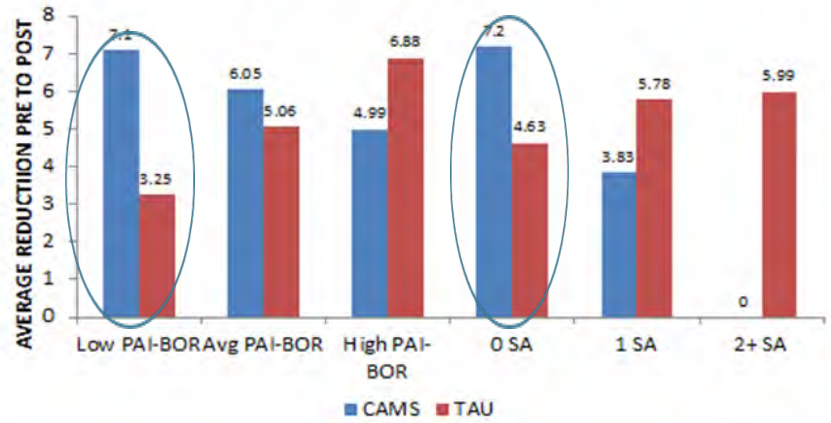


Figure 3. Hopelessness Moderated by Borderline Features



ORIGINAL ARTICLE

The effectiveness of the Collaborative Assessment and Management of Suicidality (CAMS) compared to alternative treatment conditions: A meta-analysis

Joshua K. Swift PhD, Associate Professor | Wilson T. Trusty MS, Doctoral Candidate | Elizabeth A. Penix MS, Doctoral Candidate

Introduction: This meta-analysis aimed to test the efficacy of the Collaborative Assessment and Management of Suicidality (CAMS) intervention against other commonly used interventions for the treatment of suicide ideation and other suicide-related variables.

Method: Database, expert, and treat and branch searches identified nine empirical studies that directly compared CAMS to other active interventions. A random effects model was used to calculate the effect size differences between the interventions; additionally, moderators of the effect sizes were tested for suicidal ideation.

Results: In comparison to alternative interventions, CAMS resulted in significantly lower suicidal ideation (*d* = 0.25) and general distress (*d* = 0.29), significantly higher treatment acceptability (*d* = 0.42), and significantly higher hopefulness (*d* = 0.88). No significant differences for suicide attempts, self-harm, other suicide-related correlates, or cost effectiveness were observed. The effect size differences for suicidal ideation were consistent across study types and quality, dosing of outcome measurement, and the age and ethnicity of participants; however, the effect sizes favoring CAMS were significantly smaller with active duty military/veterans samples and with male participants.

Conclusions: The existing research supports CAMS as a *Well Supported* intervention for suicidal ideation per Center of Disease Control and Prevention criteria. Limitations and future directions are discussed.

INTRODUCTION

Globally, approximately 800,000 individuals die by suicide each year (World Health Organization [WHO], 2019). The frequency of suicide-related deaths is also a major concern in the United States (U.S.), where annually 47,511 die by suicide, over 1.4 million adults attempt suicide, and 12 million have serious suicidal thoughts (Substance Abuse & Mental Health Service Administration [SAMHSA], 2020; WHO, 2019). Given the pervasive nature of this leading cause of death, studies have tested interventions addressing suicide-related deaths, attempts, self-harm, and ideation. A recent meta-analysis of this research (Fox et al., 2020) that included data from 590 articles found that interventions for addressing suicidal thoughts and behaviors are effective overall; however, the effects tend to be small and have not improved over time. Although the results from Fox and colleagues's (2020) meta-analysis provide an overall picture of the research, the

Swift et al's (2021) meta-analysis of nine CAMS clinical trials: CAMS is a "well supported" intervention for suicidal ideation as per CDC criteria

Figure 2. Forest plot of effect sizes for suicidal ideation, general distress, suicide attempts, and self-harm.

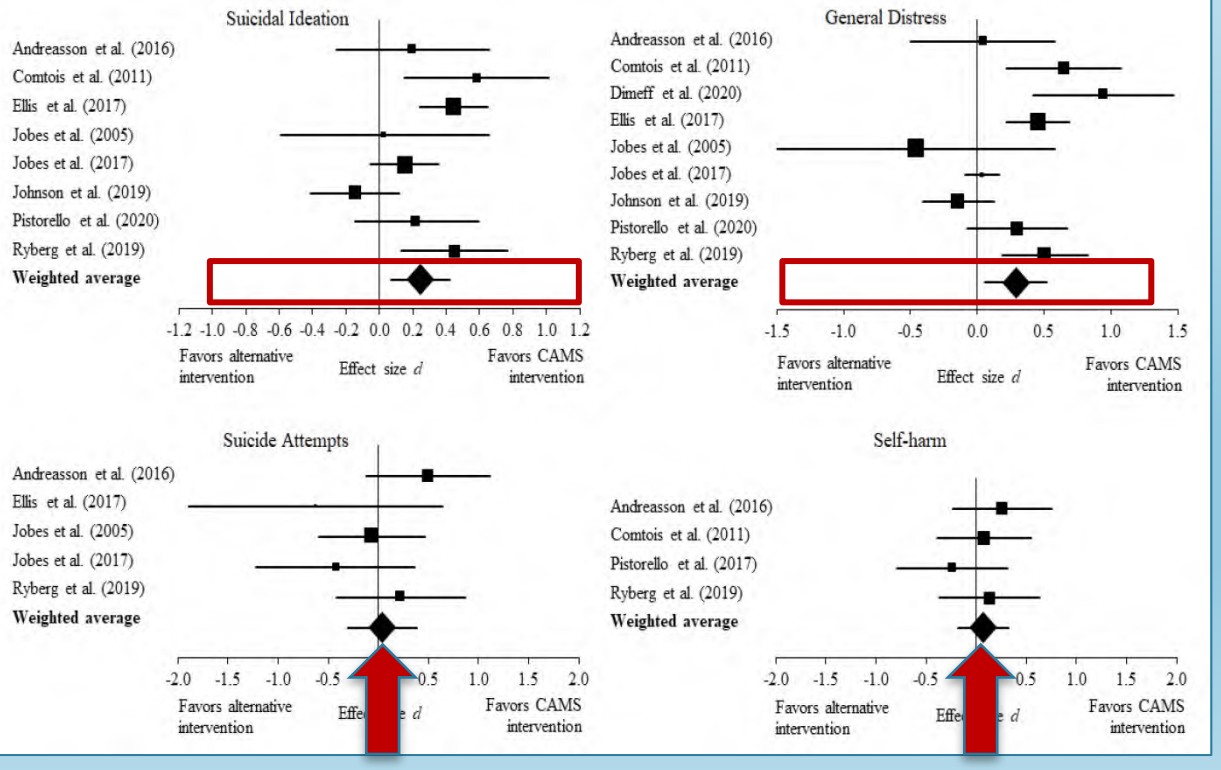
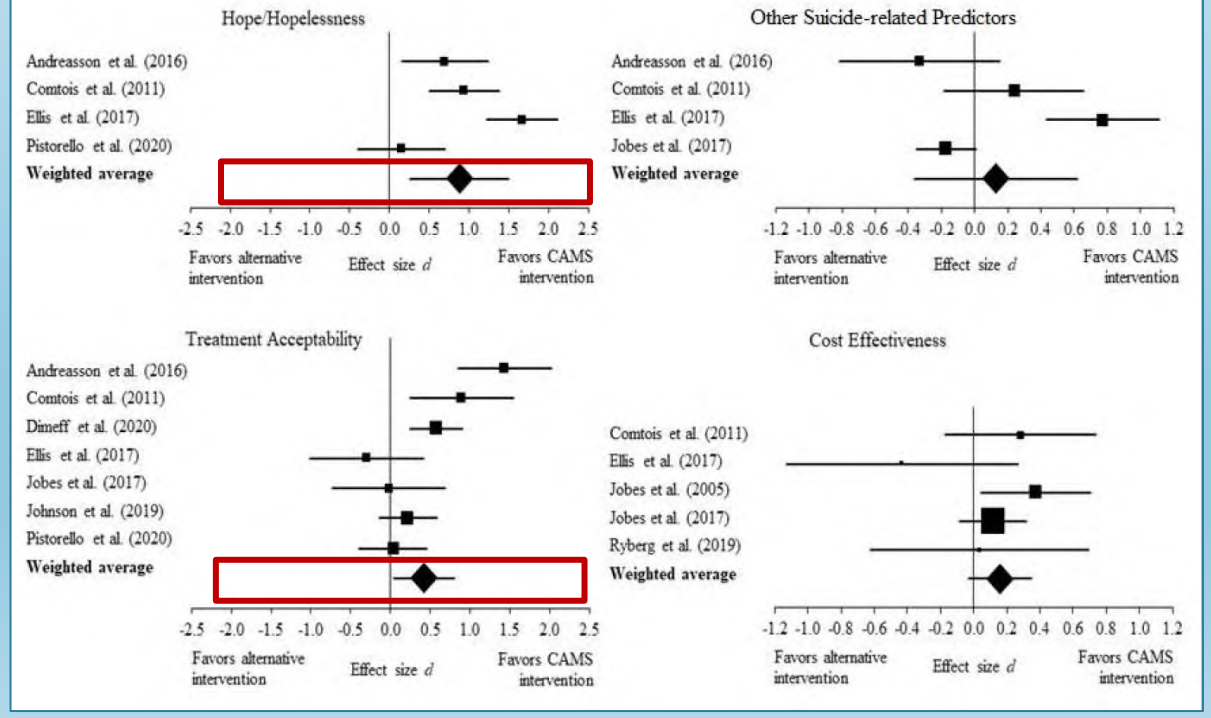
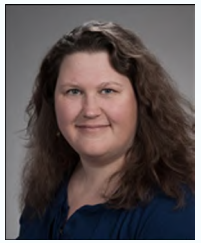


Figure 3. Forest plot of effect sizes for hope/hopelessness, other suicide-related predictors, treatment acceptability, and cost effectiveness.



Aftercare Focus Study (AFS—funded by AFSP)



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Research paper

Reducing short term suicide risk after hospitalization: A randomized controlled trial of the Collaborative Assessment and Management of Suicidality

Katherine Anne Comtois [a,*], Karin E. Hendricks [a,1], Christopher R. DeCou [a], Samantha A. Chalker [b,2], Amanda H. Kerbrat [a], Jennifer Crumlish [b], Tierney K. Huppert [a,3], David Jobes [b]

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ARTICLE INFO

Keywords:
Suicide/self-harm
Suicidal ideation
Clinical trials
Treatment
Psychotherapy
Health services

ABSTRACT

Background: This study compared the "next day appointment" (NDA) use of the Collaborative Assessment and Management of Suicidality (CAMS) to treatment as usual (TAU) for individuals discharged from the hospital following a suicide-related crisis. We hypothesized that CAMS would significantly reduce suicidal thoughts and behaviors as well as improve psychological distress, quality of life/overall functioning, treatment retention and patient satisfaction.
Methods: Participants were 150 individuals who had at least one lifetime actual, aborted, or interrupted attempt and were admitted following a suicide-related crisis. There were 75 participants in the experimental condition who received adherent CAMS and 75 participants who received TAU. Suicidal thoughts and behaviors, psychological distress, and quality of life/overall functioning were assessed at baseline and at 1, 3, 6, and 12 months post-baseline. Treatment retention and patient satisfaction were assessed at post-treatment.
Results: Participants in both conditions improved from baseline to 12 months but CAMS was not superior to TAU for the primary outcomes. A small but significant improvement was found in probability of suicidal ideation at 3 months favoring TAU and amount of suicidal ideation at 12 months favoring CAMS. CAMS participants experienced less psychological distress at 12 months compared to baseline.
Limitations: The study was limited by only one research clinic, lower than expected recruitment, and imbalance of suicidal ideation at baseline. Conclusions: All participants improved but CAMS was not more effective than TAU. The NDA clinic was feasible and acceptable to clients and staff in both conditions and future research should investigate its potential benefit.

1. Introduction

1.1. The challenges of suicide risk

In 2019, 47,511 Americans died by suicide (Drapeau and McIntosh, 2020); 1,400,000 attempted suicide and 12,200,000 had *serious* suicidal thoughts (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). In response, national policy calls for accessible evidence-based treatments that: a) prevent suicidal behavior; b) increase clinician confidence/willingness to work with suicidal risk; and c) are feasible, trainable, adaptable, and flexible across care systems (Grumet et al., 2019).

Risk for suicide following discharge from inpatient care is clear (Chung et al., 2017) and finding providers who see recently discharged

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[1] Ms. Hendricks is now at the University of South Alabama, Mobile, Alabama.
[2] Dr. Chalker is now at the Veterans Affairs San Diego Healthcare System, San Diego, California.
[3] Ms. Huppert is now at the Uniformed Services University of the Health Sciences, Bethesda, Maryland.

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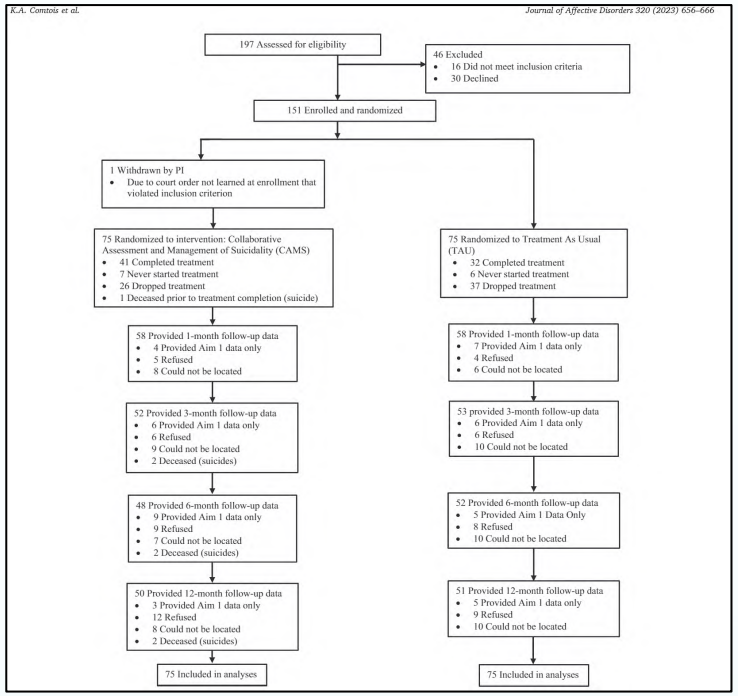

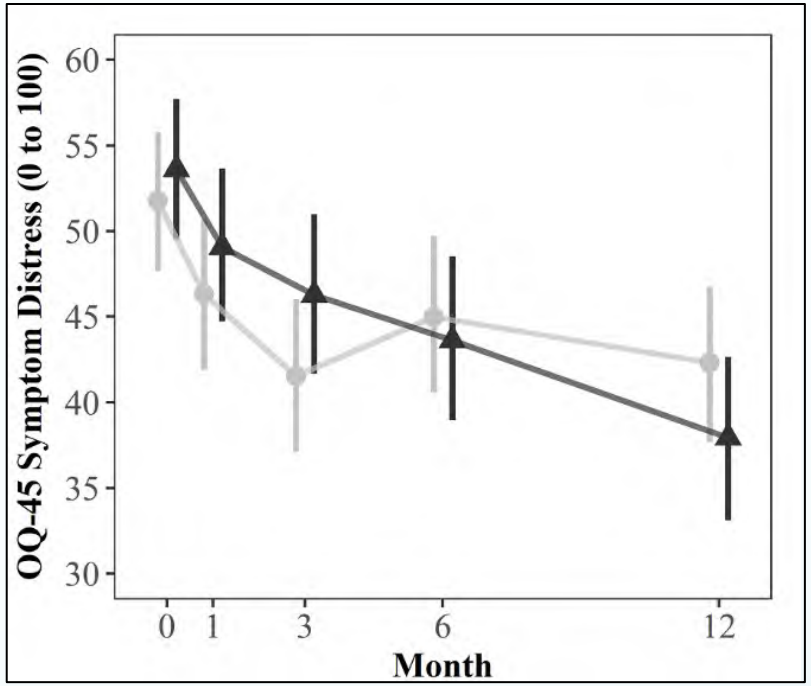

Results: Participants in both conditions improved from baseline to 12 months but CAMS was not superior to TAU for the primary outcomes. A small but significant improvement was found in probability of suicidal ideation at 3 months favoring TAU and amount of suicidal ideation at 12 months favoring CAMS. CAMS participants experienced less psychological distress at 12 months compared to baseline.

There was a significant preference for CAMS vs TAU among clinicians;
There was also an argument for suicide clinics like we see in Denmark!

The Cost-Effectiveness of CAMS

PLOS ONE

RESEARCH ARTICLE

Costs, benefits, and cost-benefit of Collaborative Assessment and Management of Suicidality versus enhanced treatment as usual

Phoebe K. McCutchan[1]*, Brian T. Yates[1], David A. Jobes[2], Amanda H. Kerbrat[3], Katherine Anne Comtois[3]

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Abstract

Suicide rates have been steadily increasing in both the U.S. general population and military, with significant psychological and economic consequences. The purpose of the current study was to examine the economic costs and cost-benefit of the suicide-focused Collaborative Assessment and Management of Suicidality (CAMS) intervention versus enhanced treatment as usual (ETAU) in an active duty military sample using data from a recent randomized controlled trial of CAMS versus ETAU. The full intent-to-treat sample included 148 participants (mean age 26.8 years ± 6.9 SD years; 80% male; 53% White). Using a micro-costing approach, the cost of each condition was calculated at the individual level from a healthcare system perspective. Benefits were estimated at the individual level as cost savings in past-year healthcare expenditures based on direct care reimbursement rates. Cost-benefit was examined in the form of cost-benefit ratios and net benefit. Total costs, benefits, cost-benefit ratios, and net benefit were calculated and analyzed using general linear mixed modeling on multiply imputed datasets. Results indicated that treatment costs did not differ significantly between conditions; however, CAMS was found to produce significantly greater benefit in the form of decreased healthcare expenditures at 6-month follow-up. CAMS also demonstrated significantly greater cost-benefit ratios (i.e., benefit per dollar spent on treatment) and net-benefit (i.e., total benefit less the cost of treatment) at 12-month follow-up. The current study suggests that beyond its clinical effectiveness, CAMS may also convey potential economic advantages over usual care for the treatment of suicidal active duty service members. Our findings demonstrate cost savings in the form of reduced healthcare expenditures, which theoretically represent resources that can be reallocated toward other healthcare system needs, and thus lend support toward the overall value of CAMS.

OPEN ACCESS

Citation: McCutchan PK, Yates BT, Jobes DA, Kerbrat AH, Comtois KA (2022) Costs, benefits, and cost-benefit of Collaborative Assessment and Management of Suicidality versus enhanced treatment as usual. PLoS ONE 17(2): e0262582. https://doi.org/10.1371/journal.pone.0262582

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Data Availability Statement: Public sharing of data used in this study is prohibited under the protocol approved by the U.S. Army Medical Research and Development Command Office of Research

COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY IN THE AFTERCARE FOCUS STUDY: COSTS, COST-EFFECTIVENESS, BENEFITS, AND COST-BENEFIT

By

Phoebe K. McCutchan

Submitted to the

Faculty of the College of Arts and Sciences

Of American University

In Partial Fulfillment of

The Requirements for the Degree of

Doctor of Philosophy

In

Clinical Psychology

Chair: _____
Brian T. Yates, Ph.D.

_____
Kathleen Gunthert, Ph.D.

_____
David A. Jobes, Ph.D., ABPP

_____
Dean of the College of Arts and Sciences

_____
Date

2023

American University

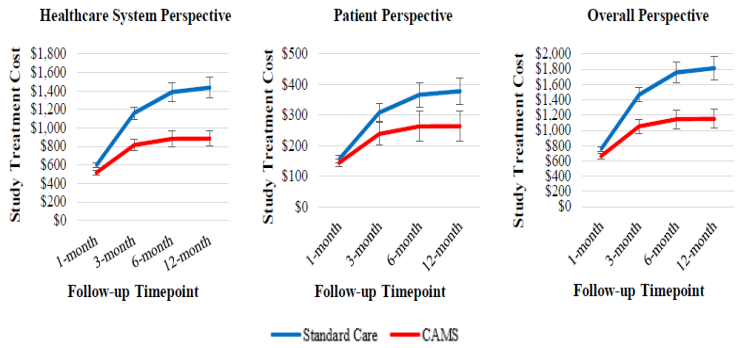
Washington, D.C. 20016

Two studies of CAMS cost-effectiveness compared to control care… (OWL & AFS)

Dr. Phoebe McCutchan

Figure 1

Mean Cumulative Study Treatment Costs Across Time



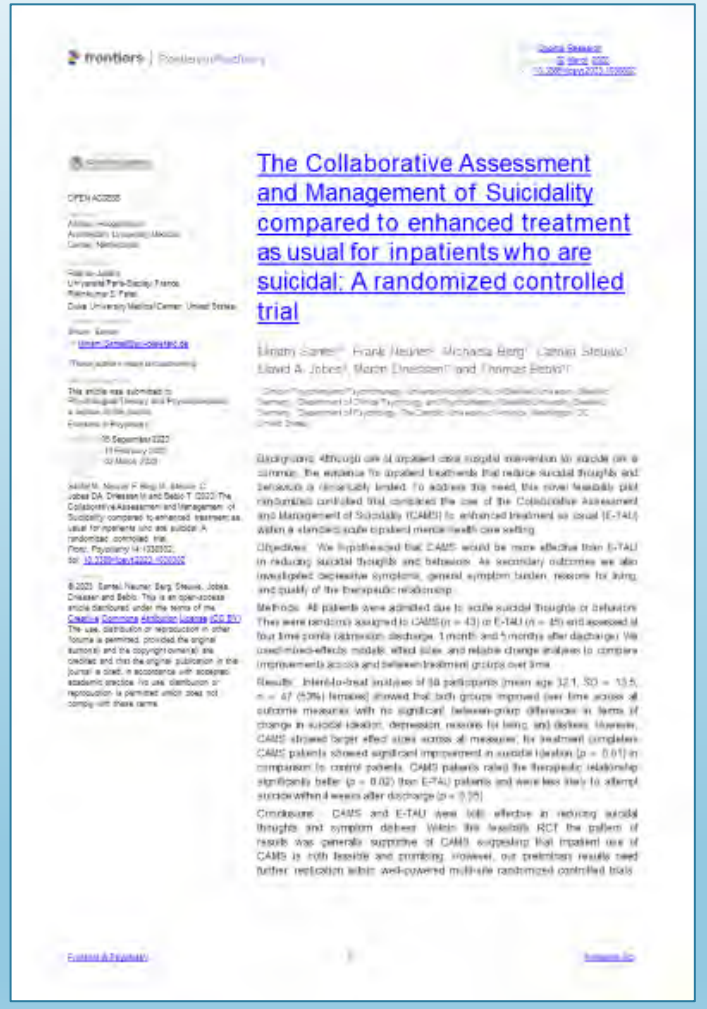
Note. Error bars reflect standard errors

Miriam Santel's Inpatient CAMS RCT (n=88)

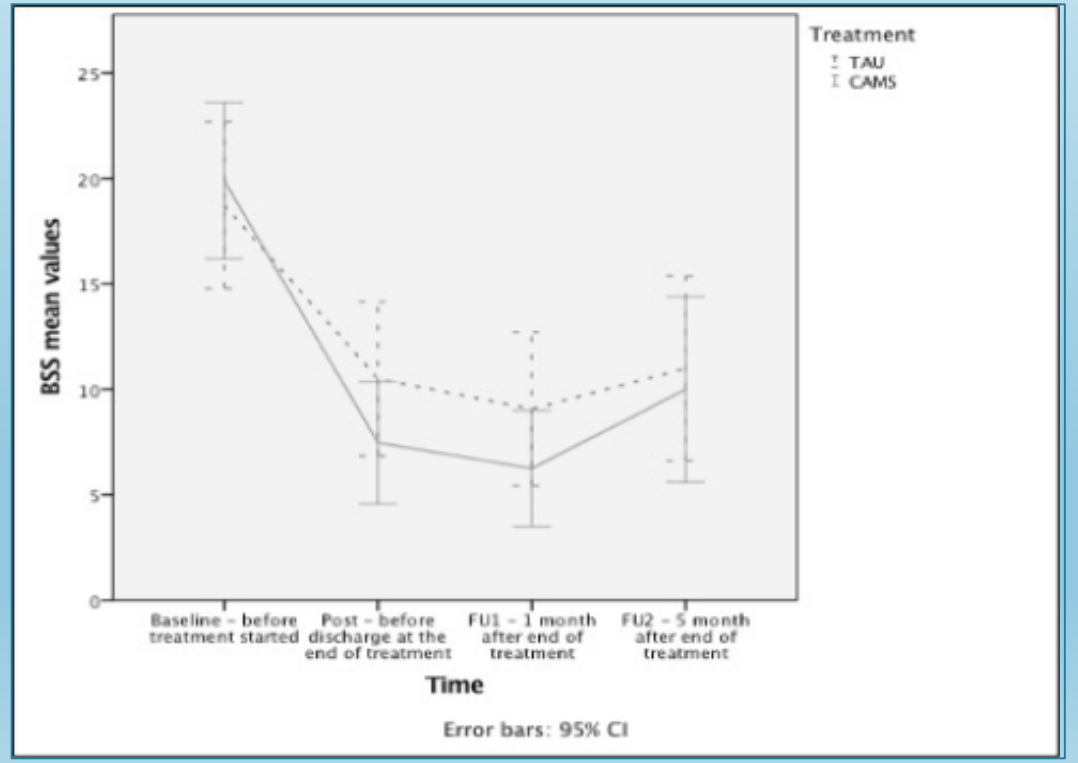

BMC Psychiatry

STUDY PROTOCOL Open Access

Collaborative Assessment and Management of Suicidality (CAMS) compared to enhanced treatment as usual (E-TAU) for suicidal patients in an inpatient setting: study protocol for a randomized controlled trial


The Collaborative Assessment and Management of Suicidality compared to enhanced treatment as usual for inpatients who are suicidal: A randomized controlled trial

Significant CAMS results for suicidal ideation, better alliance, and decreased suicide attempts post-discharge (high risk period)

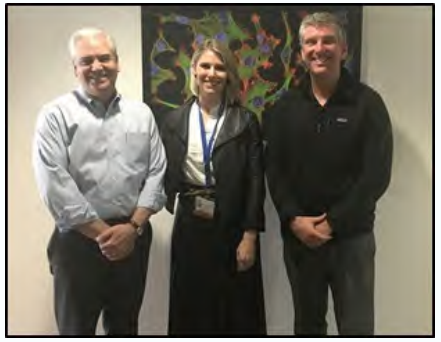


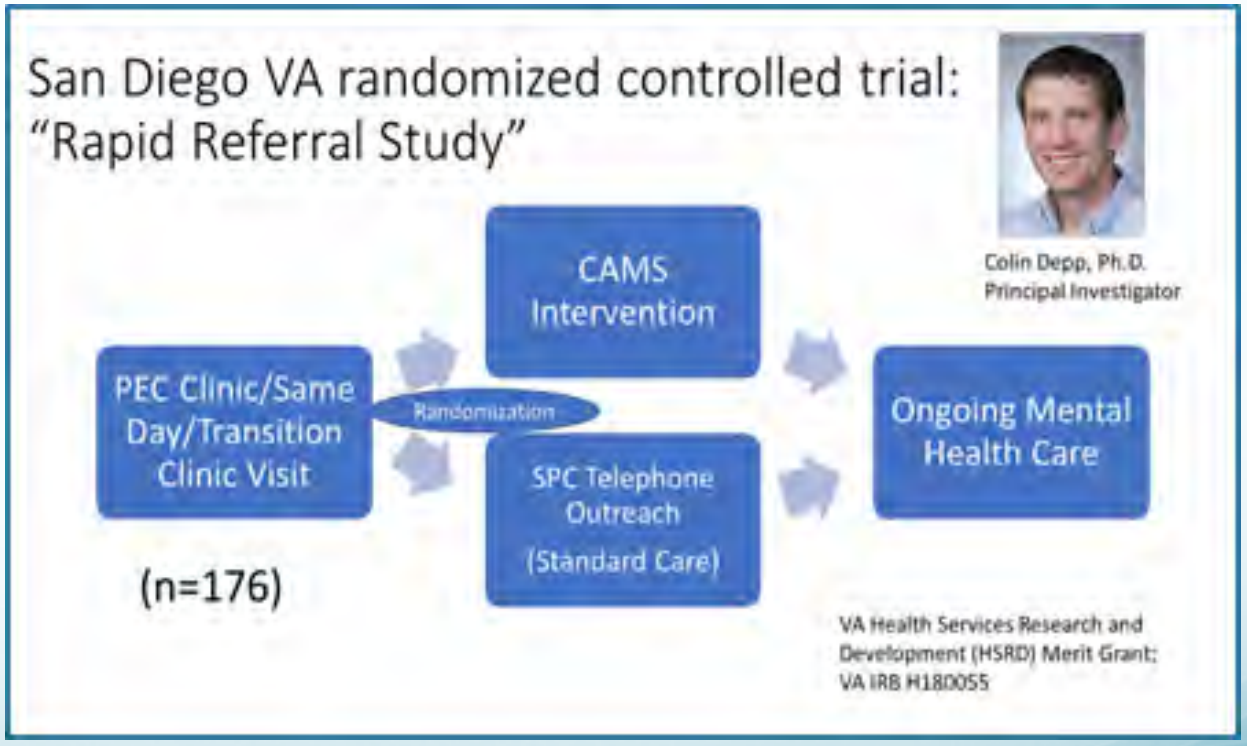
Bielefeld Germany

Seven Randomized Controlled Trials Supporting CAMS

Authors	Sample/Setting	n =	Significant Experimental Results
Comtois et al., 2011	CMH Outpatients Harborview—Seattle, WA	32	Reduced Suicide Ideation and Symptom Distress, Increased Hope, Patients Preferred CAMS
Andreasson et al., 2016	CMH Outpatients Copenhagen Denmark	108	Mixed findings: CAMS was as effective as DBT for Self Harm and Suicide Attempts
Jobes et al., 2017	Soldier Outpatients Ft. Stewart, GA	148	Reduced Suicide Ideation in 6-8 sessions; Moderator findings: Resiliency, Symptom Distress, Decreased ED visits; Cost-Effective
Ryberg et al., 2019	Inpatients/Outpatients Oslo Norway	78	Reduced Suicide Ideation and Symptom Distress Moderator finding: CAMS improves poor working alliance
Pistorello et al., 2020	College Student Outpatients University of Nevada, Reno	62	Reductions in Suicide Ideation and Depression Moderator finding: Reductions in Hopelessness
Comtois et al., 2022	CMH Outpatients (SME)	150	Mixed findings: TAU worked better early, CAMS worked better later in terms of Suicidal Ideation and Symptom Distress; Clinicians were more satisfied with CAMS
Santel et al., 2023	Psychiatric Inpatients Bielefeld Germany	88	Decreased Suicide Ideation, Symptom Distress, and Suicide Attempts Post-D/C; Stronger Alliance

San Diego VAMC CAMS RCT—Depp et al (data analysis coming Spring 2025)

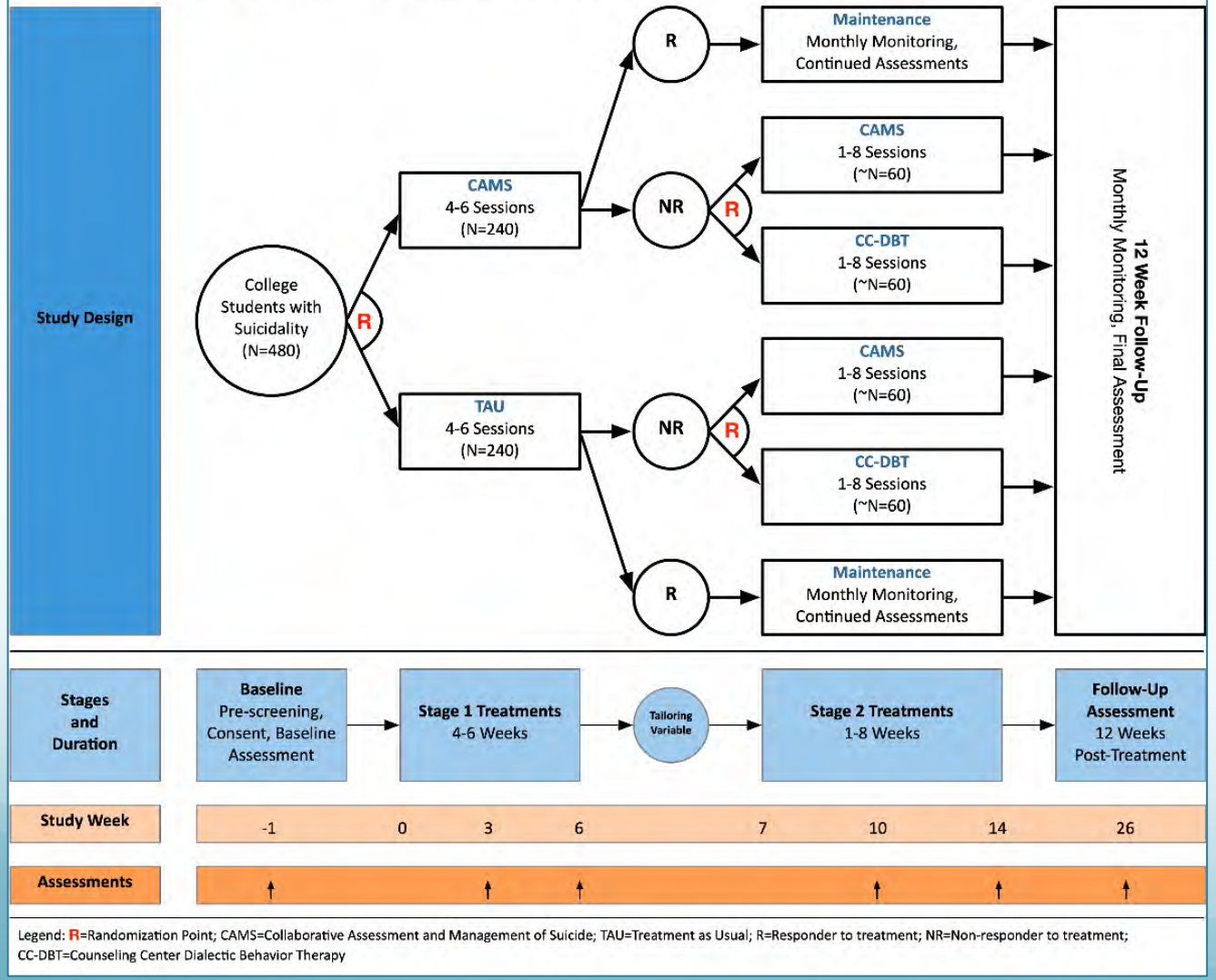




Now standing up a "Suicide Stabilization Clinic" at SD VAMC focused on suicide-specific care, training young clinical providers, and cost-effectiveness!

Comprehensive Adaptive Multisite Prevention of University student Suicide

Figure 1. CAMPUS Trial Study Design
(Comprehensive Adaptive Multisite Prevention of University student Suicide)



Legend: R=Randomization Point; CAMS=Collaborative Assessment and Management of Suicide; TAU=Treatment as Usual; R=Responder to treatment; NR=Non-responder to treatment; CC-DBT=Counseling Center Dialectic Behavior Therapy

The CAMPUS Study

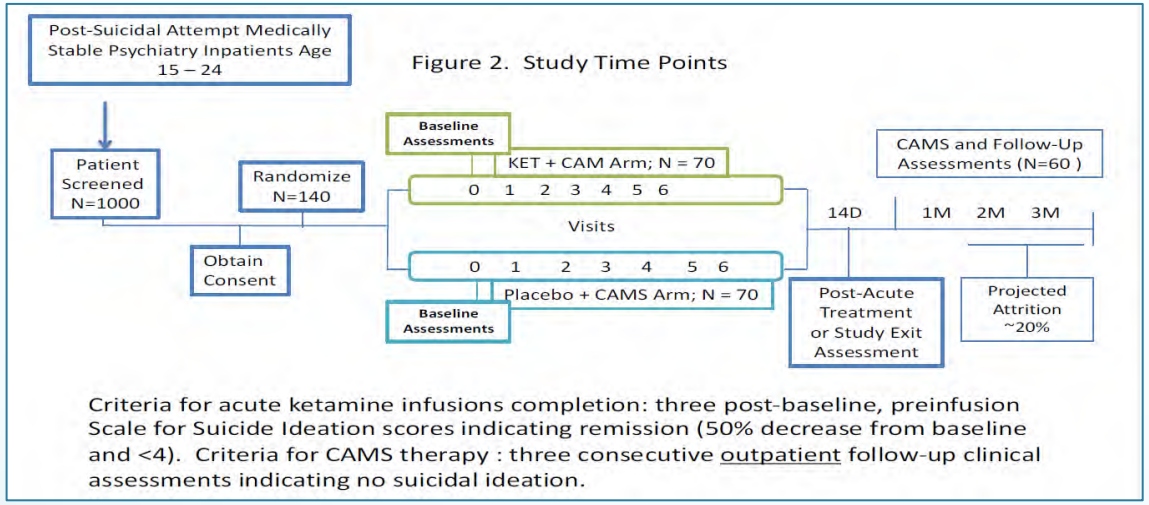
NIMH-funded ($11M) multisite SMART of n=480 college students who are suicidal at four university counseling centers (University of Oregon, University of Nevada-Reno, Duke University, and Rutgers University).

Authorized to do a feasibility trial for academic years 2020-2022 to study online training and online treatment.

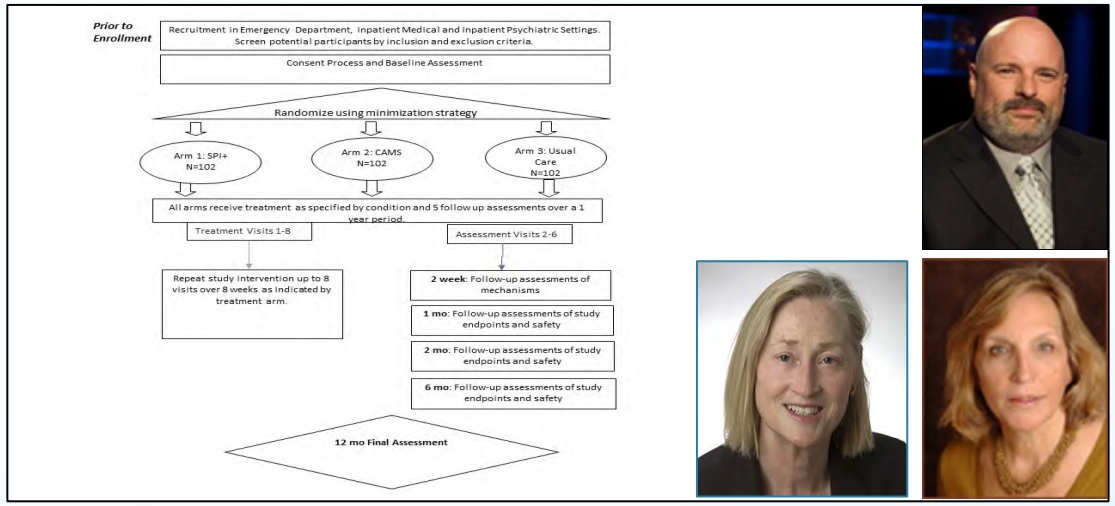
The actual trial (finally) began Fall 2022;
ITT data collection occurred from 2023-2024
Outcome data analyses in February 2025

NIMH R01 Funded "CAMS-4Teens" RCT's

CAMS & Ketamine RCT
Cleveland Clinic & Mass General Hospital
(PI's: Anand & Falcone)



CAMS-4Teens vs. SPI+ vs. TAU
Seattle Children's & Nationwide
(PI's: Adrian & Bridge)



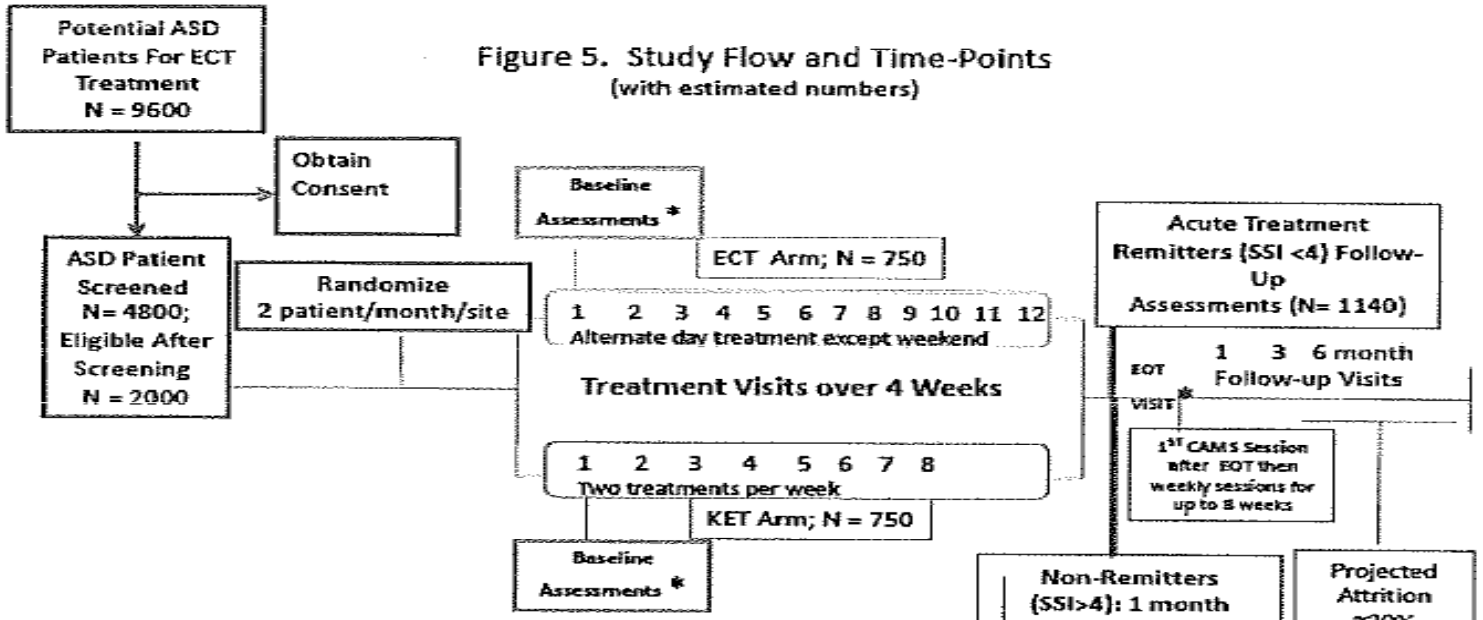
PCORI-funded RCT: Inpatient Treatment of Acute Suicide Risk

Inpatients randomized to either ECT or IV-Ketamine + 8 sessions of CAMS

Dr. Anand of MGH is PI of a 7-year PCORI-funded RCT. We are in a 2-year feasibility phase; if approved, ITT would start in April 2025

D. Study Design and Methods *(Criterion 3. Scientific merit [research design, analysis, and outcomes]; RQ-3, 4, 5, 6)*

Figure 5. Study Flow and Time-Points
(with estimated numbers)



*Baseline and End of Treatment Visit (EOT) Ratings to be done by an independent blinded rater

CAMS-Brief Intervention (CAMS-BI)—one session

LSU Psychology Department Mitigation of Suicide Behavior Lab led by Dr. Ray Tucker has been using CAMS-BI with inpatients.

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Letter to the editor

An observational pilot of the collaborative assessment and management of suicidality brief intervention (CAMS-BI) for adult inpatients

Level one (inpatient) psychiatry is a commonly used service delivery system for treating patients experiencing suicidal thoughts and behaviors (STB) [1]. Patients treated for STB within the level one setting may undergo risk assessment, safety monitoring, medication management, milieu therapy, and step-down treatment planning; however, the exact nature of services offered between units is extremely variable and difficult to track [1]. Some evidence suggests that this model of level one psychiatric care may increase patient risk for post-discharge STB [1,2] while patient-centered, behavioral interventions that target suicide risk are typically neglected and/or relegated to outpatient providers [3]. The Collaborative Assessment and Management of Suicidality Brief Intervention (CAMS-BI) [4] is an evidence based [5], targeted intervention that may standardize this gap in patient care, facilitate subjective distress reduction, and improve motivation to continue living [1]. Given the CAMS framework direct alignment with the assess, intervene, and monitor (AIM-SP) model within the Zero Suicide Framework and evidence of efficacy in adult level one patients [3,6], an observational pilot was conducted for CAMS-BI; see Online Supplemental Table 1.

Six attending psychiatrists across three inpatient psychiatric units and the medical surgical floor referred patients ($N = 143$; see Table 1) 18 years of age or older exhibiting non-zero risk for outpatient suicide attempt for a CAMS-BI session with a graduate student clinician at a Level 1 Trauma center in the Southeastern United States. Outcomes were measured at pre- and post-session via subjective units of distress (SUDS; 0–100) and the Living Ladder (i.e., motivation to live [0–8]) [7]. Study procedures were approved for collection by the Franciscan Missionaries of Our Lady University Institutional Review Board under expedited review procedures. A significantly greater proportion of patients reported reduced subjective distress from pre- to post-session (58.04%, $n = 83$); a smaller proportion reported no change (32.86%, $n = 47$) or an increase (9.09%, $n = 13$; $X^2 = 51.413$, $p < .001$) in subjective distress. A significant reduction in subjective distress was observed from pre ($M = 37.62$, $SD = 32.60$) to post session ($M = 25.13$, $SD = 25.87$), $t(142) = 7.489$, $p < .001$, $d = 0.626$. The average reduction in subjective distress was above 10 points ($M = 12.49$, 95% CI[9.19,15.79]; Online Supplemental Fig. 1).

A significant difference in pre-session subjective distress was observed between groups (i.e., improve, no change, worsened), $F(2,140) = 16.373$, $p < .001$; Tukey's HSD test for multiple comparison found the mean value of pre-session subjective distress to be significantly different between patients who improved and patients whose subjective distress worsened ($p < .05$, 95% CI[−41.55,-4.51]) and patients whose subjective distress did not change and patients whose subjective distress improved ($p < .001$, 95% CI[−37.34,-14.68]). No significant difference was observed between patients who reported no change and patients whose subjective distress worsened ($p = .930$, 95% CI[−22.43, 16.48]; Online Supplemental Fig. 2).

The majority of patients reported no change (63.64%, $n = 91$) in motivation to live from pre- to post-session; a significantly smaller proportion reported improvement (32.86%, $n = 47$) or worsening (3.49%, $n = 5$; $X^2 = 77.594$, $p < .001$) in motivation to live. On average, a significant increase in motivation to live was observed from pre ($M = 6.26$, $SD = 2.24$) to post-session ($M = 6.78$, $SD = 1.79$), $t(142) = 4.854$, $p < .001$, $d = 0.405$. However, the average increase in motivation to live was small, ($M = 0.52$, 95% CI[0.31, 0.73]). Results of a Wilcoxon matched pairs signed rank test confirmed the direction and significance of change in motivation to live, indicating a significant median shift in motivation to live from pre- to post-session, $Z = -4.801$, $p < .001$(Online Supplemental Fig. 1).

Results indicated a significant difference in pre-session motivation to live between groups (i.e., improve, no change, worsened), $F(2,140) = 13.915$, $p < .001$. Tukey's HSD test for multiple comparison found the mean value of motivation to live pre-session to be significantly different between patients who reported no change and those who improved ($p < .001$, 95% CI[1.04,2.78]). No significant difference was observed in pre-session motivation to live between patients who reported no change and a worsening ($p = .99$, 95% CI[−2.34,2.10]), nor between those who reported improvement and a worsening in motivation to live ($p = .09$, 95% CI[−4.31,0.24]; Online Supplemental Fig. 3).

The foregoing findings are preliminary and observational; no follow-up measurement was conducted, and no control group included, significantly limiting causal conclusions that may be drawn. Future CAMS-BI work should replicate and extend these findings using control condition (i.e., treatment as usual) and thorough, follow-up assessment. Taken in this limiting context, the results suggest CAMS-BI may be an effective tool for accomplishing subjective distress reduction and enhancing motivation to live for a significant proportion of adult level one patients in just 60-min. A significant reduction in subjective distress was observed on average, while only a half point improvement in motivation to live was observed; a one-point increase on the LL has been associated with a 31% decrease in likelihood of experiencing suicidal ideation during follow-up periods in veterans [7]. A ceiling effect was observed for both outcomes such that patients rating extreme scores pre-session were less likely to report improvements at post-session; thus, more intensive intervention for patients of high severity is warranted [8]. Single session interventions [9] like CAMS-BI may be effective tools for accomplishing clinically meaningful change for patients in the short and long-term [10]; these are scalable to level one care, other rapid service delivery systems (e.g., emergency departments, primary care), and rural localities that lack access to evidence based intervention.

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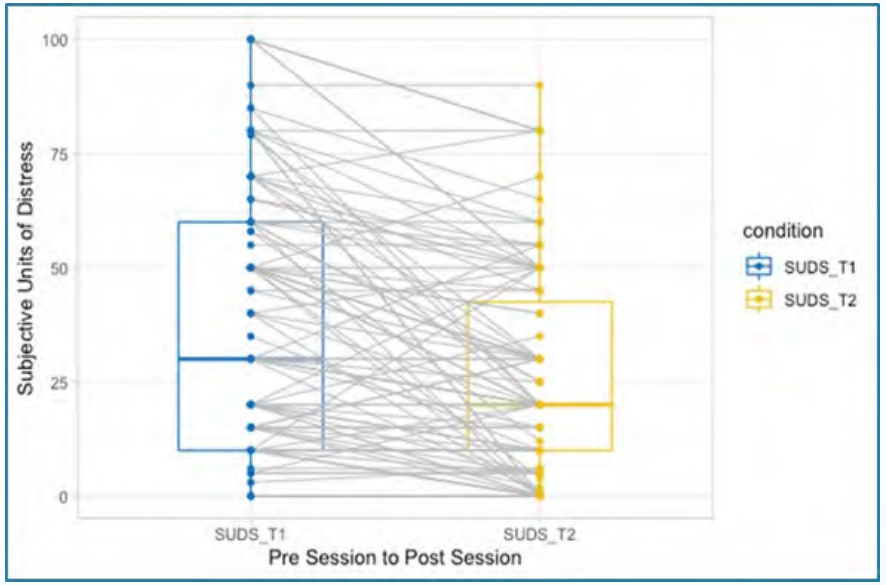
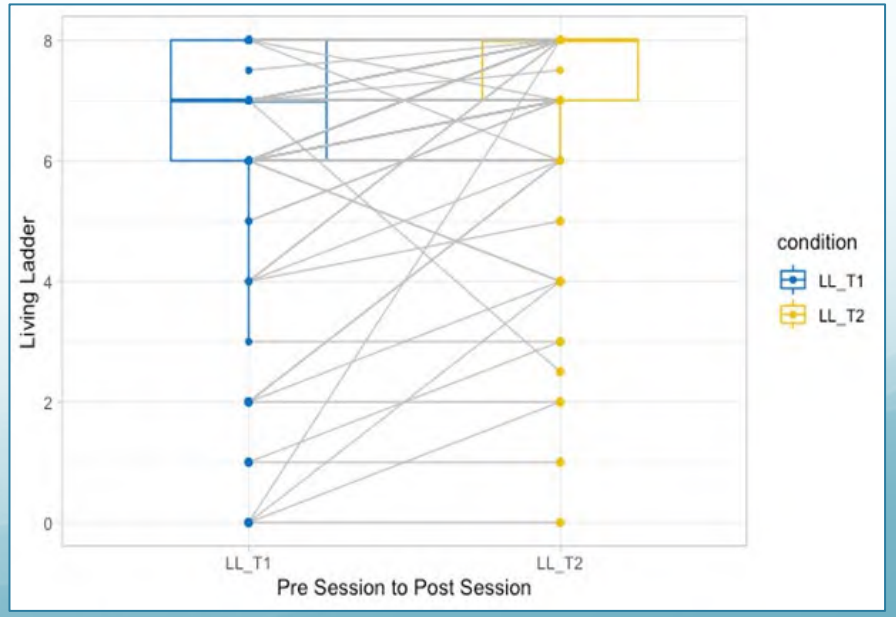


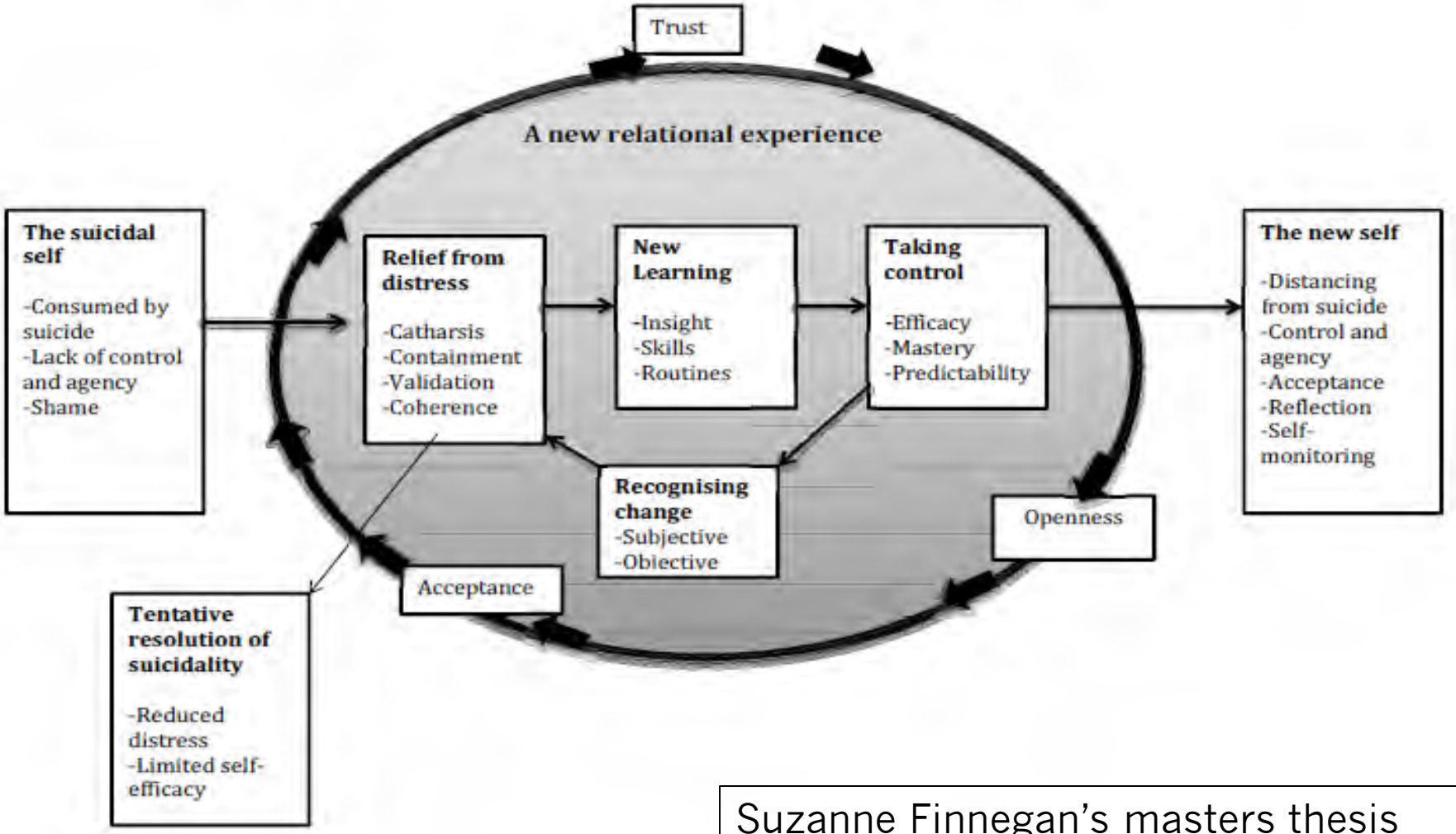


D Nicolas Oakey-Frost

Summary of CAMS Research Findings to Date

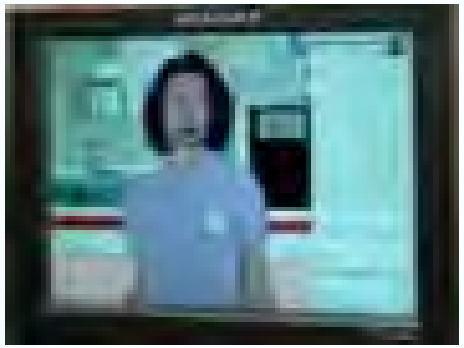
- Across 10 published non-randomized clinical trials of CAMS, 2 meta-analyses, and 7 published randomized controlled clinical trials, and 5 unpublished RCT (100+ pubs):
  - CAMS significantly reduces suicidal ideation in 6-8 sessions
  - CAMS significantly reduces overall symptom distress, depression, hopelessness, and changes suicidal cognitions
  - CAMS significantly increases hope and improves clinical retention to care
  - CAMS is significantly more cost-effective (e.g., reduced emergency department visits)
  - Patients like CAMS and the process of doing CAMS; clinicians prefer 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 further replication of German RCT is needed)
  - CAMS is relatively easy to learn (adherence is typically attained with first patient)

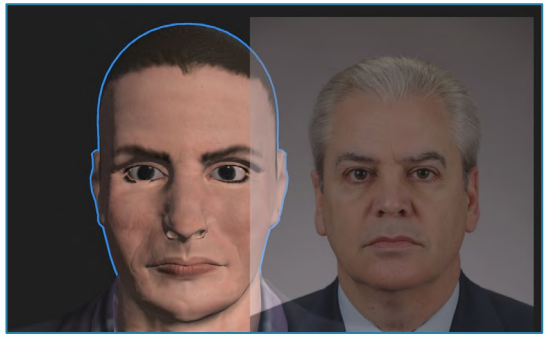
Figure 1. Preliminary theoretical model of the process of change in resolving and recovering from suicidality



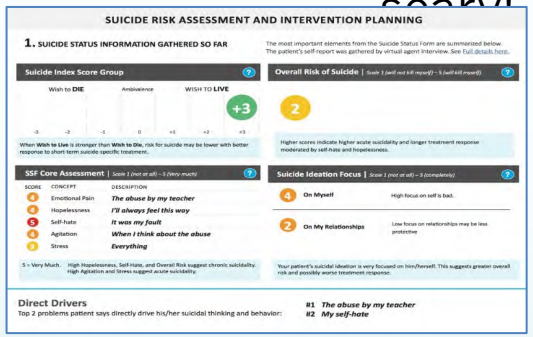
Suzanne Finnegan's masters thesis (n=10) at Trinity College—Dublin, IRE

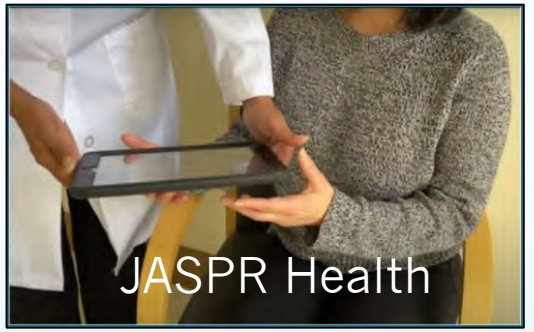
NIMH-funded SBIR Projects: CAMS-RAS and JASPR Health for Suicidal Risk in EDs (Linda Dimeff & Kelly Koerner)

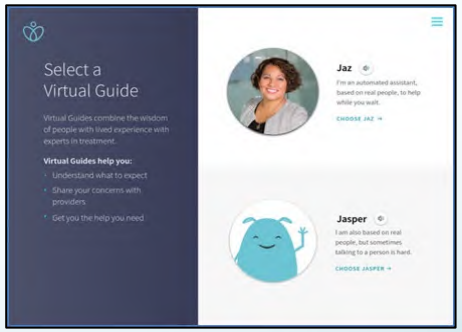



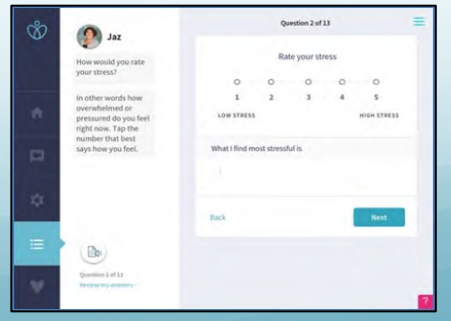


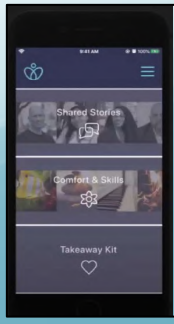
"Nurse Louise" "Dr. Dave?" The initial relational agent prototypes were a bit scary!



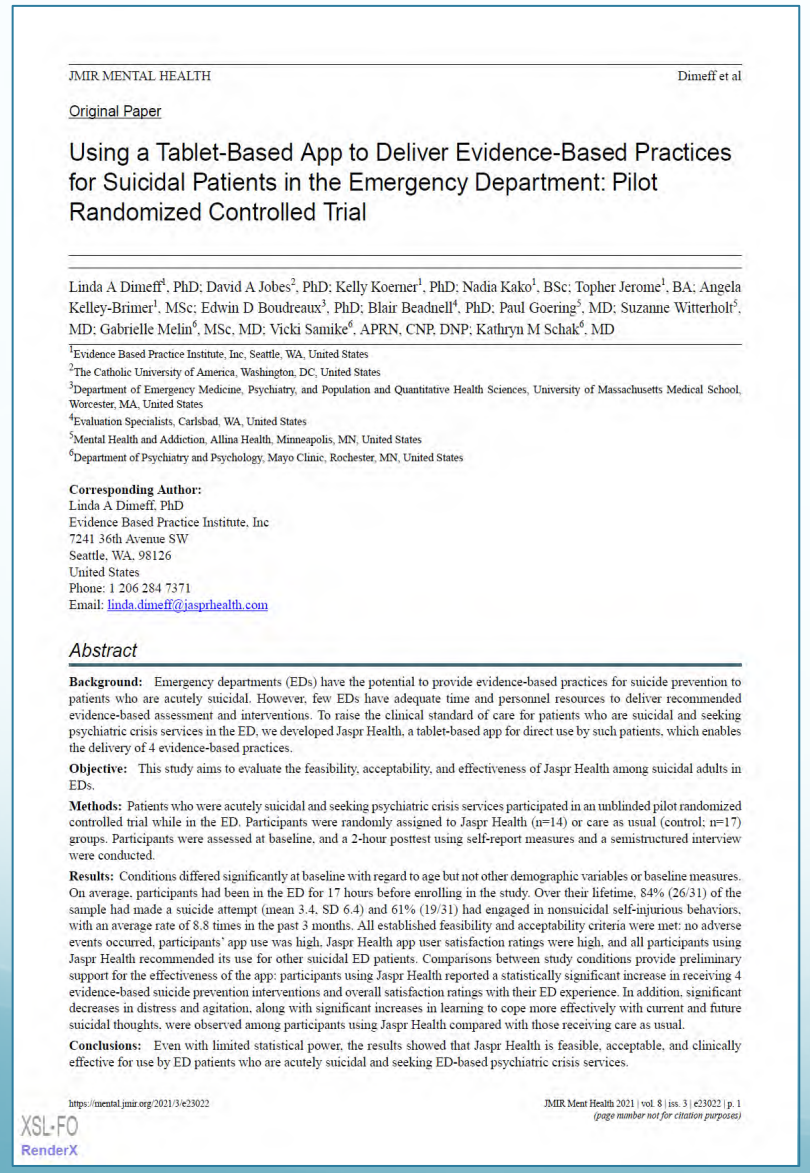








Jaspr Health RCT findings and next steps...



Original Paper

Using a Tablet-Based App to Deliver Evidence-Based Practices for Suicidal Patients in the Emergency Department: Pilot Randomized Controlled Trial

Linda A Dimeff[1], PhD; David A Jobes[2], PhD; Kelly Koerner[1], PhD; Nadia Kako[1], BSc; Topher Jerome[1], BA; Angela Kelley-Brimer[1], MSc; Edwin D Boudreaux[3], PhD; Blair Beadnell[4], PhD; Paul Goering[5], MD; Suzanne Witterholt[5], MD; Gabrielle Melin[6], MSc, MD; Vicki Samike[6], APRN, CNP, DNP; Kathryn M Schak[6], MD

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Abstract

Background: Emergency departments (EDs) have the potential to provide evidence-based practices for suicide prevention to patients who are acutely suicidal. However, few EDs have adequate time and personnel resources to deliver recommended evidence-based assessment and interventions. To raise the clinical standard of care for patients who are suicidal and seeking psychiatric crisis services in the ED, we developed Jaspr Health, a tablet-based app for direct use by such patients, which enables the delivery of 4 evidence-based practices.

Objective: This study aims to evaluate the feasibility, acceptability, and effectiveness of Jaspr Health among suicidal adults in EDs.

Methods: Patients who were acutely suicidal and seeking psychiatric crisis services participated in an unblinded pilot randomized controlled trial while in the ED. Participants were randomly assigned to Jaspr Health (n=14) or care as usual (control; n=17) groups. Participants were assessed at baseline, and a 2-hour posttest using self-report measures and a semistructured interview were conducted.

Results: Conditions differed significantly at baseline with regard to age but not other demographic variables or baseline measures. On average, participants had been in the ED for 17 hours before enrolling in the study. Over their lifetime, 84% (26/31) of the sample had made a suicide attempt (mean 3.4, SD 6.4) and 61% (19/31) had engaged in nonsuicidal self-injurious behaviors, with an average rate of 8.8 times in the past 3 months. All established feasibility and acceptability criteria were met: no adverse events occurred, participants' app use was high, Jaspr Health app user satisfaction ratings were high, and all participants using Jaspr Health recommended its use for other suicidal ED patients. Comparisons between study conditions provide preliminary support for the effectiveness of the app: participants using Jaspr Health reported a statistically significant increase in receiving 4 evidence-based suicide prevention interventions and overall satisfaction ratings with their ED experience. In addition, significant decreases in distress and agitation, along with significant increases in learning to cope more effectively with current and future suicidal thoughts, were observed among participants using Jaspr Health compared with those receiving care as usual.

Conclusions: Even with limited statistical power, the results showed that Jaspr Health is feasible, acceptable, and clinically effective for use by ED patients who are acutely suicidal and seeking ED-based psychiatric crisis services.

XSL•FO
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- RCT of n=31 emergency department patients
- Jaspr patients effectively received four evidence-based suicide-focused interventions
- Significant between-group decreases in distress and agitation compared to treatment as usual (TAU)
- Significant between-group increases in coping with current and future suicidal thoughts compared to TAU
- 100% of patients recommended use of Jaspr for others

Routledge

OPEN ACCESS

Using the Delphi Method for Determining Key Performance Elements for Delivery of Optimal Suicide-Specific Interventions in Emergency Departments

Linda A. Dimeff, David A. Jobes, Tia Tyndal, Irene Zhang, Susan Stefan, Nadia Kako, Hannah Lawrence, and Maria Ilac

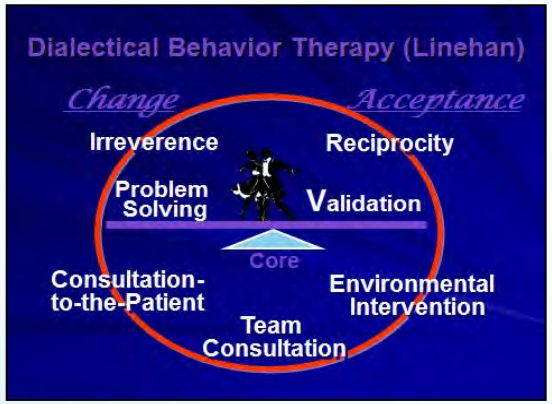
Jaspr Health is a central component to UMASS P-50 focused on ED care and FDA approval is currently pending...

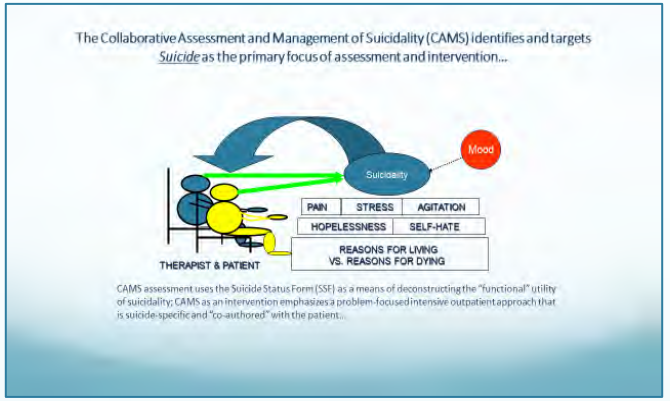
FDA

The Suicide Crisis→ Stabilization Challenge

- Zero Suicide: we need to screen and safety plan
- Zero Suicide: but we also need to *treat* suicide risk directly
- Denmark has successful suicide-specific regional centers
- In US: people in suicidal crisis → ED, hospital, get Rx
- Getting outpatient care may take weeks if not months
- The Lifeline already had significant capacity issues before 988
- Concerns about “active rescue” by law enforcement
- To decrease suicidal suffering—and to save lives—alternatives to the status quo are clearly needed

Using DBT and CAMS together?





- DBT now has 44 RCTs of support
- CAMS has 7 RCT's and 2 meta-analyses of support (5 ongoing RCTs)
- Both stabilize suicidal risk and endeavor to keep patients out of the hospital
- DBT reduces suicide attempts and self-harm behaviors (chronic suicidality)
- CAMS reduces suicidal ideation and overall symptom distress; increases hope while decreasing hopelessness

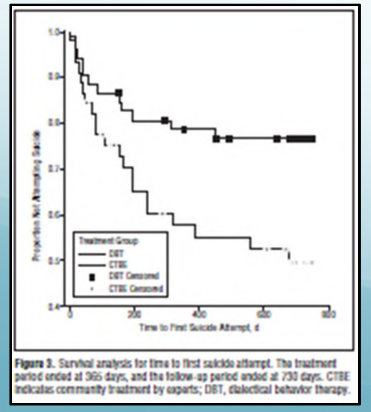
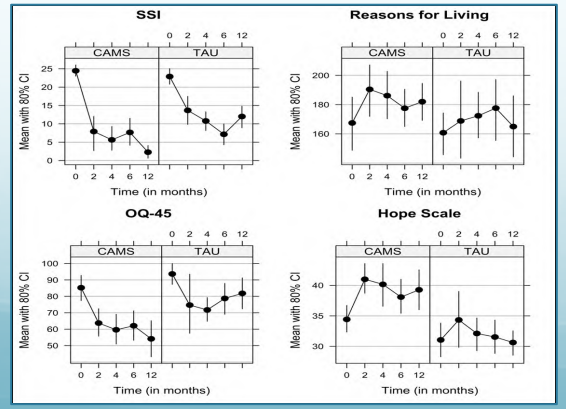
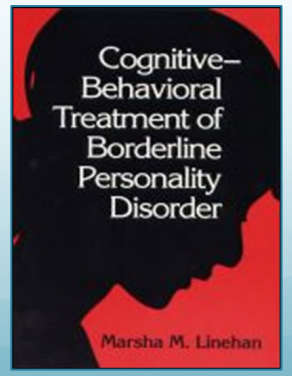
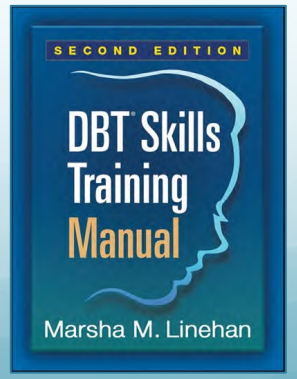
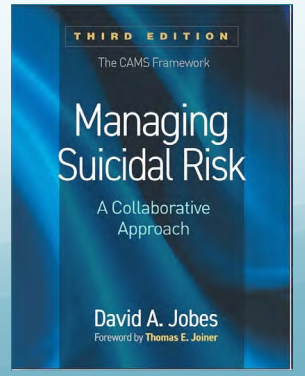


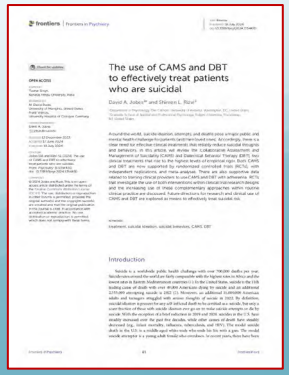
Figure 3. Survival analysis for time to first suicide attempt. The treatment period ended at 365 days, and the follow-up period ended at 730 days. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.



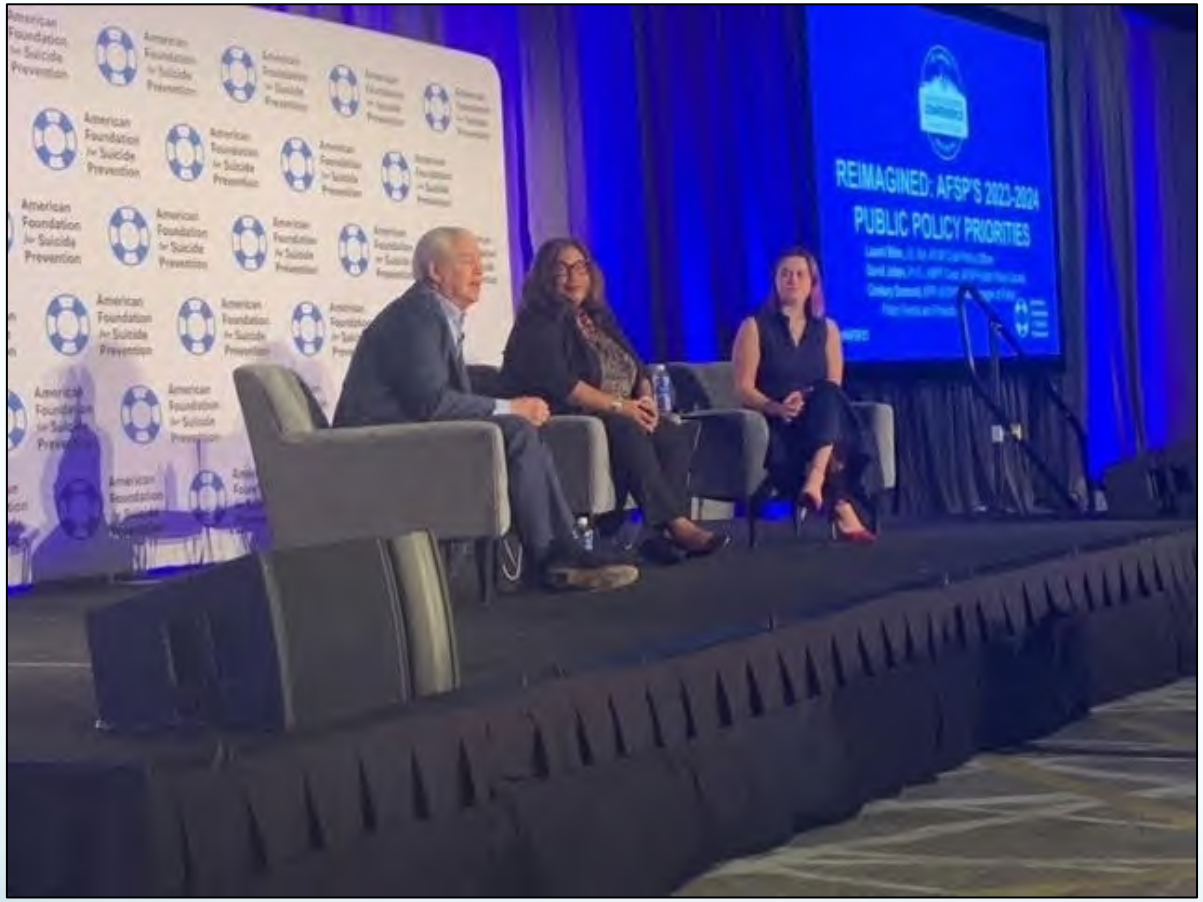


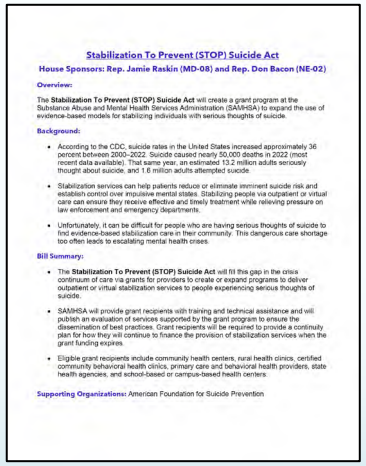






Post 988, we must increase focus on crisis stabilization





Stabilization To Prevent (STOP) Suicide Act

House Sponsors: Rep. Jamie Raskin (MD-08) and Rep. Don Bacon (NE-02)

Overview:

The **Stabilization To Prevent (STOP) Suicide Act** will create a grant program at the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand the use of evidence-based models for stabilizing individuals with serious thoughts of suicide.

Background:

- According to the CDC, suicide rates in the United States increased approximately 36 percent between 2000–2022. Suicide caused nearly 50,000 deaths in 2022 (most recent data available). That same year, an estimated 13.2 million adults seriously thought about suicide, and 1.6 million adults attempted suicide.
- Stabilization services can help patients reduce or eliminate imminent suicide risk and establish control over impulsive mental states. Stabilizing people via outpatient or virtual care can ensure they receive effective and timely treatment while relieving pressure on law enforcement and emergency departments.
- Unfortunately, it can be difficult for people who are having serious thoughts of suicide to find evidence-based stabilization care in their community. This dangerous care shortage too often leads to escalating mental health crises.

Bill Summary:

- The **Stabilization To Prevent (STOP) Suicide Act** will fill this gap in the crisis continuum of care via grants for providers to create or expand programs to deliver outpatient or virtual stabilization services to people experiencing serious thoughts of suicide.
- SAMHSA will provide grant recipients with training and technical assistance and will publish an evaluation of services supported by the grant program to ensure the dissemination of best practices. Grant recipients will be required to provide a continuity plan for how they will continue to finance the provision of stabilization services when the grant funding expires.
- Eligible grant recipients include community health centers, rural health clinics, certified community behavioral health clinics, primary care and behavioral health providers, state health agencies, and school-based or campus-based health centers.

Supporting Organizations: American Foundation for Suicide Prevention

As Chair of the AFSP Public Policy Council, I help lead our efforts to inform, shape, and craft mental health and suicide-related policy and legislation at the federal, state, and local levels.

Can we create a new legislative act that supports funding for new initiatives in the suicide crisis stabilization?

Such initiatives would be:

- Suicide-focused
- Evidence-based
- Least restrictive
- Self-sustaining
- Use quality assurance research to ensure effectiveness

Stabilization to Prevent (STOP) Suicide Act was introduced on Sept 13,2024!

From professional crisis to a possible tipping point?

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 in models of health care delivery, the role of research, and issues of diversity). These aspects command an intense contemplation, 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 stigmatizations 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 psychiatrists' 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 vignettes aptly 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-Ramsey 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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Clinical Assessment and Treatment of Suicidal Risk: A Critique of Contemporary Care and CAMS as a Possible Remedy

David A. Jobes
The Catholic University of America

There is a significant need to improve clinical practices related to suicidal patients within contemporary mental health practice. It is argued that there is a general over-reliance on psychotropic medications and the use of inpatient psychiatric hospitalizations for suicidal risk. This reliance is puzzling given the lack of empirical support for these approaches; the evidence supporting the use of psychotropics is mixed and there are recent challenges to the routine use of inpatient care that tends not to be suicide-specific and may increase post-discharge risk. Importantly there are several psychological treatments proven effective in rigorous randomized controlled trials (RCTs). Of the *replicated* RCTs, dialectical behavior therapy (DBT), two forms of suicide-specific cognitive-behavioral therapy—cognitive therapy for suicide prevention (CT-SP) and brief cognitive behavioral therapy (BCBT)—and the collaborative assessment and management of suicidality (CAMS) have shown robust data for effectively treating suicidal risk. But despite the data these treatments are not widely used. Possible reasons for an inadequate professional response to suicidality may include: (a) countertransference, (b) fear of malpractice litigation, (c) lack of knowledge about suicide risk assessment, and (d) lack of knowledge about effective treatment for suicidal risk. CAMS is discussed as a possible remedy for the professional and clinical issues raised in this article.

Clinical Impact Statement
This article critiques current contemporary practices related to suicidal patients with general suggestions for raising the standard of clinical care. Various evidence-based approaches to improving practices with suicidal patients are considered and the Collaborative Assessment and Management of Suicidality (CAMS) is discussed in depth.

Keywords: suicide risk assessment, suicide treatment, malpractice liability, CAMS

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Suicide is the fatality of mental health practice and is the 10th leading cause of death in the United States with upward of 44,000 deaths per year (Centers for Disease Control and Prevention, 2015). There are over 1 million suicide attempts and 9.8 million Americans struggle with suicidal thoughts each year (Piscopo, Lipari, Cooney, & Glasheen, 2016). Despite these appalling data, many mental health professionals (across disciplines) do not receive suicide-specific assessment and treatment training within their professional curriculums (Bongar, 2013). It has been previously argued that the state of affairs pertaining to the assessment and treatment of suicidal patients amounts to a professional—*even ethical*—crisis for the field of

The author would like to disclose the following potential conflicts: grant funding for clinical trial research from the Department of Defense, the American Foundation for Suicide Prevention, and the National Institute of Mental Health; book royalties from American Psychological Association Press and Guilford Press; and Co-ownership of CAMS-care, LLC (a clinical training/consulting company). I thank past and present collaborators who have made the work described in this article possible. Special appreciation goes out to members of The Catholic University of America Suicide Prevention Laboratory.

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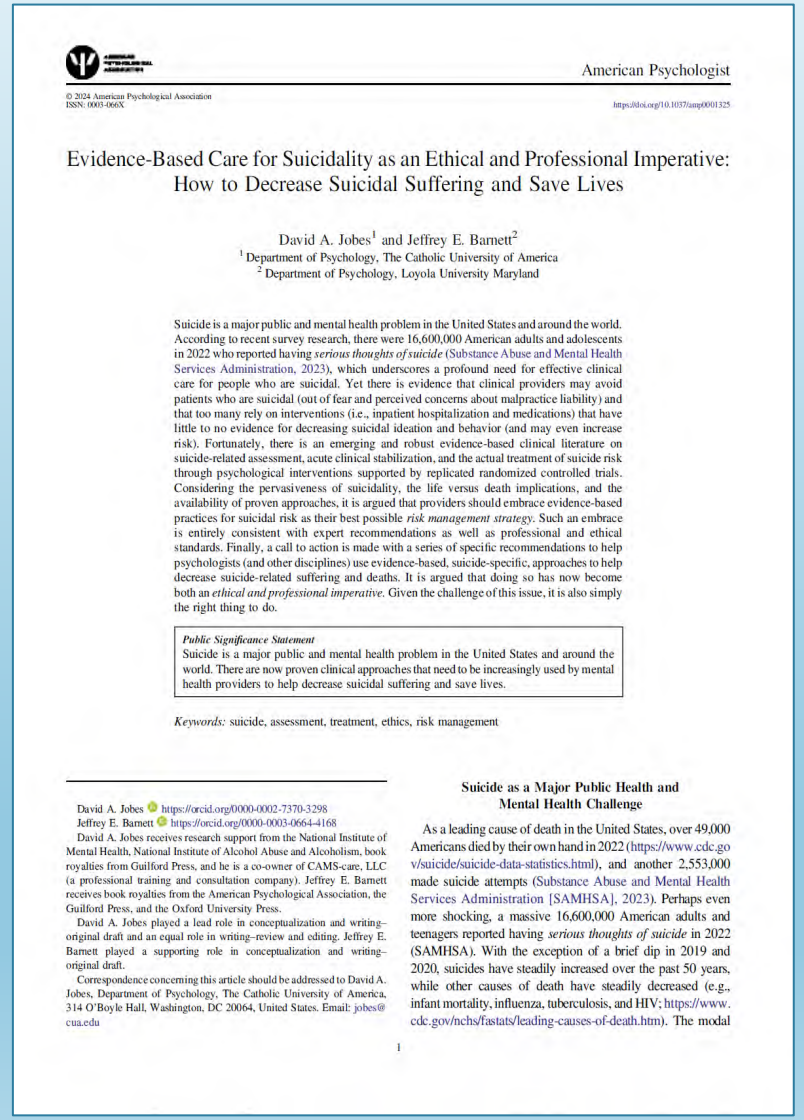

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Evidence-Based Care for Suicidality as an Ethical and Professional Imperative: How to Decrease Suicidal Suffering and Save Lives

David A. Jobes[1] and Jeffrey E. Barnett[2]
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[2] Department of Psychology, Loyola University Maryland

Suicide is a major public and mental health problem in the United States and around the world. According to recent survey research, there were 16,600,000 American adults and adolescents in 2022 who reported having *serious thoughts of suicide* (Substance Abuse and Mental Health Services Administration, 2023), which underscores a profound need for effective clinical care for people who are suicidal. Yet there is evidence that clinical providers may avoid patients who are suicidal (out of fear and perceived concerns about malpractice liability) and that too many rely on interventions (i.e., inpatient hospitalization and medications) that have little to no evidence for decreasing suicidal ideation and behavior (and may even increase risk). Fortunately, there is an emerging and robust evidence-based clinical literature on suicide-related assessment, acute clinical stabilization, and the actual treatment of suicide risk through psychological interventions supported by replicated randomized controlled trials. Considering the pervasiveness of suicidality, the life versus death implications, and the availability of proven approaches, it is argued that providers should embrace evidence-based practices for suicidal risk as their best possible *risk management strategy*. Such an embrace is entirely consistent with expert recommendations as well as professional and ethical standards. Finally, a call to action is made with a series of specific recommendations to help psychologists (and other disciplines) use evidence-based, suicide-specific, approaches to help decrease suicide-related suffering and deaths. It is argued that doing so has now become both an *ethical and professional imperative*. Given the challenge of this issue, it is also simply the right thing to do.

Public Significance Statement
Suicide is a major public and mental health problem in the United States and around the world. There are now proven clinical approaches that need to be increasingly used by mental health providers to help decrease suicidal suffering and save lives.

Keywords: suicide, assessment, treatment, ethics, risk management

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David A. Jobes played a lead role in conceptualization and writing–original draft and an equal role in writing–review and editing. Jeffrey E. Barnett played a supporting role in conceptualization and writing–original draft.

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Suicide as a Major Public Health and Mental Health Challenge

As a leading cause of death in the United States, over 49,000 Americans died by their own hand in 2022 (https://www.cdc.gov/suicide/suicide-data-statistics.html), and another 2,553,000 made suicide attempts (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). Perhaps even more shocking, a massive 16,600,000 American adults and teenagers reported having *serious thoughts of suicide* in 2022 (SAMHSA). With the exception of a brief dip in 2019 and 2020, suicides have steadily increased over the past 50 years, while other causes of death have steadily decreased (e.g., infant mortality, influenza, tuberculosis, and HIV; https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm). The modal

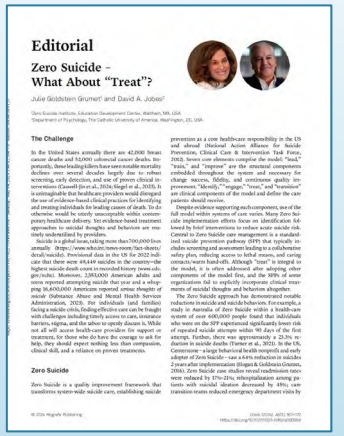
Is there a new receptivity to cutting-edge ideas in clinical suicidology?

Jobes & Barnett (2024) recommendations:

1. Changes in graduate curricula to include evidence-based approaches.
2. Revise APA accreditation to include core competency in clinical suicidology.
3. Create and disseminate a model curriculum of clinical suicidology.
4. Require licensed professionals to possess knowledge in the clinical suicidology.
5. Board Certification should include a focus on clinical suicidology.
6. Inclusion of evidence-based assessment and management on state licensing exams and for license renewal.
7. APA and government agencies should provide support for suicide-focused clinics that provide evidence-based training and care.
8. APA should advocate for legislation/policy at the national, state, and local levels.
9. APA should advocate for the modification of CPT codes
10. APA should convene an inter-professional group to create evidence-based clinical practice guidelines
11. APA's journals should curate special editions and sections on clinical suicidology.

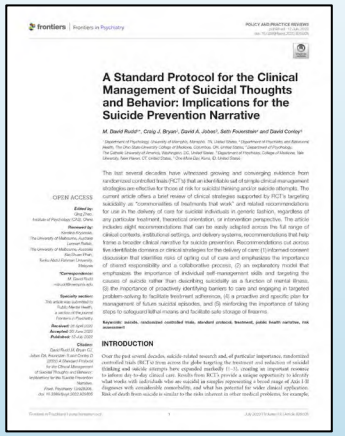

American Psychologist

Evidence-Based Care for Suicidality as an Ethical and Professional Imperative: How to Decrease Suicidal Suffering and Save Lives


Editorial

Zero Suicide – What About "Treat"?

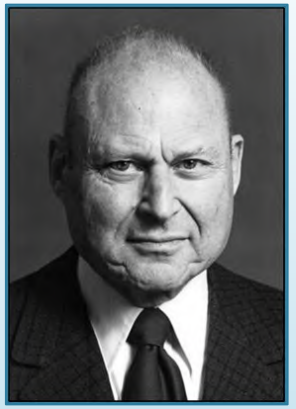
Julie Goldstein Grumet and David A. Jobes


A Standard Protocol for the Clinical Management of Suicidal Thoughts and Behavior: Implications for the Suicide Prevention Narrative

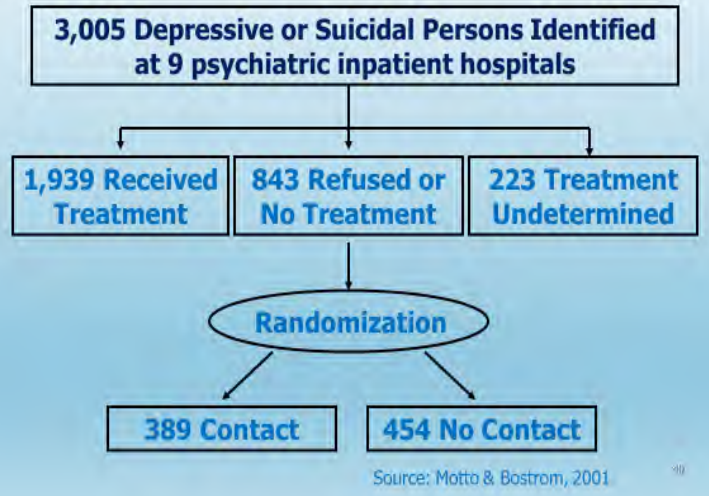
Goldstein Grumet & Jobes (2024) recommendations:

1. Research Addressing Obstacles to Using EBPs.
2. Structural Changes to Suicide-Focused Care.
3. Increased Awareness and Training.
4. Malpractice/Root Cause Analysis Reform
5. Reimburse Suicide-Specific EBPs.
6. Accountability, Accreditation, and Licensing.

Motto's Classic Caring Letter Study: A simple letter sent every 1-4 months for 5 years



Caring-Contact RCT Design

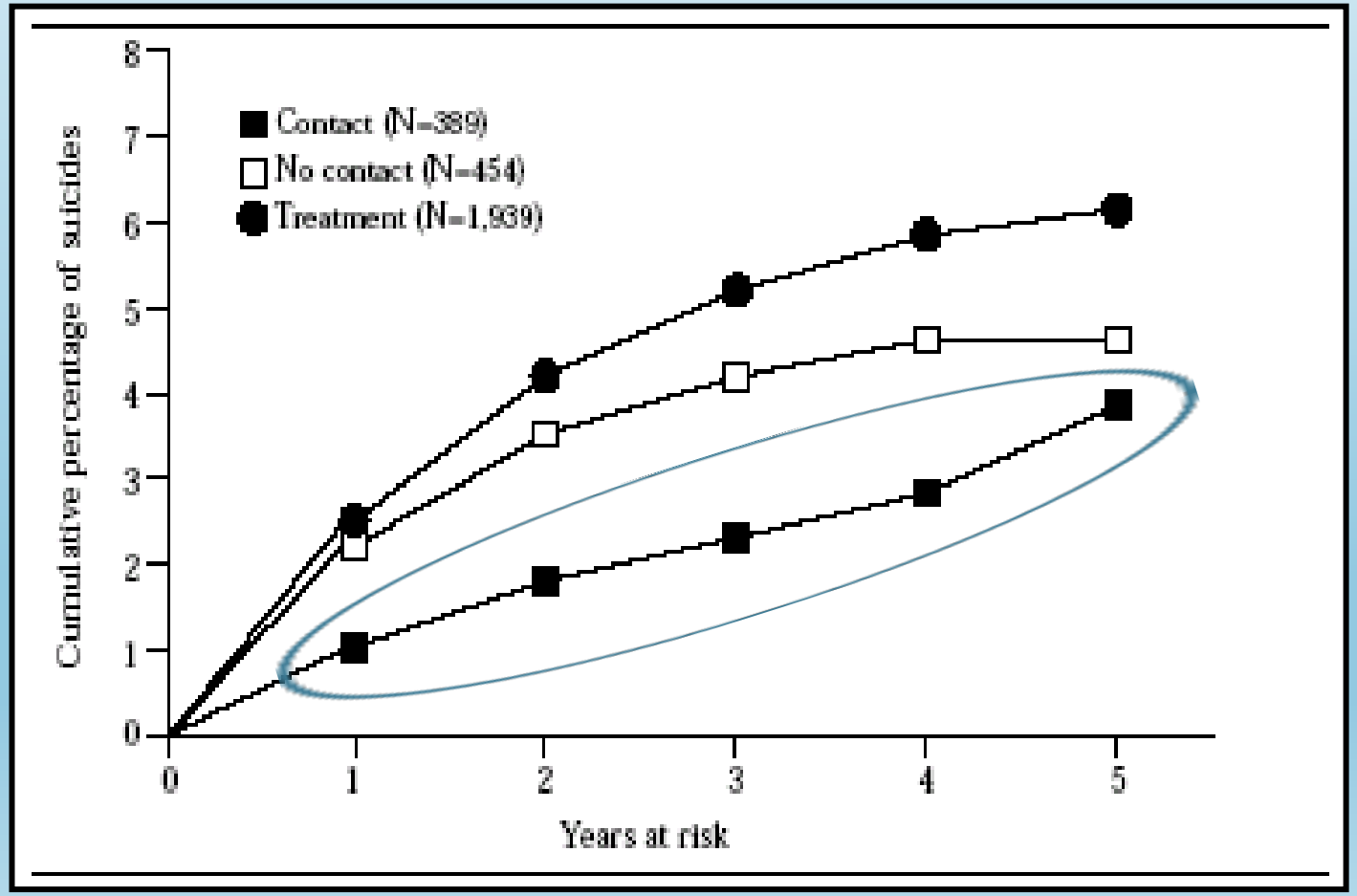


Source: Motto & Bostrom, 2001

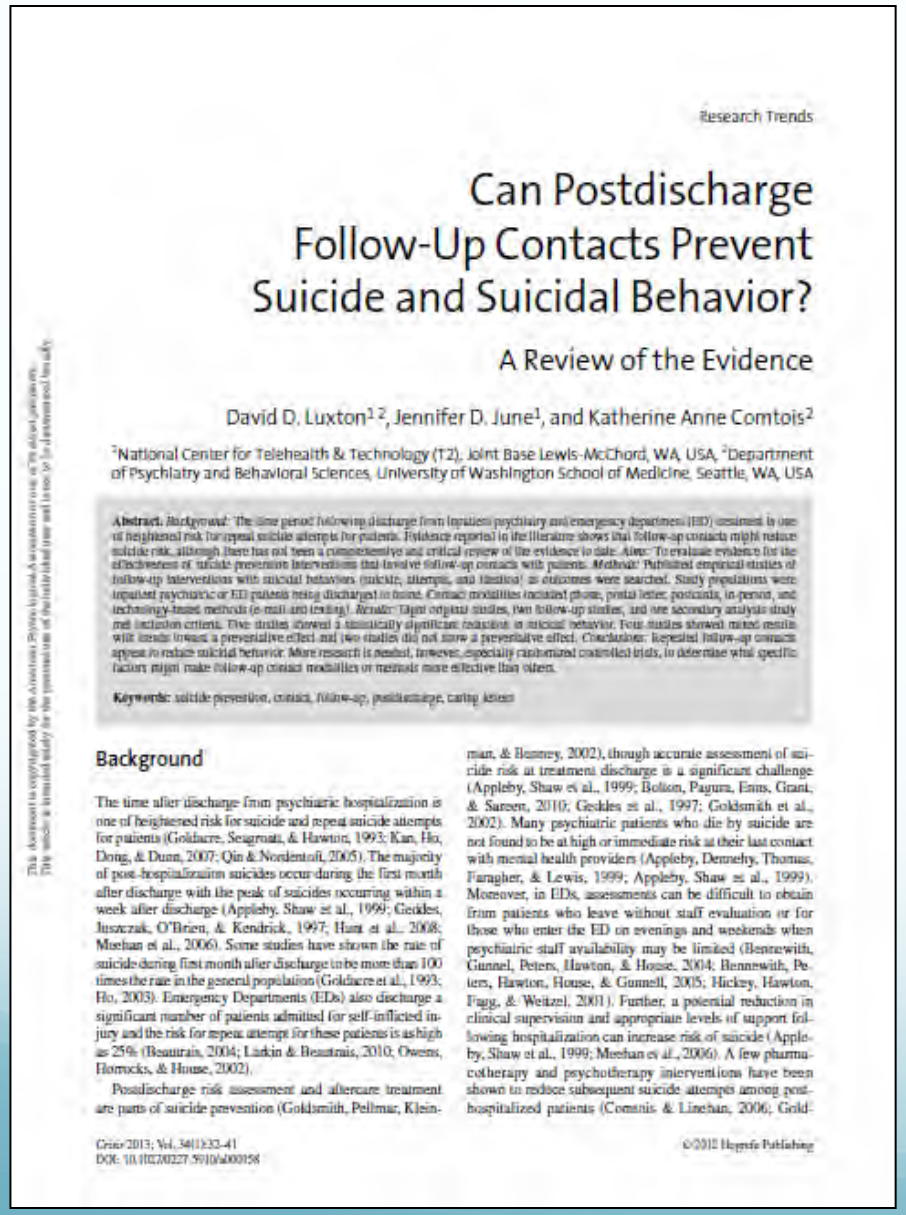
Dear *Patient's Name:*

"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."

(signed by attending M.D.)



Caring Contact Outreach



Research Trends

Can Postdischarge Follow-Up Contacts Prevent Suicide and Suicidal Behavior?

A Review of the Evidence

David D. Luxton[1,2], Jennifer D. June[1], and Katherine Anne Comtois[2]

[1]National Center for Telehealth & Technology (T2), Joint Base Lewis-McChord, WA, USA, [2]Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, Seattle, WA, USA

Abstract. *Background:* The time period following discharge from inpatient psychiatry and emergency department (ED) treatment is one of heightened risk for repeat suicide attempts for patients. Evidence reported in the literature shows that follow-up contacts might reduce suicide risk, although there has not been a comprehensive and critical review of the evidence to date. *Aims:* To evaluate evidence for the effectiveness of suicide prevention interventions that involve follow-up contacts with patients. *Methods:* Published empirical studies of follow-up interventions with suicidal behaviors (suicide, attempts, and ideation) as outcomes were searched. Study populations were inpatient psychiatric or ED patients being discharged to home. Contact modalities included phone, postal letter, postcards, in-person, and technology-based methods (e-mail and texting). *Results:* Eight original studies, two follow-up studies, and one secondary analysis study met inclusion criteria. Five studies showed a statistically significant reduction in suicidal behavior. Four studies showed mixed results with trends toward a preventative effect and two studies did not show a preventative effect. *Conclusions:* Repeated follow-up contacts appear to reduce suicidal behavior. More research is needed, however, especially randomized controlled trials, to determine what specific factors might make follow-up contact modalities or methods more effective than others.

Keywords: suicide prevention, contact, follow-up, postdischarge, caring letters

Background

The time after discharge from psychiatric hospitalization is one of heightened risk for suicide and repeat suicide attempts for patients (Goldacre, Seagroatt, & Hawton, 1993; Kan, Ho, Dong, & Dunn, 2007; Qin & Nordentoft, 2005). The majority of post-hospitalization suicides occur during the first month after discharge with the peak of suicides occurring within a week after discharge (Appleby, Shaw et al., 1999; Geddes, Juszczak, O'Brien, & Kendrick, 1997; Hunt et al., 2008; Meehan et al., 2006). Some studies have shown the rate of suicide during first month after discharge to be more than 100 times the rate in the general population (Goldacre et al., 1993; Ho, 2003). Emergency Departments (EDs) also discharge a significant number of patients admitted for self-inflicted injury and the risk for repeat attempt for these patients is as high as 25% (Beautrais, 2004; Larkin & Beautrais, 2010; Owens, Horrocks, & House, 2002).

Postdischarge risk assessment and aftercare treatment are parts of suicide prevention (Goldsmith, Pellmar, Kleinman, & Bunney, 2002), though accurate assessment of suicide risk at treatment discharge is a significant challenge (Appleby, Shaw et al., 1999; Bolton, Pagura, Enns, Grant, & Sareen, 2010; Geddes et al., 1997; Goldsmith et al., 2002). Many psychiatric patients who die by suicide are not found to be at high or immediate risk at their last contact with mental health providers (Appleby, Dennehy, Thomas, Faragher, & Lewis, 1999; Appleby, Shaw et al., 1999). Moreover, in EDs, assessments can be difficult to obtain from patients who leave without staff evaluation or for those who enter the ED on evenings and weekends when psychiatric staff availability may be limited (Bennewith, Gunnel, Peters, Hawton, & House, 2004; Bennewith, Peters, Hawton, House, & Gunnell, 2005; Hickey, Hawton, Fagg, & Weitzel, 2001). Further, a potential reduction in clinical supervision and appropriate levels of support following hospitalization can increase risk of suicide (Appleby, Shaw et al., 1999; Meehan et al., 2006). A few pharmacotherapy and psychotherapy interventions have been shown to reduce subsequent suicide attempts among post-hospitalized patients (Comtois & Linehan, 2006; Gold-

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- Caring letters
- Caring postcards
- Caring phone calls
- Caring emails
- Caring texts
- ED follow-up calls
- Inpatient follow-up phone calls
- Post-discharge home visits (e.g., VA)

People who are suicidal do not seek mental health care…

Coping With Thoughts of Suicide: Techniques Used by Consumers of Mental Health Services

Mary Jane Alexander, Ph.D.
Gary Haugland, M.A.
Peter Ashenden, B.S.
Ed Knight, Ph.D.
Isaac Brown

Coping strategy	First responses (N=198) Rank[a]	N	%	All responses (N=745) Rank[a]	N	%
Spirituality and religious practices	1	36	18	3	104	14
Talking to someone and companionship	2	27	14	1	118	16
Positive thinking	3	26	13	2	106	14
Using the mental health system	4	23	12	4	71	10
Considering consequences to people close to me		18	9	7	50	7
Using peer supports	6	16	8	6	55	7
Doing something pleasurable	6		8	5	63	9
Protecting myself from means of harm	8	10	5	10	25	3
Doing grounding activities	9	8	4	8	45	6
Considering consequences to self	10	5	3	9	30	4
Doing tasks to keep busy	11	4	2	11	24	3
Maintaining sobriety	12	3	2	15	6	1
Finding a safe place	13	2	1	12	17	2
Helping others	14	1	1	13	10	1
Seeking emotional outlets	14	1	1	14	8	1
Resting	—	0	—	16	7	1
Cannot categorize	—	2	1	—	6	1

[a] When values tie for the same rank, the next rank is skipped.


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Treatment of suicidal people around the world†

R. Bruffaerts, K. Demyttenaere, I. Hwang, W.-T. Chiu, N. Sampson, R. C. Kessler, J. Alonso, G. Borges, G. de Girolamo, R. de Graaf, S. Florescu, O. Gureje, C. Hu, E.-G. Karam, N. Kawakami, S. Kostyuchenko, V. Kovess-Masfety, S. Lee, D. Levinson, H. Matschinger, J. Posada-Villa, R. Sagar, K. M. Scott, D. J. Stein, T. Tomov, M. C. Viana and M. K. Nock


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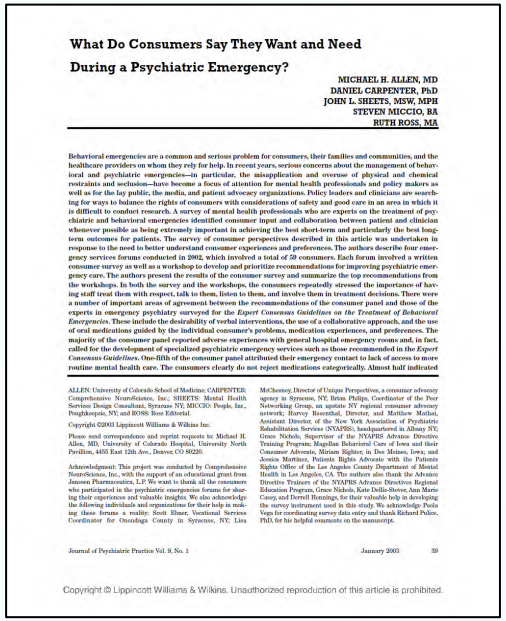
Editorial

Cross-cultural attitudes to help-seeking among individuals who are suicidal: new perspective for policy-makers†

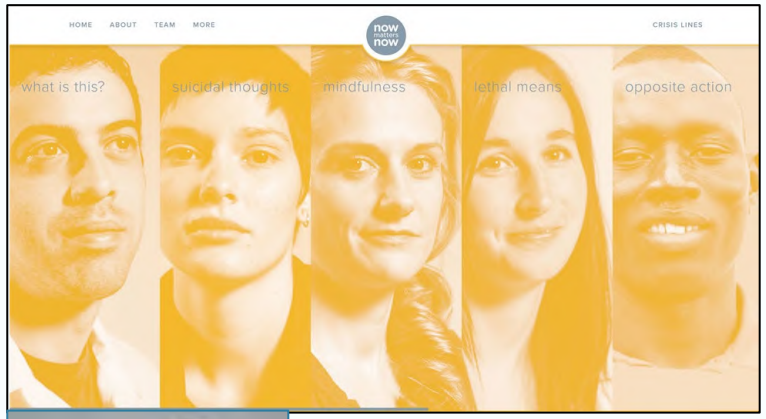
Alexandra Pitman and David P. J. Osborn

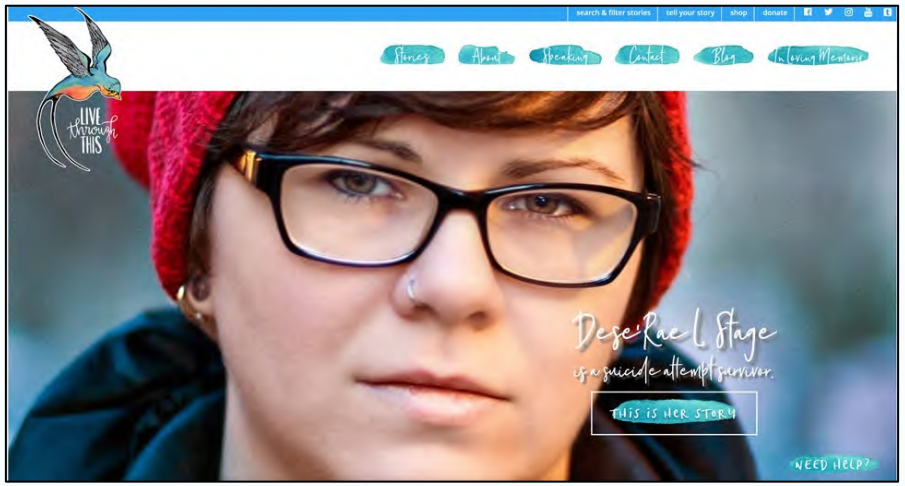

What Do Consumers Say They Want and Need During a Psychiatric Emergency?

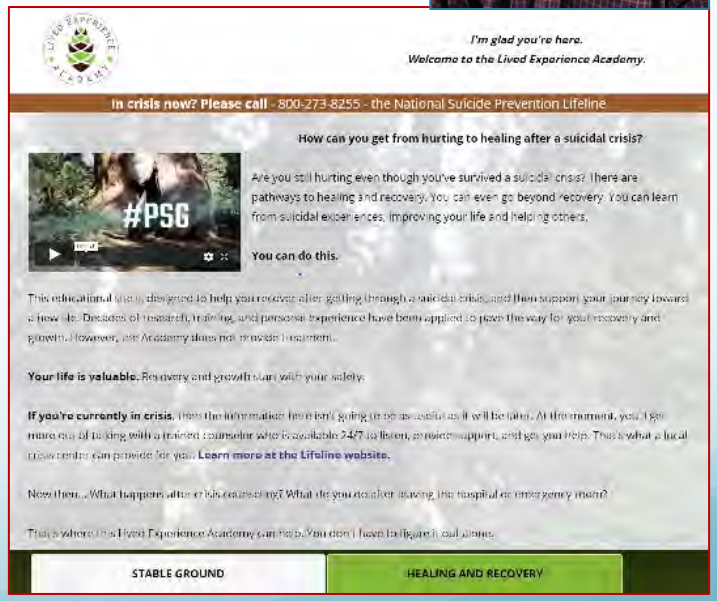
MICHAEL H. ALLEN, MD
DANIEL CARPENTER, PhD
JOHN L. SHEETS, MSW, MPH
STEVEN MICCIO, BA
RUTH ROSS, MA

- Most who are suicidal do not receive mental health care
- Most *do not want to seek mental health care* because of their attitudes towards mental health
- When they do seek care (e.g., ED-based care), they want something quite different than what they get (e.g., a more humanistic and person-centered response)

Lived-Experience Peer-Based Support







And the power of using technology to reach more people at risk for suicide...

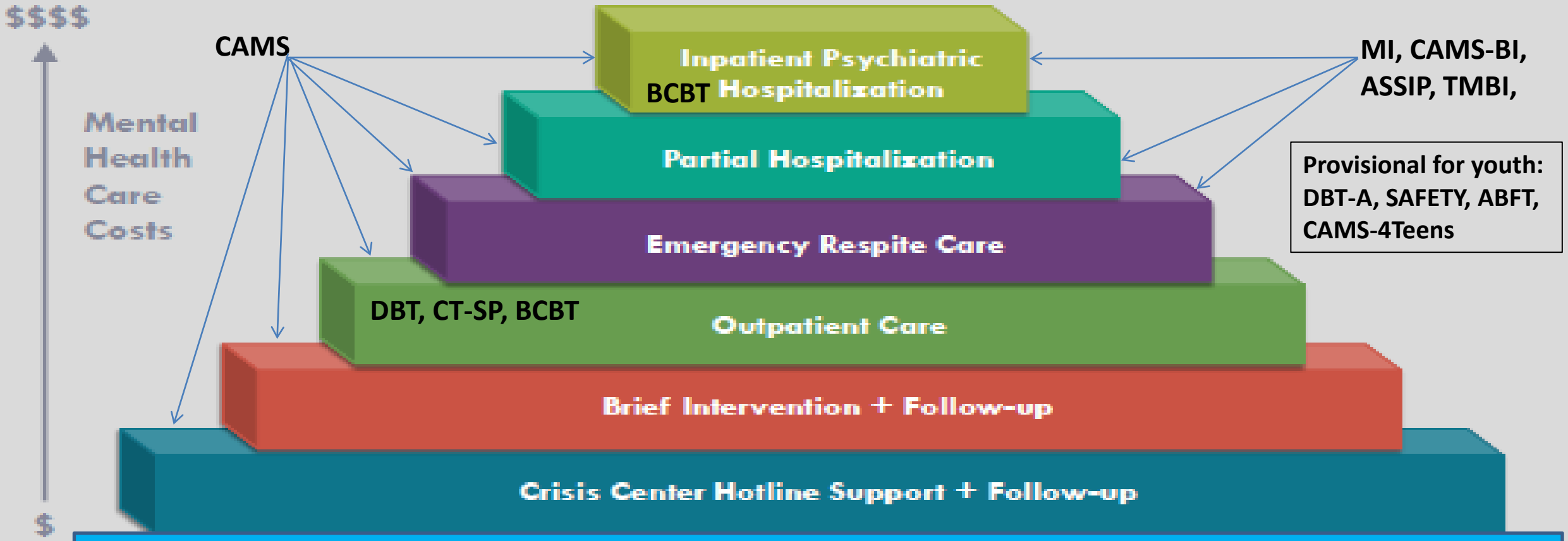
A Stepped Care Model for Suicide Care

Stabilization Planning + Lethal Means Safety + caring follow-up used throughout the model

Suicide-specific Care at Each Step

From Least to Most Restrictive Intervention

Suicide-focused care that is:
- **evidence-based**
- **least-restrictive**
- **cost-effective**



Mental Health Service Corp—paraprofessionals (and people with lived experience) creating the necessary work force