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CLINICAL WEBINARS

FOR HEALTH SERVICE PSYCHOLOGISTS

TRANSLATING RESEARCH TO PRACTICE

A Common Sense Approach to Clinical Suicidology and Risk Management

David A. Jobes, Ph.D., ABPP
Professor of Psychology
Director, Suicide Prevention Laboratory
The Catholic University of America

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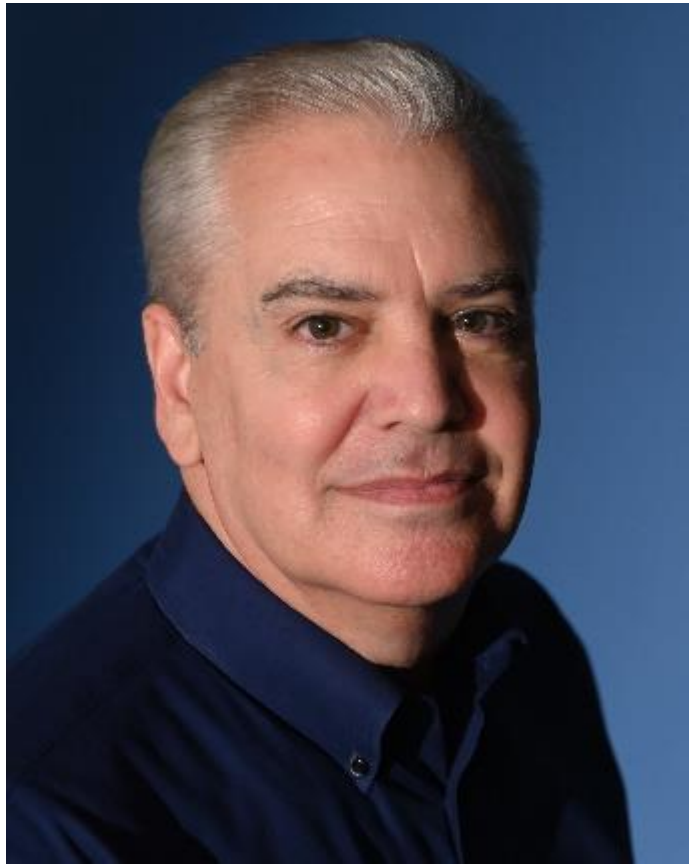
David A. Jobes, PhD, ABPP



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Disclosures

- Two NIMH treatment research grants and one NIAAA grant
- Book royalties (APA Press and The Guilford Press)
- Founder and Partner, CAMS-care, LLC (professional training and consultation)
- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy of the Department of Defense, the Department of the Army, the US Army Medical Department, Veteran's Affairs, or the United States Government.

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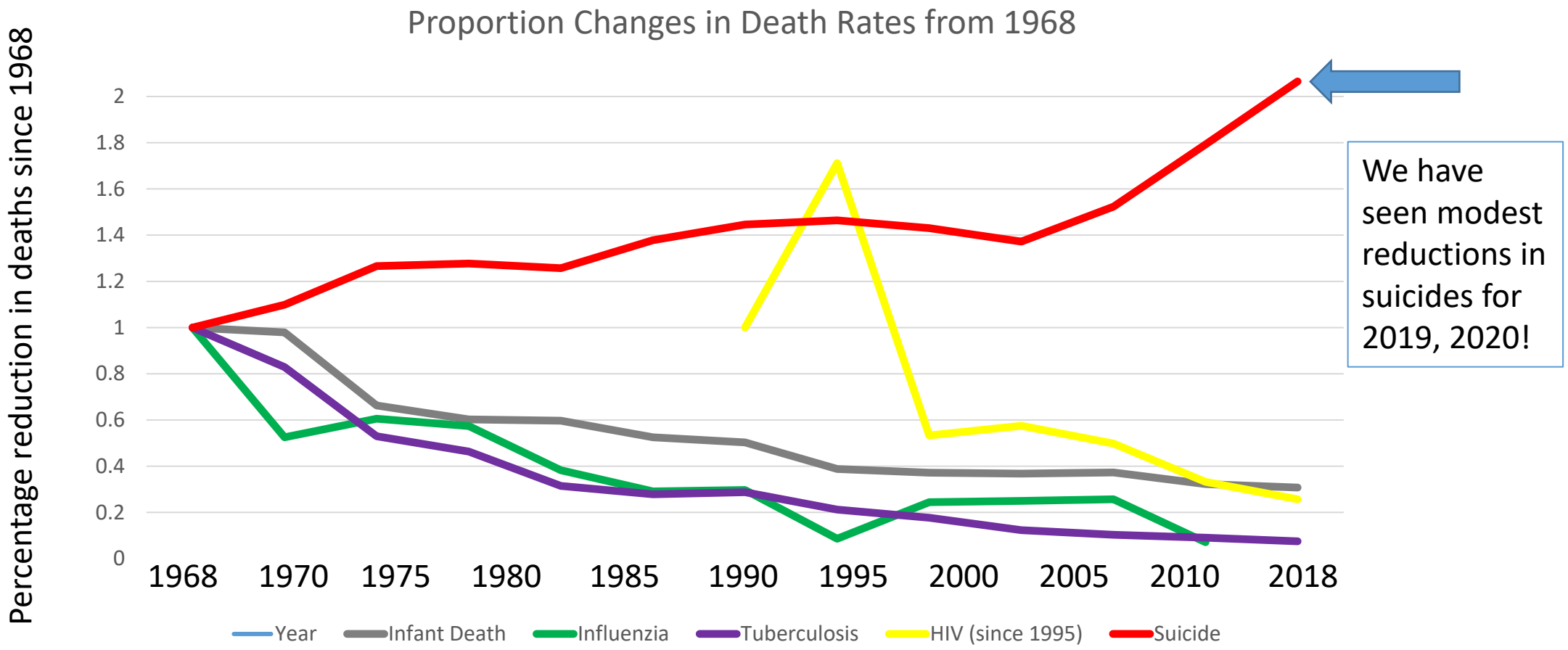
Learning Objectives

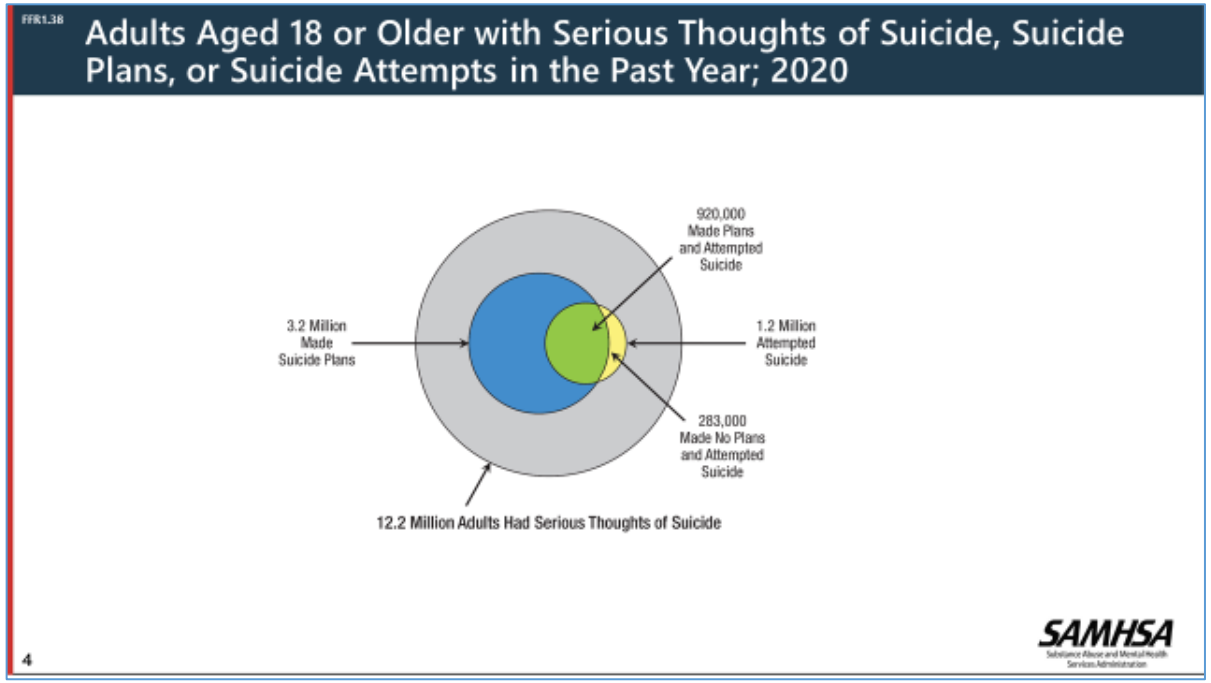
1. List components of informed consent relevant to working with suicidal risk.
2. Demonstrate screening and assessment approaches for suicidal risk.
3. Discuss effective management of suicidal crises and treatment of suicidal risk.

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



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

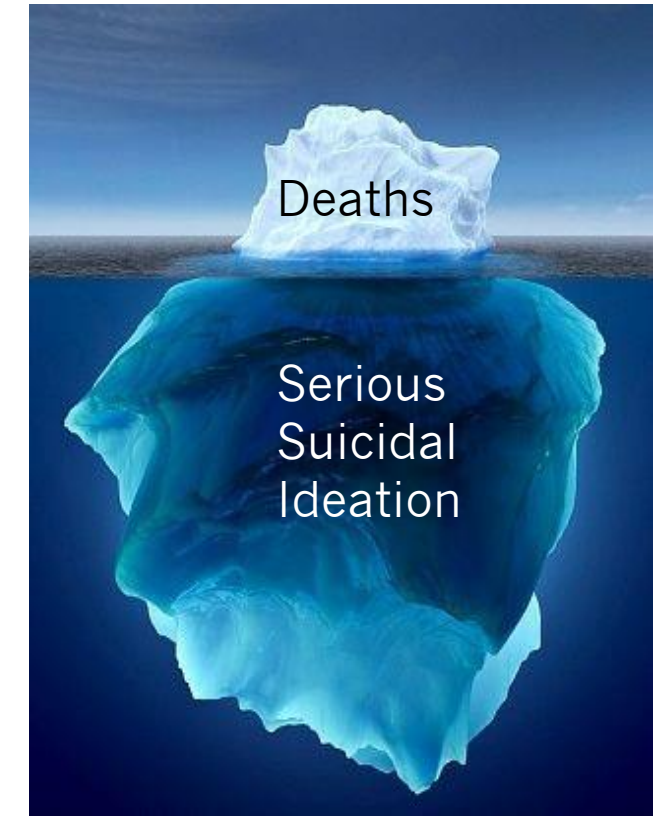
The Importance of Suicidal Ideation



Editorial

Reflections on Suicidal Ideation

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



We are understandably preoccupied with 1.2M attempts and 47,949 deaths in 2020. But what about the largest population challenge of all—those people with *serious thoughts of suicide* in the past 30 days?

2020 CDC YRBS data adds another 3,000,000 adolescents with serious thoughts of suicide

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15,000,000 total Americans with serious suicidal thoughts!

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The field has a professional crisis…

FOCUS ON ETHICS
Jeffrey E. Barnett, Editor

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

David A. Jobes
The Catholic University of America

M. David Rudd
Texas Tech University

James C. Overholser
Case Western Reserve University

Thomas E. Joiner Jr.
Florida State University

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

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

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

David A. Jobes

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

DAVID A. JOBES received his PhD in clinical psychology at American University, and he completed his clinical internship at the Washington, DC, Veterans Affairs Medical Center. He is a professor of psychology and a codirector of clinical training at The Catholic University of America. He maintains a private clinical and forensic practice at the Washington Psychological Center (Washington, DC). His areas of professional interest include clinical suicidology, ethics, and risk management.

M. DAVID RUDD received his PhD in psychology from the University of Texas–Austin and completed his internship in clinical psychology at Silas B. Hays Army Community Hospital, Fort Ord, California. He completed 2 years of postdoctoral training at the Beck Institute in Philadelphia. He is a professor and chair of the Department of Psychology at Texas Tech University and also maintains a part-time private practice and risk management consulting business.

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THOMAS E. JOINER JR. received his PhD in clinical psychology from the University of Texas at Austin. He is a distinguished research professor and the Bright-Burton professor of psychology at Florida State University. His areas of research interest are the psychology, neurobiology, and treatment of suicidal behavior and related conditions.

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Professional Psychology: Research and Practice 2009, Vol. 40, No. 4, 405–413

0735-7028/09/$12.00 DOI: 10.1037/a0012896

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.

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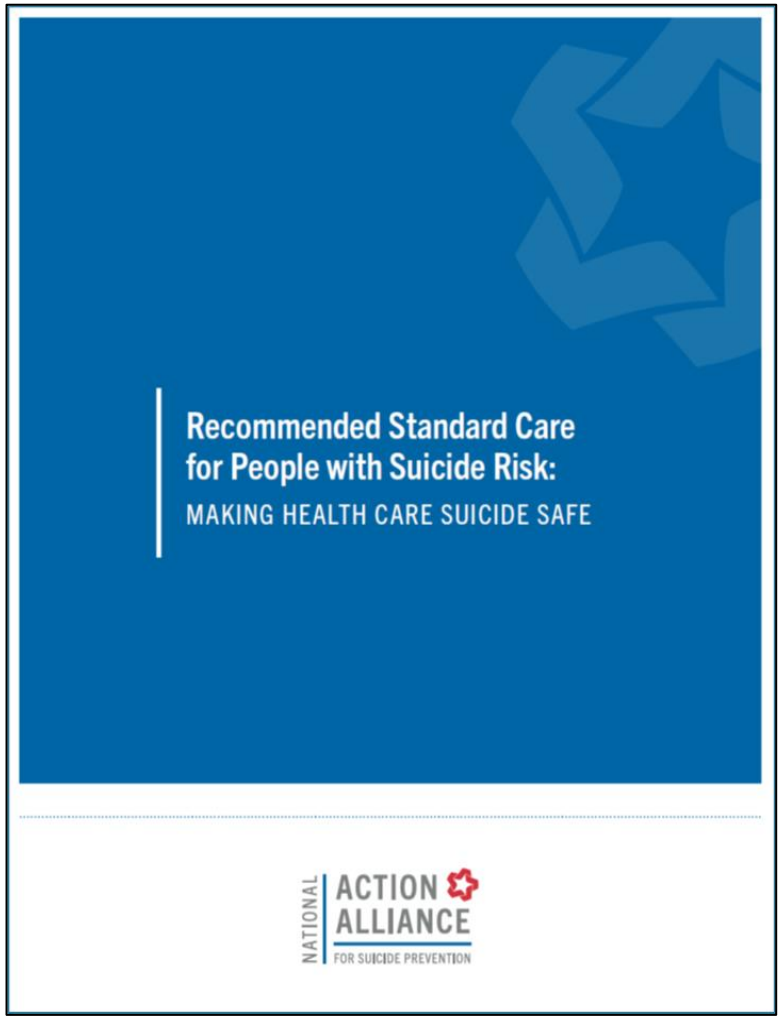
A Commonsense Approach to Clinical Suicidology



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

Journal of Health Service Psychology
https://doi.org/10.1007/s42843-020-00020-1

Commonsense Recommendations for Standard Care of Suicidal Risk

David A. Jobes

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Abstract

Suicide is the tenth leading cause of death in the United States, yet many mental health providers have limited academic-based training in its assessment and treatment. A commonsense approach to caring for suicide risk includes (a) identification, (b) assessment, (c) safety planning with lethal means discussion and offer of resources, and (c) the use of caring contact. In addition, it is optimal to explore the specifics of the patient's suicidal struggle to better understand, manage, and treat those issues and problems that compel the patient to consider suicide. Examples of the phrasing for interventions and clinically relevant commentary are provided.

Keywords Suicide · Suicidal risk · Suicidal assessment · Safety plans · Lethal means · Caring contact

Vignettes

Tom Groves, PhD, is a 55-year-old clinical psychologist who has maintained a successful private practice in a medium-sized metropolitan area for 25 years. Over his career he has seen a handful of suicidal patients, but now he does not want to see any suicidal patients. To this end, he has developed an intake process to identify potential suicidal risk and refer away any such patient (although he has a tough time finding colleagues who will take a suicidal patient). His avoidance of suicidal cases is largely based on an extremely negative experience about five years ago when a new patient, "June," was referred by a trusted colleague. In their third session, June readily acknowledged having frequent suicidal thoughts and a history of past attempts including overdoses, cutting, and one serious attempt to hang herself by a rope that broke. As he had done with previous suicidal cases, he immediately moved to get June hospitalized given her history and current suicidal thoughts and to get his consulting psychiatrist involved to prescribe some medication. The patient was surprised by his sudden moves and fought against hospitalization and medication. He ultimately had to call the police and have her committed against her will. She was hospitalized for four days and then signed out against medical advice, demanding a follow-up appointment with Tom. She left abusive messages on his voicemail and threatened to hire an attorney because of his "malpractice." He ignored her appeals and threats, and she finally left him alone. It was a harrowing experience, and he firmly decided that he was done seeing suicidal patients for good.

Debra Jones is a 28-year-old graduate student in clinical psychology doing her internship in a university counseling center. Her patient, "Dan," is a 20-year-old junior engineering student who was recently dumped by his girlfriend, Gail (after three years of dating). Dan was convinced that Gail "was the one" and the relationship ending was devastating. In the wake of this breakup Dan had been oversleeping, skipping classes, drinking, and smoking marijuana. He had become quite depressed and was in academic trouble. Dan was Debra's first suicidal client, and she was determined to help him. Her clinical supervisor was skittish about Debra seeing Dan and frequently suggested hospitalization. Against Dan's preference, her supervisor pressed for him to see their consulting nurse practitioner for medication. Dan was subsequently prescribed an SSRI for depression and a benzodiazepine to be used PRN for episodes of anxiety. Dan said he felt "wired" on the antidepressant and suddenly stopped taking the medicine after a week. He quickly went through the anxiolytic and wanted to increase the dose because it was the only thing that made him feel better. At the end of each session, Debra had Dan sign a "no-suicide contract" (which the counseling center used), but its use felt ineffective and Dan increasingly resented signing it. Debra really cared about Dan but felt lost. Her supervisor was increasingly worried and told Debra she was in over her head and pressed to refer Dan away to another agency or provider. The case had created a lot of tension within the supervisory relationship.

The Clinical Challenge of Suicide Risk

The challenges of working with suicidal risk can be formidable. Suicidal states can wax and wane. Some patients who have no intention to die will insist that they are in imminent

Published online: 30 October 2020

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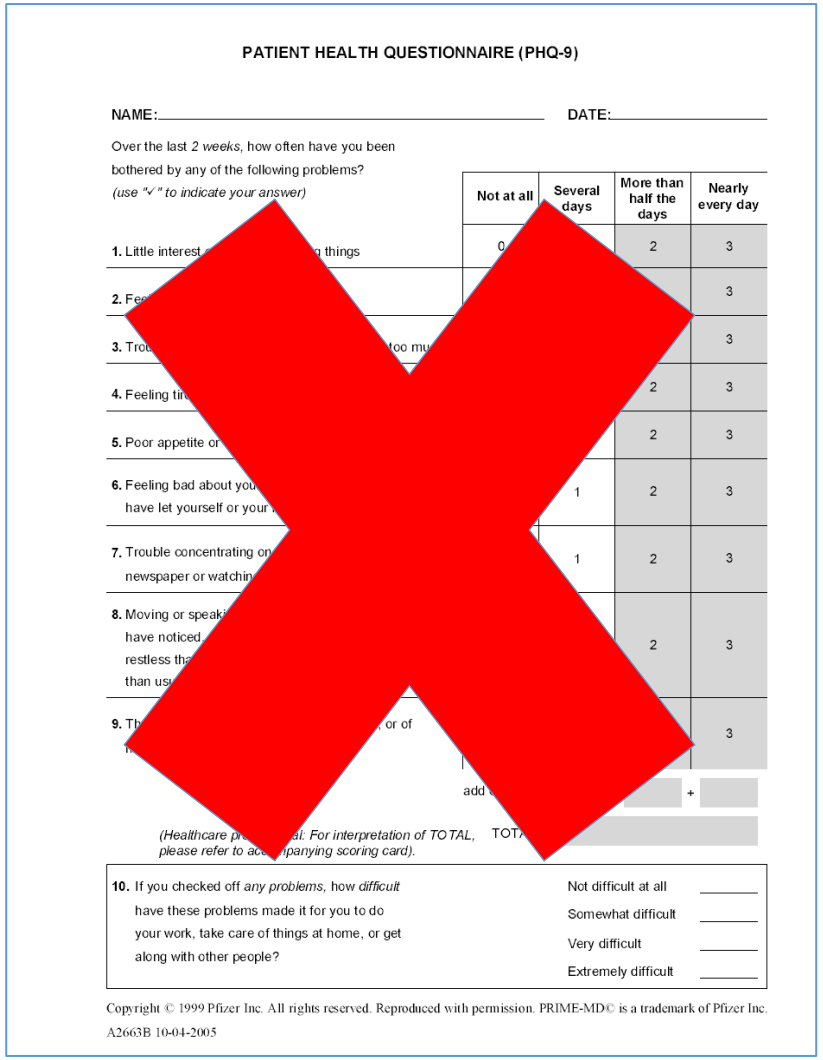
Screening & Assessment for Suicidal Risk



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. Fee…				3
3. Trou… too mu…				3
4. Feeling ti…			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 tha… than us…			2	3
9. Th… or of …				3
		add …	+	

(Healthcare pr… al: For interpretation of TOTAL, please refer to ac… panying scoring card). TOT…

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	_____

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

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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…

Actuarial assessments always beat clinical judgement!

Professor Paul Meehl

And hundreds more!

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Managing Acute Risk: Stabilization Planning

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

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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.

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',[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'.

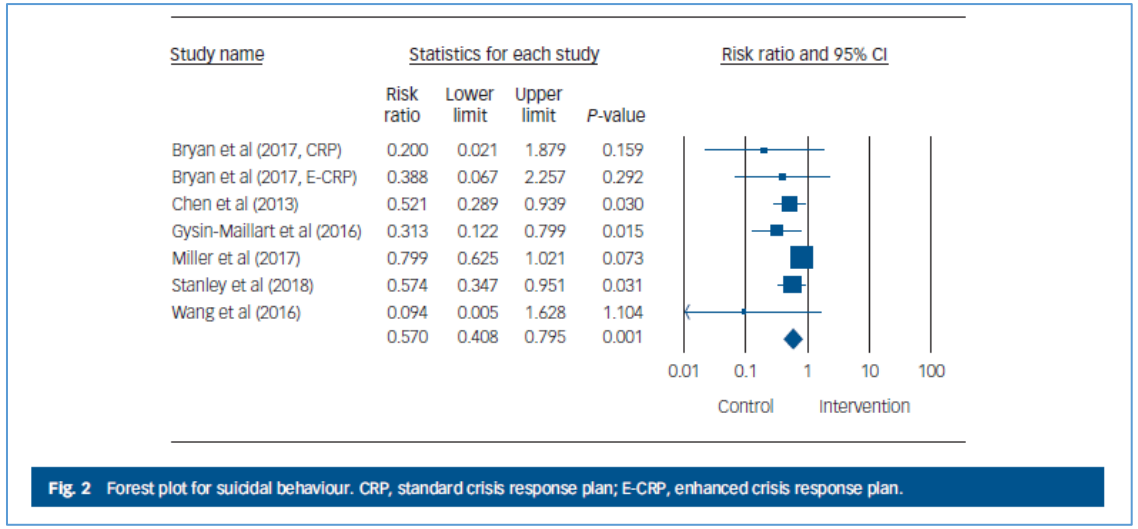


Fig. 2 Forest plot for suicidal behaviour. CRP, standard crisis response plan; E-CRP, enhanced crisis response plan.

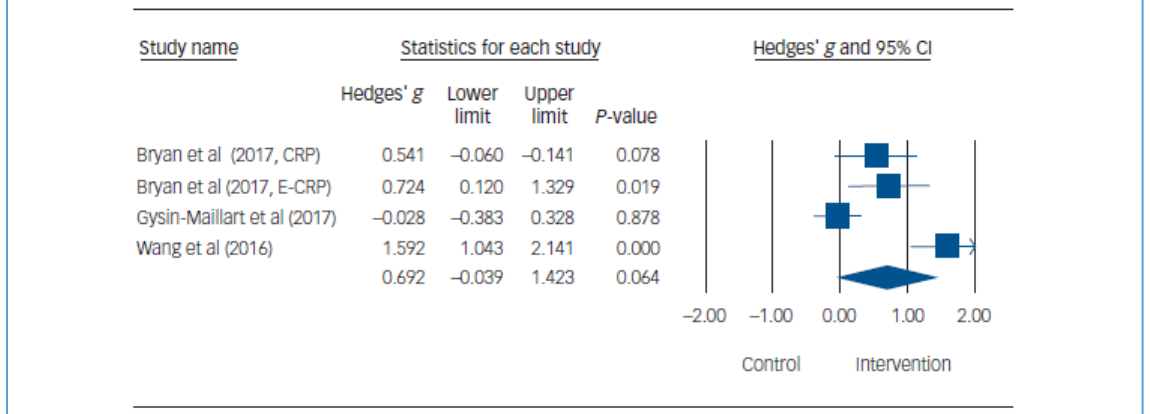


Fig. 3 Forest plot for suicidal ideation. CRP, standard crisis response plan; E-CRP, enhanced crisis response plan.

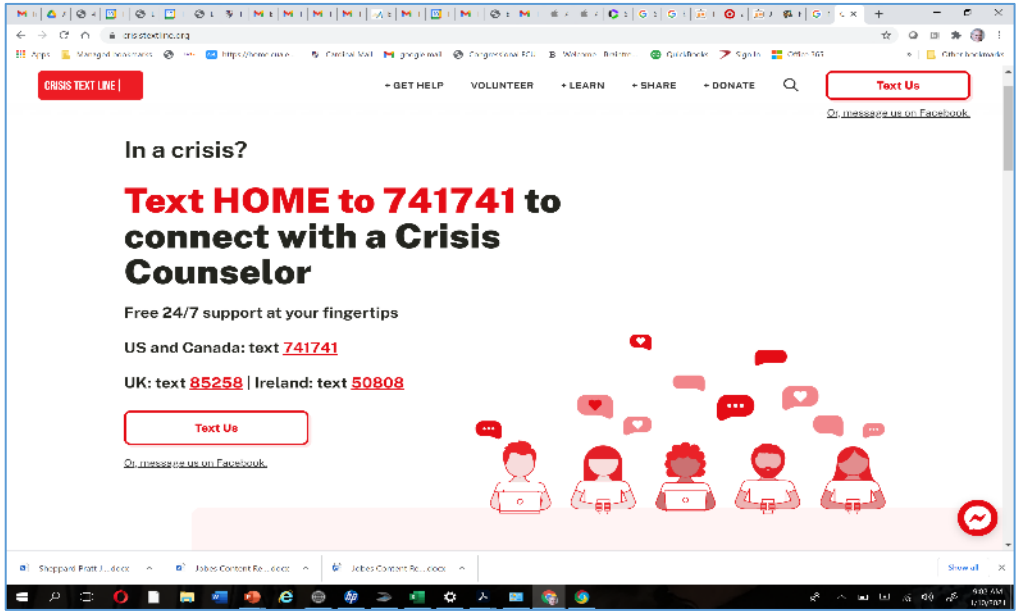
Managing Acute Suicidal Risk: Crisis Lifeline and Textline and lethal means safety

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

Logo of the National Suicide Prevention Lifeline

Formation	December 6, 2004[1][2]
Purpose	Suicide prevention
Headquarters	50 Broadway, New York City, New York, U.S. 10004
Region	Nationwide
Official language	English
Key people	Dr. John Draper
Volunteers (2014)	150
Website	suicidepreventionlifeline.org (https://suicidepreventionlifeline.org/)

1) Always provide Lifeline/Textline number
2) Discuss access to lethal means
3) Verify that means have been secured
4) Consider providing access to your own number



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< Previous Article | September 2014 Volume 47, Issue 3, Supplement 2, Pages S264–S272 | Next Article >

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Reducing a Suicidal Person's Access to Lethal Means of Suicide

A Research Agenda

Catherine W. Barber, MPA, Matthew J. Miller, MD, ScD
Harvard Injury Control Research Center, Harvard School of Public Health, Boston, Massachusetts

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

The importance of lethal means safety discussions

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A big idea that has been brewing for 27 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

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Steidman 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

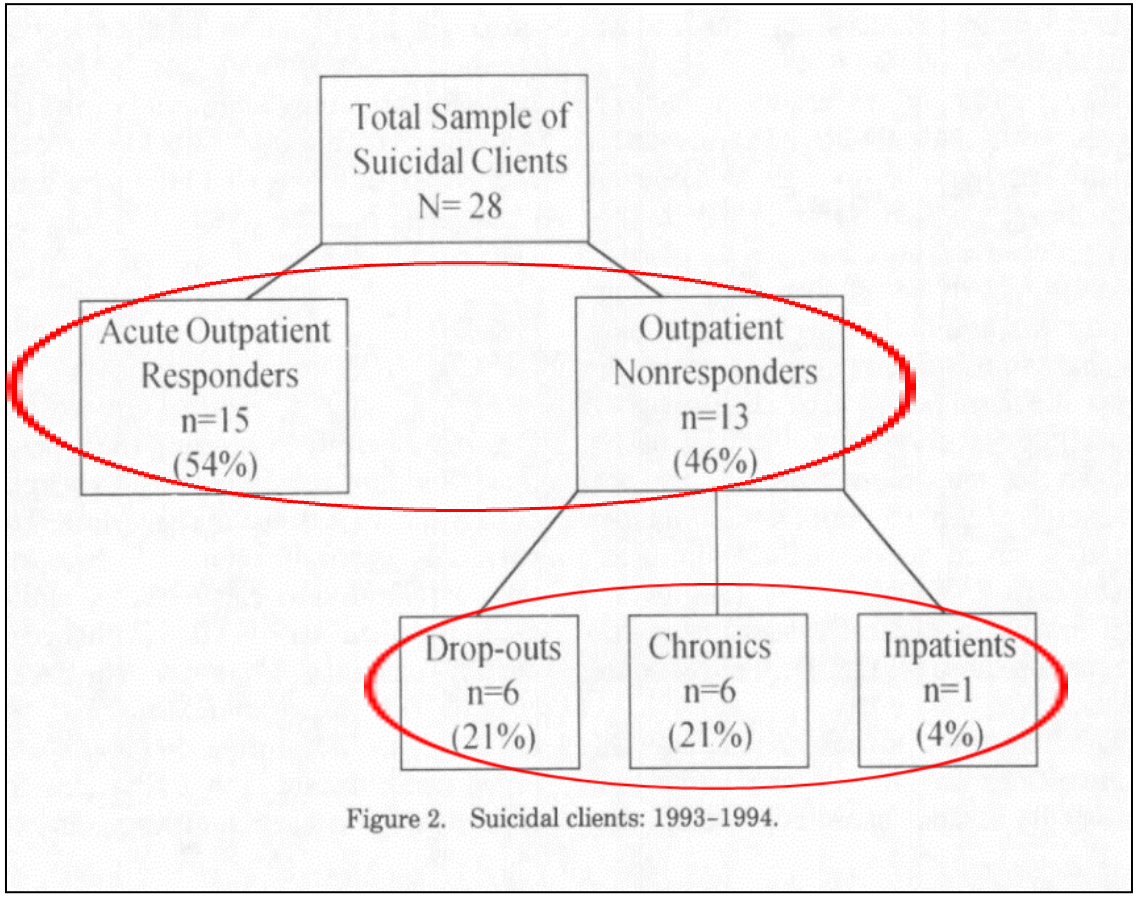


Figure 2. Suicidal clients: 1993–1994.

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).

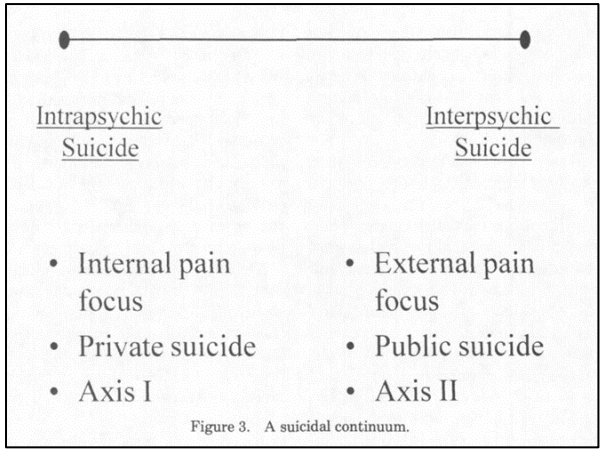


Figure 3. A suicidal continuum.

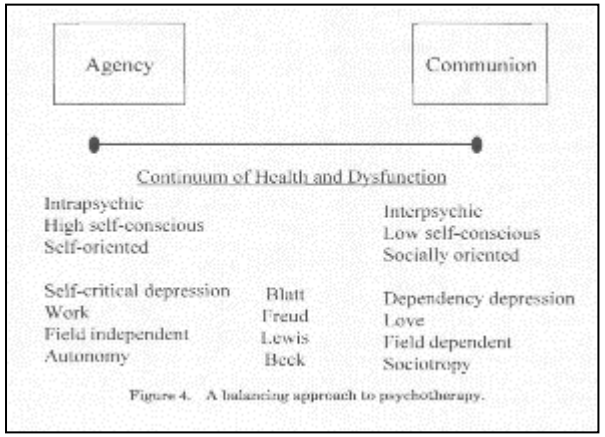
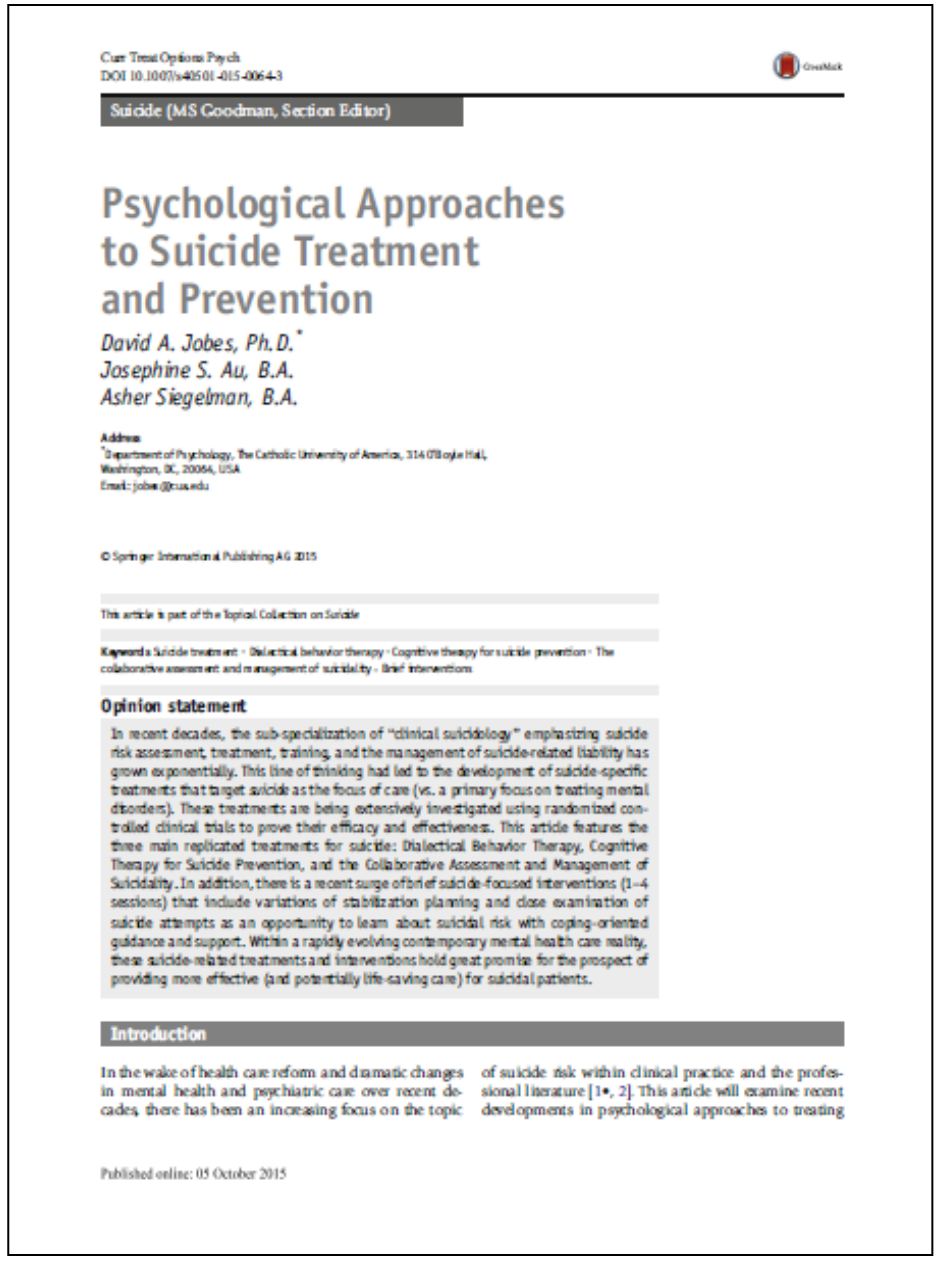


Figure 4. A balancing approach to psychotherapy.

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

Evidence-Based Treatments for Suicidal Risk



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.

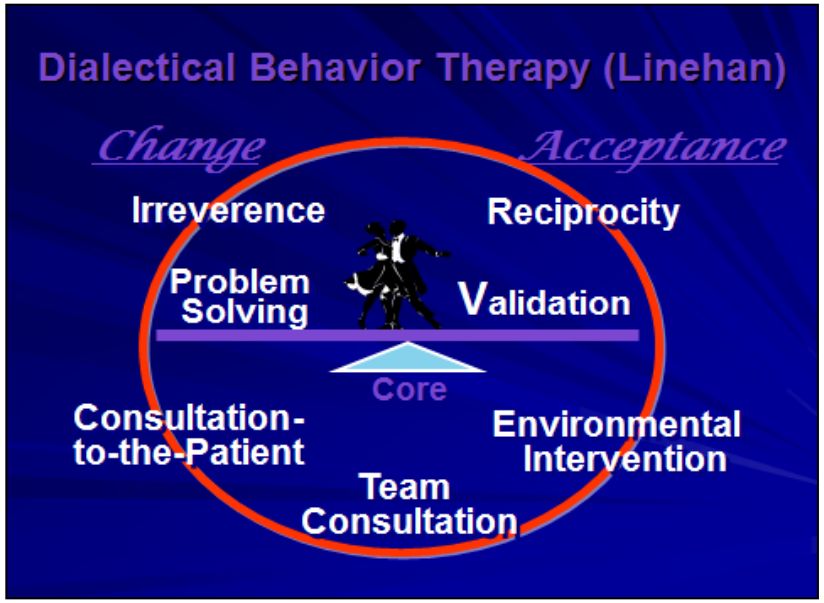
Introduction

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

Published online: 05 October 2015

- There are 100+ RCT's with suicidal ideation and behavioral outcomes
- There is no support for inpatient hospitalization; there is increased risk of suicide post-discharge
- There are a handful of treatments with single RCT support in need of replication (e.g., ASSIP and mentalization-based therapy)
- There are now well-studied suicide-specific interventions with *replicated* RCT support; these include:
  - Dialectical Behavior Therapy (DBT)
  - Two types of suicide-specific CBT (CT-SP & BCBT)
  - Collaborative Assessment and Management of Suicidality (CAMS)
  - Non-demand follow-up "caring contact"

Dialectical Behavior Therapy (DBT)



ORIGINAL ARTICLE

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

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

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

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

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

Setting: University outpatient clinic and community practice.

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

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

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

Results: Dialectical behavior therapy was associated with better outcomes in the intent-to-treat analysis than community treatment by experts in most target areas during the 2-year treatment and follow-up period. Subjects receiving DBT were half as likely to make a suicide attempt (hazard ratio, 2.66; $P=.005$), required less hospitalization for suicide ideation ($F_{1,82}=7.3$; $P=.004$), and had lower medical risk ($F_{1,30}=3.2$; $P=.04$) across all suicide attempts and self-injurious acts combined. Subjects receiving DBT were less likely to drop out of treatment (hazard ratio, 3.2; $P<.001$) and had fewer psychiatric hospitalizations ($F_{1,82}=6.0$; $P=.007$) and psychiatric emergency department visits ($F_{1,82}=2.9$; $P=.04$).

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

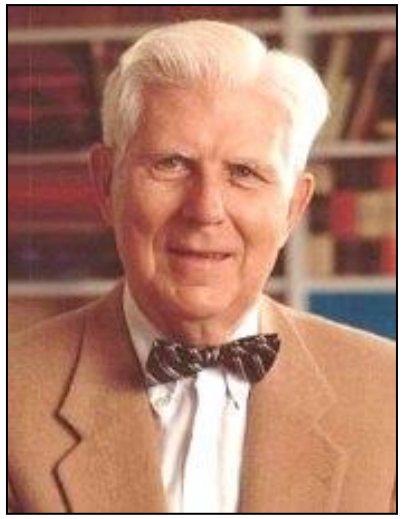
Arch Gen Psychiatry. 2006;63:757-766

SUICIDAL BEHAVIOR IS A BROAD term that includes death by suicide and intentional, nonfatal, self-injurious acts committed with or without intent to die. It is associated with several mental disorders, including depression, substance dependence, and schizophrenia. Borderline personality disorder (BPD) is 1 of only 2 *DSM-IV* diagnoses for which suicidal behavior is a criterion.[1] Borderline personality disorder is a severe and persistent mental disorder experience of severe emotional distress and behavioral dyscontrol.[1-3] Among patients with BPD, 60% to 80% engage in suicidal behavior,[4-9] with a suicide rate of up to 9%.[10] Forty percent of the highest users of inpatient psychiatric services receive a diagnosis of BPD.[11,12] Patients with BPD use more services than those with major depression[13] and other personality disorders.[14] Among patients with BPD seen for treatment, 72% have had at least 1 psychiatric hospitalization and 97% have received outpatient treatment from a mean of 6.1 previous therapists.[15,16] Despite this high-use pattern, patients with BPD have high rates of treatment failure.[17,18]

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

Author Affiliations are listed at the end of this article.

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 (asymptotics 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

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[13-15] have highlighted the need for randomized controlled trials with sufficient power to detect treatment differences.[16]

For editorial comment see p 623.

Author Affiliations: Departments of Psychiatry (Drs Brown and Beck) and Emergency Medicine (Dr Hollander) and Center for Clinical Epidemiology and Biostatistics (Drs Ten Have and Xie), University of Pennsylvania, Philadelphia; and Department of Graduate Psychology, James Madison University, Harrisonburg, Va (Dr Henriques).
Corresponding Author: Gregory K. Brown, PhD, Department of Psychiatry, University of Pennsylvania, 3535 Market St, Room 2020, Philadelphia, PA 19104 (gregbrow@mail.med.upenn.edu).

CAMS-care
Preventing Suicide

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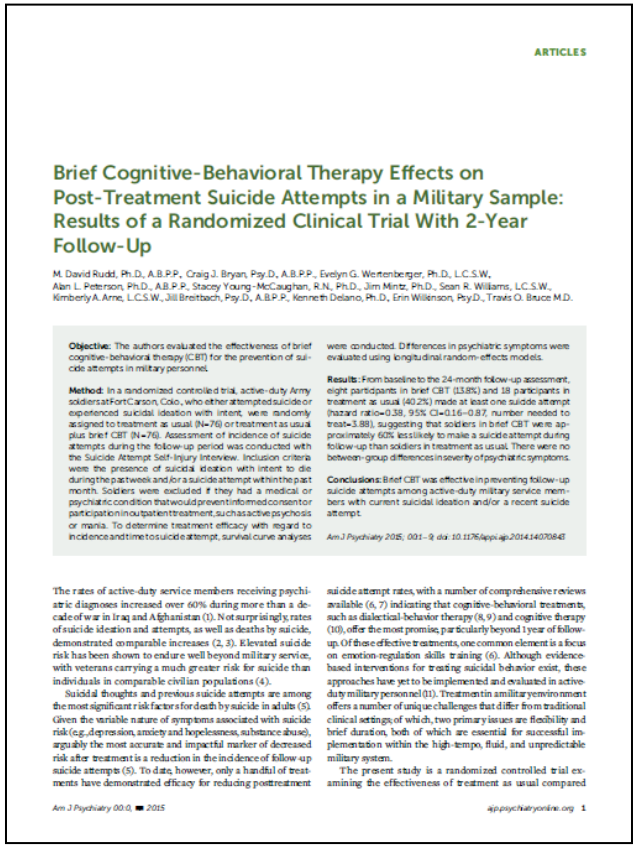
Brief Cognitive Behavior Therapy (BCBT)

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 Willenson, 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 60% less likely to make a suicide 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.2014.14070843

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

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

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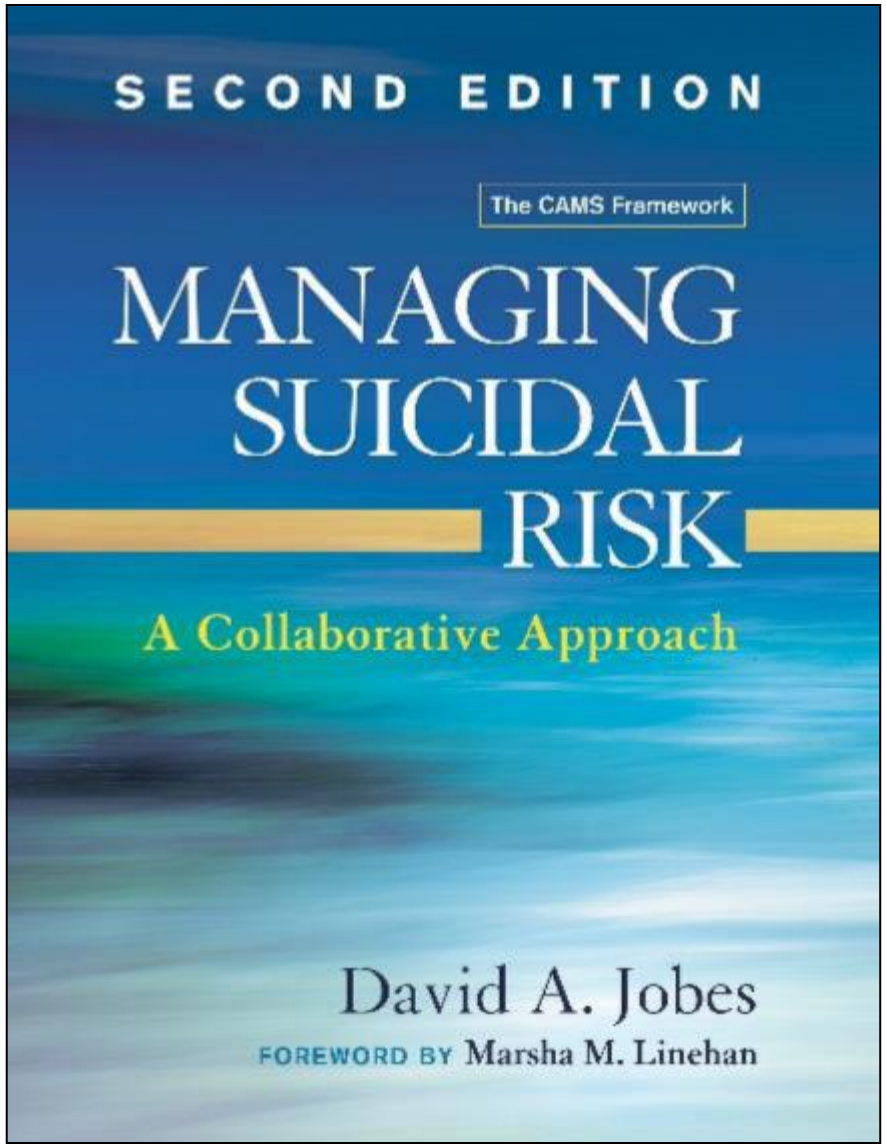
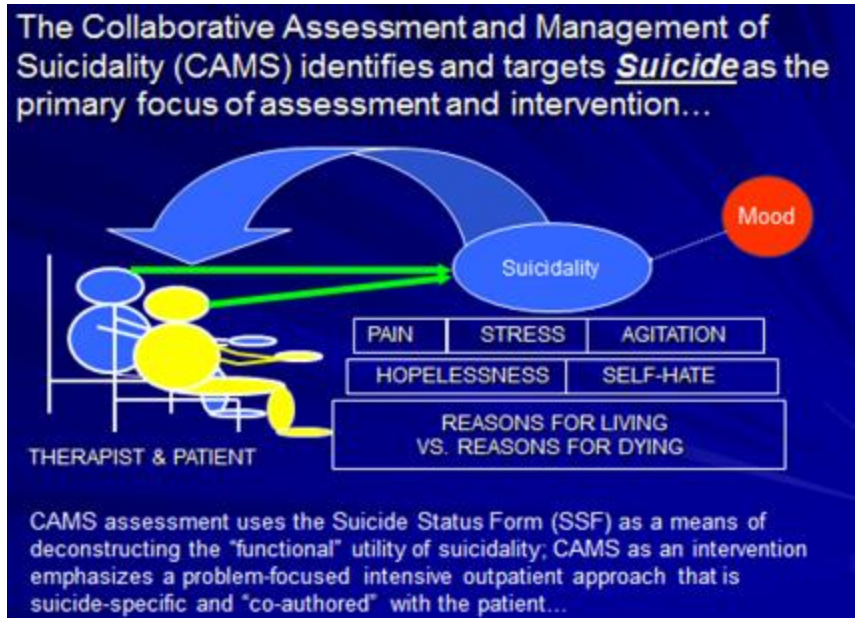
The Collaborative Assessment and Management of Suicidality (CAMS)





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"

Adherence to the CAMS Approach

CAMS is a therapeutic framework, used until suicidal risk resolves. Adherence requires thorough suicide assessment and treatment of patient-defined suicidal "drivers"

CAMS Philosophy

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

CAMS as Therapeutic Framework

- Focus on Suicide—from beginning to middle to end
- Outpatient Oriented—goal is to keep a suicidal patient in outpatient care
- Flexible and "Nondenominational"—across theories and techniques


CAMS Suicide Status Form Initial Session

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

Section A (Patient):

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

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 feel 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 feel 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
1/5	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; hating no self-esteem; hating 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)

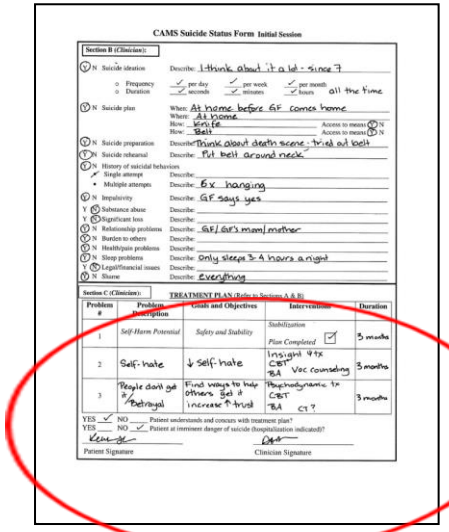
1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 : completely
2) How much is being suicidal related to thoughts and feelings about others? Not at all: 1 2 3 4 5 : completely

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 dont get it / they dont care
2	maybe something will get better	3	nothing is going to change
		4	I dont contribute to society
1	See how 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 flash thing on everyone. And then myself


CAMS Suicide Status Form Initial Session

Section B (Clinician):

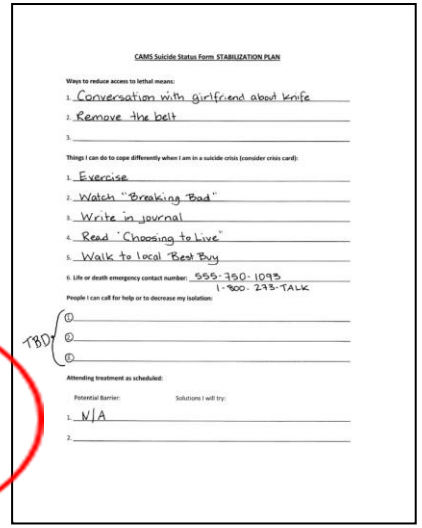
- (Y) N Suicide ideation — Describe: I think about it a lot - since 7 — Frequency: per day / per week / per month — Duration: seconds / minutes / hours — all the time
- (Y) N Suicide plan — When: At home before GF comes home — Where: At home — How: knife — Access to means: (Y) N
- (Y) N Suicide preparation — 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 — Describe: — Multiple attempts — 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): TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-Harm Potential	Safety and Stability	Stabilization Plan Completed ☑	3 months
2	Self-hate	↓ Self-hate	Insight 4 tx CBT BA Voc counseling	3 months
3	People don't get it / Betrayal	Find ways to help others See 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 — Patient Signature
Clinician Signature


CAMS Suicide Status Form 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 (consider crisis card):

1. Exercise
2. Watch "Breaking Bad"
3. Write in journal
4. Read "Choosing to Live"
5. Walk to local "Best Buy"

6. Life or death emergency contact number: 555-790-1093 1-800-273-TALK

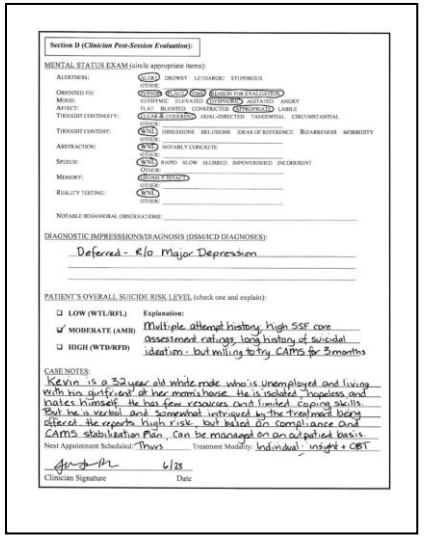
People I can call for help or to decrease my isolation:

TBD
①
②
③

Attending treatment as scheduled:

Potential Barrier: Solutions I will try:

1. N/A
2.


Section D (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS

ORIENTED TO: (PERSON) PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE

THOUGHT CONTINUITY: (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/ICD DIAGNOSES):

Deferred - R/o Major Depression

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ LOW (WTL/RFL) Explanation:
☑ MODERATE (AMB) Multiple attempt history, high SSF score, assessment ratings, long history of suicidal ideation - but willing to try CAMS for 3 months
☐ HIGH (WTD/RFD)

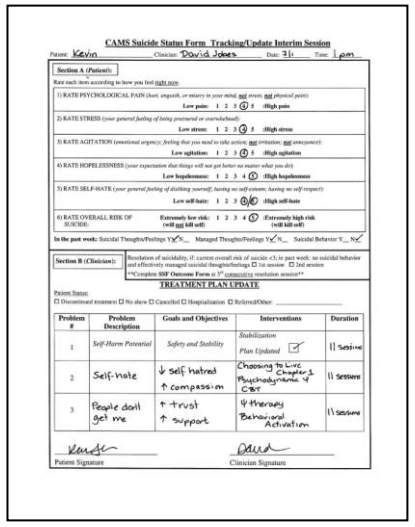
CASE NOTES:

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 6/23 Date

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


CAMS Suicide Status Form Tracking/Update Interim Session

Patient: Kevin Clinician: David Jdoes Date: 7/1 Time: 1pm

Section A (Patient):

Rate 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; hating no self-esteem; hating 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 Form at 3rd consecutive resolution session

TREATMENT PLAN UPDATE

Patient Status:
☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other:

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

Kevin — Patient Signature
David — Clinician Signature


Section C (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS

ORIENTED TO: (PERSON) PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE

THOUGHT CONTINUITY: (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/ICD DIAGNOSES):

Major Depression

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

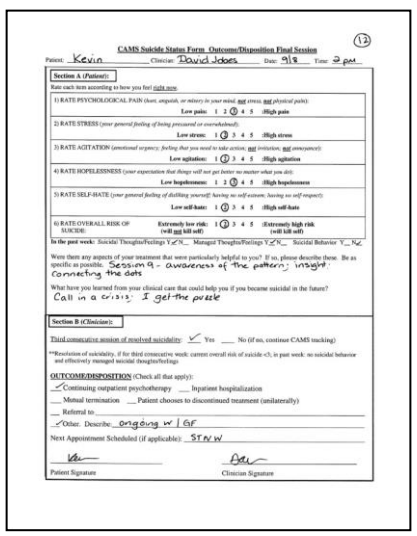
☐ MILD (WTL/RFL) Explanation:
☑ MODERATE (AMB) Continues to have high SSF score, assessment ratings - is managing suicidal thoughts and feelings
☐ HIGH (WTD/RFD)

CASE NOTES:

Kevin, 32 year old white male, unemployed, lives with GF at her mother's house. Completed CAMS Therapeutic Worksheet today and discussed history of abuse. Final contributes to self hate. Self hate is a primary driver of suicide for him. Updated his treatment plan to note self hate related to trauma history. Discussed Behavioral Activation for goal setting.

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

Clinician Signature 7/1 Date


CAMS Outcome/Disposition Final Session

(12)

Patient: Kevin Clinician: David Jdoes Date: 9/8 Time: 2 pm

Section A (Patient):

Rate 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: 1 (2) 3 4 5 (will not kill self) /Extremely high risk (will kill self)

Were 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 get the puzzle

Section B (Clinician):

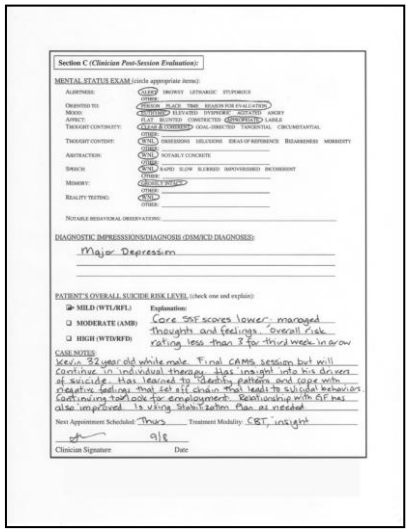
Third consecutive session of resolved suicidality: ✓ Yes ___ No (if no, continue CAMS tracking)

**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

OUTCOME/DISPOSITION (Check all that apply):

✓ Continuing outpatient psychotherapy ___ Inpatient hospitalization
___ Mutual termination ___ Patient chooses to discontinued treatment (unilaterally)
___ Referral to
✓ Other: Describe: ongoing w/ GF
Next Appointment Scheduled (if applicable): STAY W

Kevin — Patient Signature
David — Clinician Signature


Section C (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS

ORIENTED TO: (PERSON) PLACE TIME REASON FOR EVALUATION

MOOD: (EUTHYMIC) ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE

THOUGHT CONTINUITY: (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/ICD DIAGNOSES):

Major Depression

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ MILD (WTL/RFL) Explanation:
☑ MODERATE (AMB) Core SSF scores lower; managed thoughts and feelings. Overall risk rating less than 3 for third week in a row
☐ HIGH (WTD/RFD)

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 at all times that lead to suicidal behaviors. Continuing to look for employment. Relationship with GF has also improved. Is using Stabilization Plan as needed.

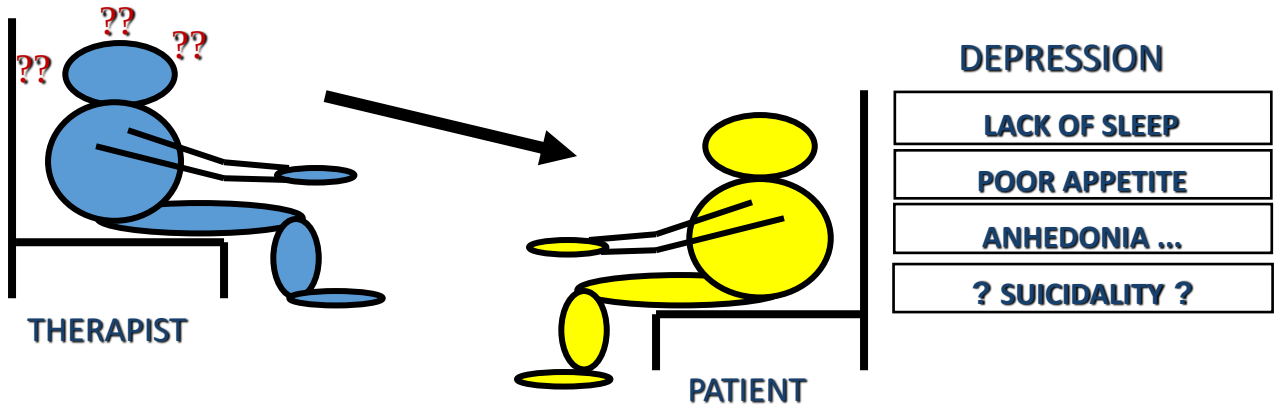
Next Appointment Scheduled: Thurs Treatment Modality: CBT, insight

9/8
Clinician Signature Date

CAMS Tracking/Update Sessions

CAMS Outcome/Disposition Session

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…

CAMS-care
Preventing Suicide

NATIONAL REGISTER
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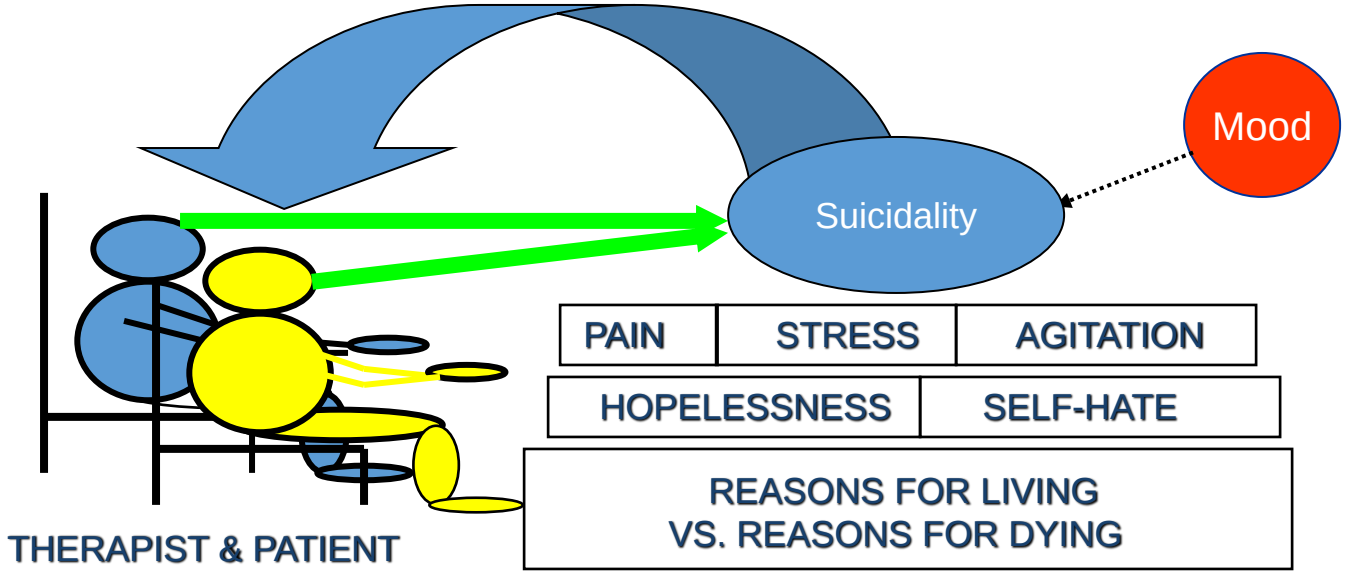
The Collaborative Assessment and Management of Suicidality (CAMS) identifies and targets

Suicide as the primary focus of assessment and intervention…



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

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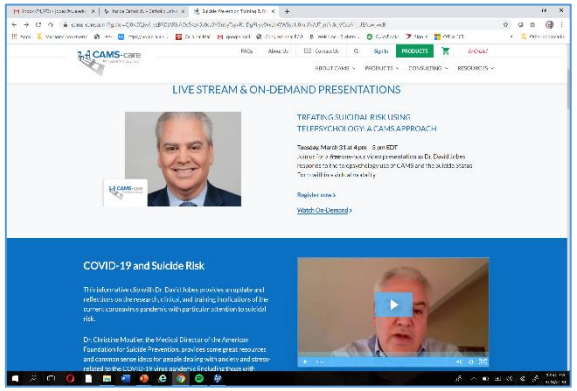
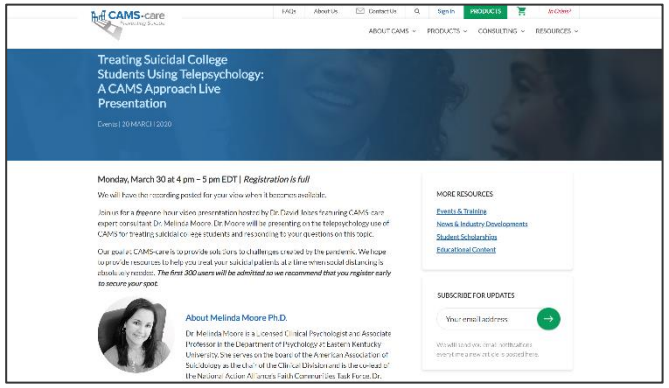
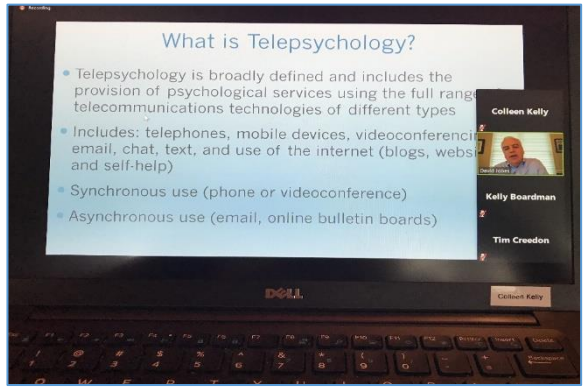
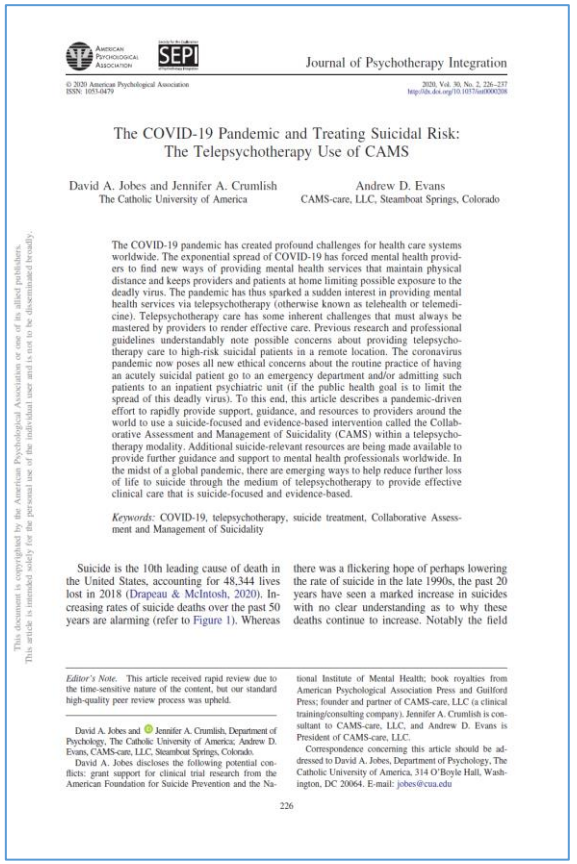
National Register
of Health Service Psychologists

Online training and telehealth use of CAMS Spring 2020









Journal of Psychotherapy Integration

© 2020 American Psychological Association
ISSN: 1053-0479

2020, Vol. 30, No. 2, 226–237
http://dx.doi.org/10.1037/int0000208

The COVID-19 Pandemic and Treating Suicidal Risk: The Telepsychotherapy Use of CAMS

David A. Jobes and Jennifer A. Crumlish
The Catholic University of America

Andrew D. Evans
CAMS-care, LLC, Steamboat Springs, Colorado

The COVID-19 pandemic has created profound challenges for health care systems worldwide. The exponential spread of COVID-19 has forced mental health providers to find new ways of providing mental health services that maintain physical distance and keeps providers and patients at home limiting possible exposure to the deadly virus. The pandemic has thus sparked a sudden interest in providing mental health services via telepsychotherapy (otherwise known as telehealth or telemedicine). Telepsychotherapy care has some inherent challenges that must always be mastered by providers to render effective care. Previous research and professional guidelines understandably note possible concerns about providing telepsychotherapy care to high-risk suicidal patients in a remote location. The coronavirus pandemic now poses all new ethical concerns about the routine practice of having an acutely suicidal patient go to an emergency department and/or admitting such patients to an inpatient psychiatric unit (if the public health goal is to limit the spread of this deadly virus). To this end, this article describes a pandemic-driven effort to rapidly provide support, guidance, and resources to providers around the world to use a suicide-focused and evidence-based intervention called the Collaborative Assessment and Management of Suicidality (CAMS) within a telepsychotherapy modality. Additional suicide-relevant resources are being made available to provide further guidance and support to mental health professionals worldwide. In the midst of a global pandemic, there are emerging ways to help reduce further loss of life to suicide through the medium of telepsychotherapy to provide effective clinical care that is suicide-focused and evidence-based.

Keywords: COVID-19, telepsychotherapy, suicide treatment, Collaborative Assessment and Management of Suicidality

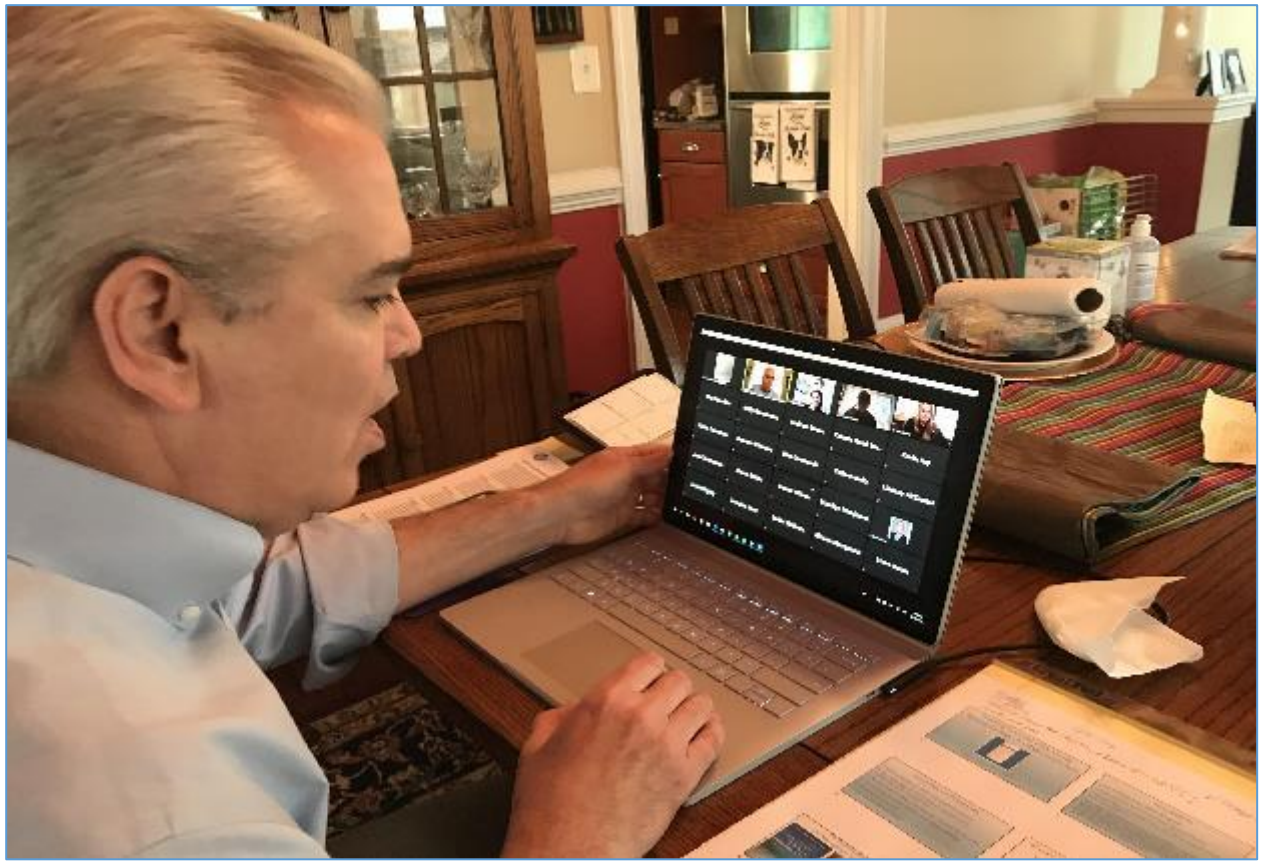
Suicide is the 10th leading cause of death in the United States, accounting for 48,344 lives lost in 2018 (Drapeau & McIntosh, 2020). Increasing rates of suicide deaths over the past 50 years are alarming (refer to Figure 1). Whereas there was a flickering hope of perhaps lowering the rate of suicide in the late 1990s, the past 20 years have seen a marked increase in suicides with no clear understanding as to why these deaths continue to increase. Notably the field

Editor's Note. This article received rapid review due to the time-sensitive nature of the content, but our standard high-quality peer review process was upheld.

David A. Jobes and Jennifer A. Crumlish, Department of Psychology, The Catholic University of America; Andrew D. Evans, CAMS-care, LLC, Steamboat Springs, Colorado.

David A. Jobes discloses the following potential conflicts: grant support for clinical trial research from the American Foundation for Suicide Prevention and the National Institute of Mental Health; book royalties from American Psychological Association Press and Guilford Press; founder and partner of CAMS-care, LLC (a clinical training/consulting company). Jennifer A. Crumlish is consultant to CAMS-care, LLC, and Andrew D. Evans is President of CAMS-care, LLC.

Correspondence concerning this article should be addressed to David A. Jobes, Department of Psychology, The Catholic University of America, 314 O'Boyle Hall, Washington, DC 20064. E-mail: jobes@cua.edu



Online Suicide-Focused Treatment:

The Telehealth Use of CAMS

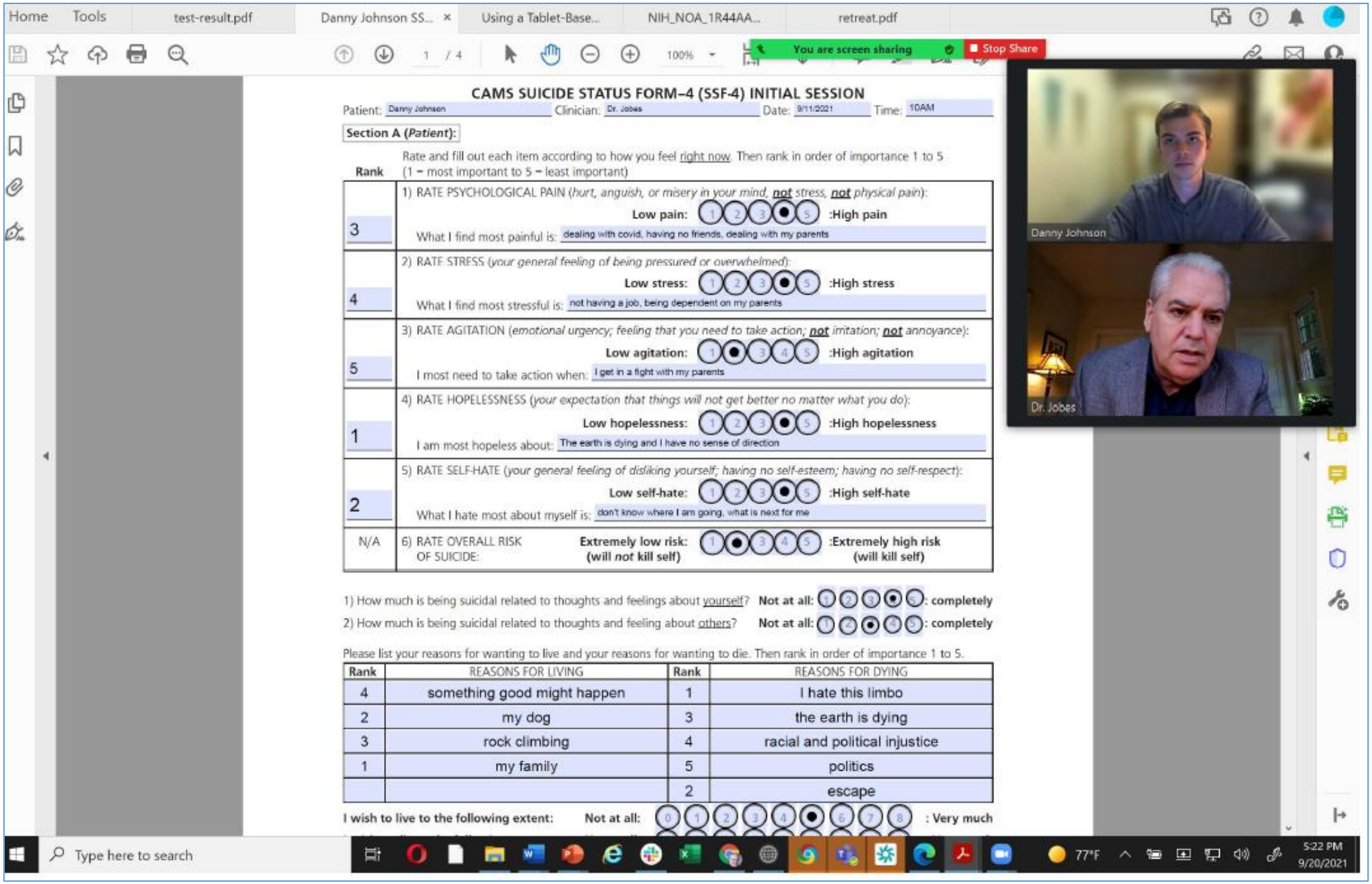
Mary V. Tipton, B.A.[1], Josh Brenner M.A.[1], Jennifer Crumlish, Ph.D.[1], Melinda Moore, Ph.D.[2], and David A. Jobes, Ph.D.[1]

[1]Department of Psychology, The Catholic University of America, Washington, D.C., USA [2]Department of Psychology, Eastern Kentucky University, Richmond, KY, USA.

Free online webinars are a corona virus pandemic silver lining!

The form-fillable PDF of the Suicide Status Form is available, and it works well!

Form-fillable PDF of the SSF for telehealth sessions



Getting back to “normal” post-pandemic?

Received: 14 February 2021 | Revised: 26 March 2021 | Accepted: 27 March 2021
DOI: 10.1002/cpp.2594

RESEARCH ARTICLE

WILEY

Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment

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[2]School of Psychology, Deakin University, Melbourne, Australia
[3]School of Social & Political Sciences, University of Melbourne, Melbourne, Australia
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Funding Information
University of Texas at San Antonio

Abstract

In-person psychotherapy (IPP) has a long and storied past, but technology advances have ushered in a new era of video-delivered psychotherapy (VDP). In this meta-analysis, pre-post changes within VDP were evaluated as were outcome differences between VDP versus IPP or other comparison groups. A literature search identified $k = 56$ within-group studies ($N = 1681$ participants) and 47 between-group studies ($N = 3564$). The pre-post effect size of VDP was large and highly significant, $g = +0.99$ 95% CI [0.67–0.31]. VDP was significantly better in outcome than wait list controls ($g = 0.77$) but negligible in difference from IPP. Within-groups heterogeneity of effect sizes was reduced after subgrouping studies by treatment target, of which anxiety, depression, and posttraumatic stress disorder (PTSD) (each with $k > 5$) had effect sizes nearing 1.00. Disaggregating within-groups studies by therapy type, the effect size was 1.34 for CBT and 0.66 for non-CBT. Adjusted for possible publication bias, the overall effect size of VDP within groups was $g = 0.54$. In conclusion, substantial and significant improvement occurs from pre- to post-phases of VDP, this in turn differing negligibly from IPP treatment outcome. The VDP improvement is most pronounced when CBT is used, and when anxiety, depression, or PTSD are targeted, and it remains strong though attenuated by publication bias. Clinically, therapy is no less efficacious when delivered via videoconferencing than in-person, with efficacy being most pronounced in CBT for affective disorders. Live psychotherapy by video emerges not only as a popular and convenient choice but also one that is now upheld by meta-analytic evidence.

KEYWORDS
affective disorders, cognitive-behavioural therapy (CBT), face-to-face, meta-analysis, online treatment, video-delivered psychotherapy

1 | TRADITIONAL DELIVERY OF PSYCHOTHERAPY

The traditional mode for delivering psychotherapy is through a meeting of therapist and client in-person and in close physical proximity, whether in a clinical, educational, or forensic setting. This has been variously referred to as in-person psychotherapy (IPP), in vivo therapy, or face-to-face therapy, and it can be formatted for use with individuals, dyads, or groups. As Kazdin (2015) recently stated, “one-to-one in-person treatment has remained as the dominant model of delivery” (pp. 7–8). This established mode of delivery has, however, come under criticism for failing to reach many of those in need, especially in

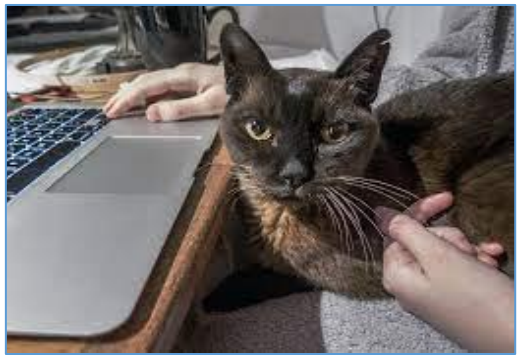
- 56 within-group studies (*N*=1,681)
- 47 between-group studies (*N*=3,564)
- Psychotherapy is no less efficacious when delivered via telehealth than in-person/face-to-face therapy
- Effects are most pronounced for CBT with affective disorders
- “Live psychotherapy by video emerges as not only a popular and convenient choice but also one that is now upheld by meta-analytic evidence.”

CAMS-care Preventing Suicide

National Register of Health Service Psychologists

The great democratization of mental health?

- With proper infrastructure and secure internet access, telehealth may potentially extend the reach of mental health care making it much more accessible to:
  - Rural populations
  - Frontier populations
  - Underserved and marginalized populations
  - Not seen walking into clinics—avoiding stigma
  - Not fighting traffic
  - Pets can join telehealth psychotherapy
  - Retention to care is better with fewer missed sessions
  - Lethal means safety can be done remotely—securing lethal means
  - PSYCHPACT—more provider options across state lines (for psychologists)



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Correlational and Open Clinical Trial Support for SSF/CAMS

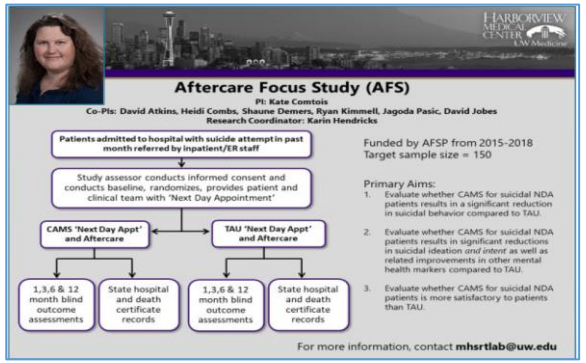
Authors	Sample/Setting	n =	Significant Results
Jobes et al., 1997	College Students	106	Pre/Post SSF Core Assessment and symptom distress
Jobes et al., 2005	USAF Outpatients	56	Between-group suicidal ideation; reduced ED/PC appts
Arkov et al., 2008	Danish CMC Outpatients	27	Pre/Post SSF Core Assessment 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
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
Adrian et al., 2021	Teenage outpatients	22	Pres/post reductions in suicidal ideation

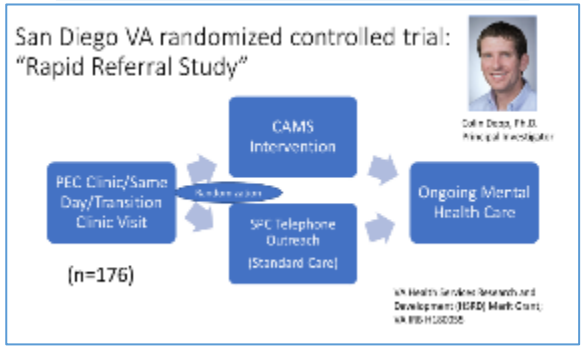
CAMS-care
Preventing Suicide

National Register of Health Service Psychologists

Randomized Controlled Trials of CAMS

Principal Investigator	Setting & Population	Design & Method	Sample Size	Status Update
Comtois (Jobes)	Harborview/Seattle CMH patients	CAMS vs. TAU Next-day appts.	32	2011 published article
Andreasson (Nordentoft)	Danish Centers CMH patients	DBT vs. CAMS superiority trial	108	2016 published article
Jobes (Comtois et al)	Ft. Stewart, GA US Army Soldiers	CAMS vs. E-CAU	148	2017 published article
Ryberg (Fosse)	Norwegian Centers Outpatient/inpatient	CAMS vs. TAU	78	2019 published articles
Pistorello (Jobes)	Univ. Nevada (Reno) College Students	SMART Design CAMS/TAU/DBT	62	2017 and 2020 - articles
Comtois (Jobes)	Harborview/Seattle Suicide attempters	CAMS vs. TAU Post-Hosp. D/C	150	ITT complete; on-going assess
Santel et al	German Crisis Unit Inpatients	CAMS vs. TAU	60	ITT complete; on-going assess
Depp et al	San Diego VAMC Walk-in Veterans	CAMS vs. Outreach Same day services	176	ITT underway (telehealth)





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 root 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 ($d = 0.28$), significantly higher treatment acceptability ($d = 0.42$), and significantly higher hope/lower hopelessness ($d = 0.68$). 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, timing of outcome measurement, and the age and ethnicity of participants; however, the effect sizes favoring CAMS were significantly smaller with active duty military/veteran 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 591 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 colleague'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.

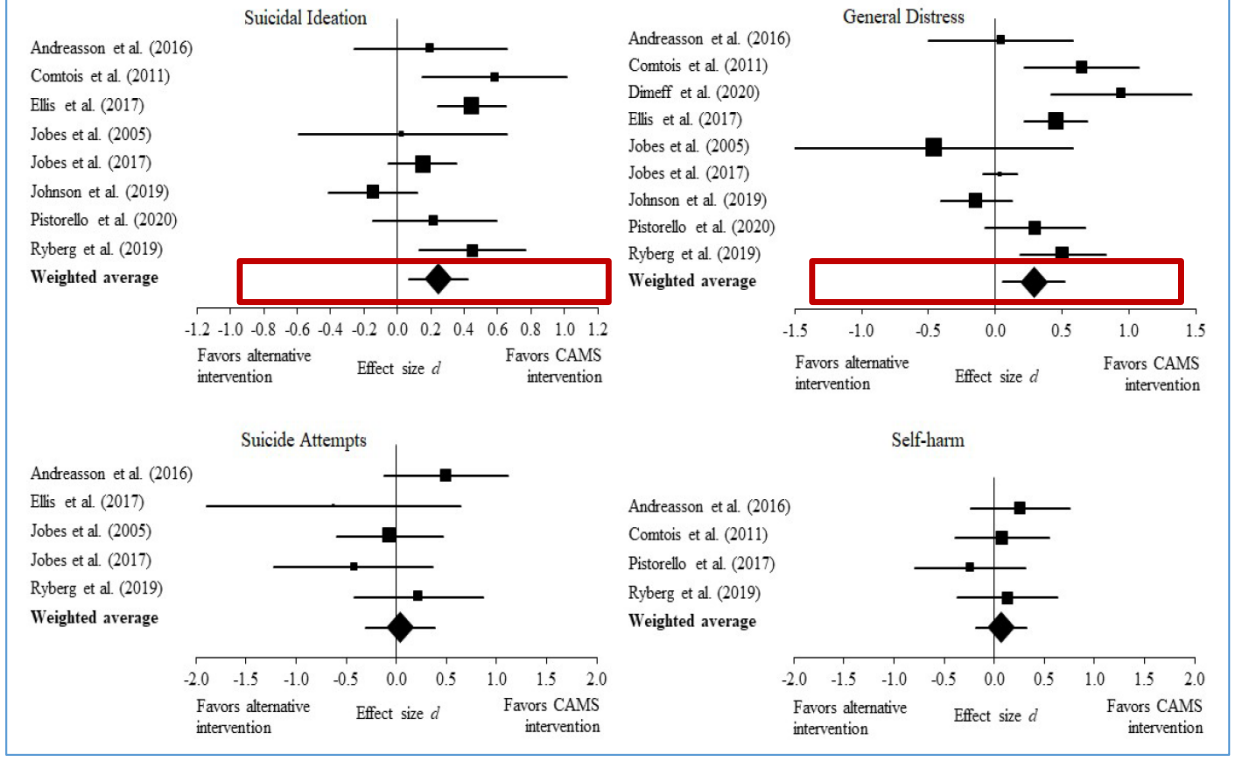
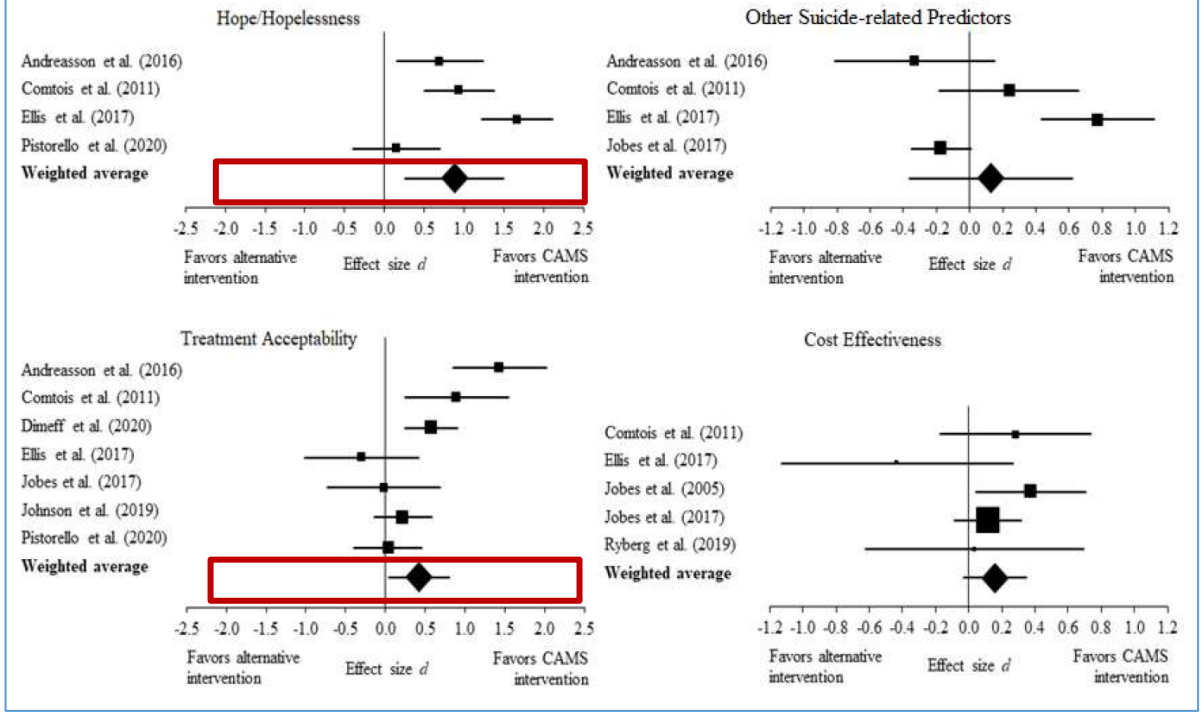


Figure 3. Forest plot of effect sizes for hope/hopelessness, other suicide-related predictors, treatment acceptability, and cost effectiveness.



Use of CAMS Around the World…

Ireland and Lithuania

China

Norway

Uruguay

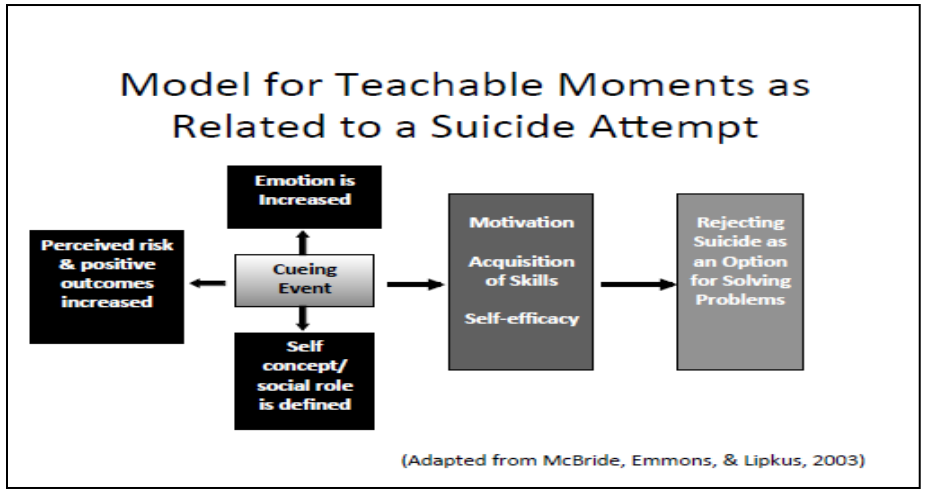
United Kingdom

Denmark

Australia

CAMS Materials translated into:

- Lithuanian
- Chinese
  - Mandarin
  - Taiwanese
- Korean
- Japanese
- German
- Polish
- Norwegian
- Latvian

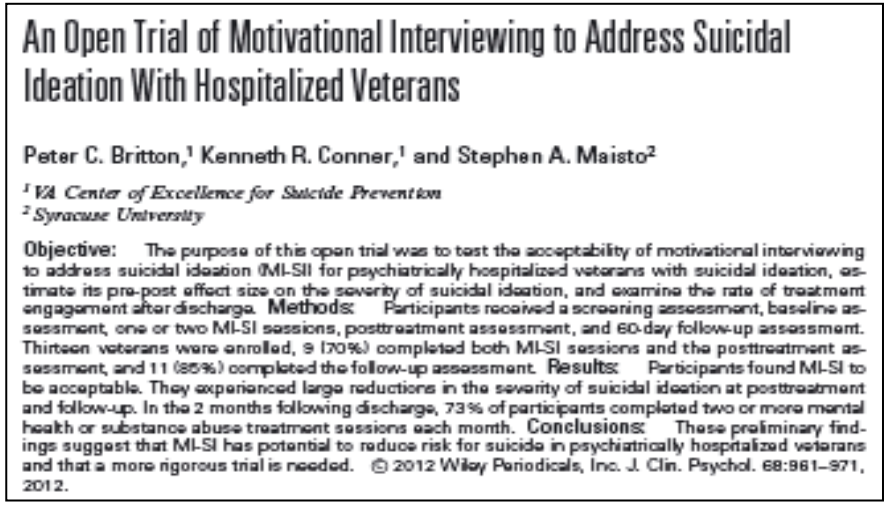


Stephen O'Connor, Ph.D.

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…

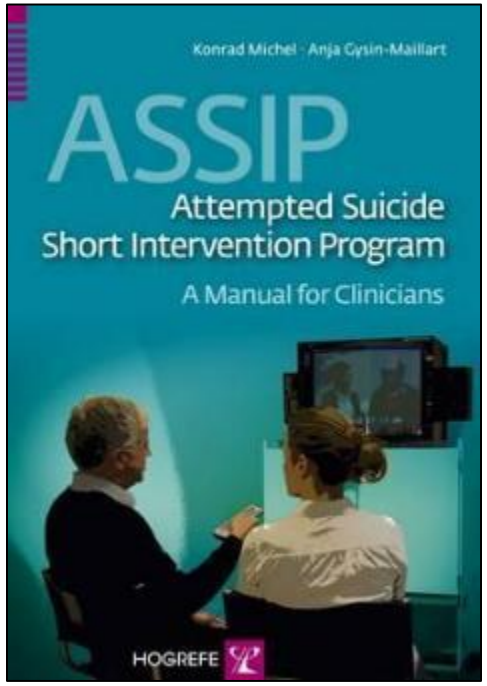


An Open Trial of Motivational Interviewing to Address Suicidal Ideation With Hospitalized Veterans

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. J. Clin. Psychol. 68:961–971, 2012.



BRIEF SUICIDE-SPECIFIC INTERVENTIONS…

Konrad Michel, M.D.

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

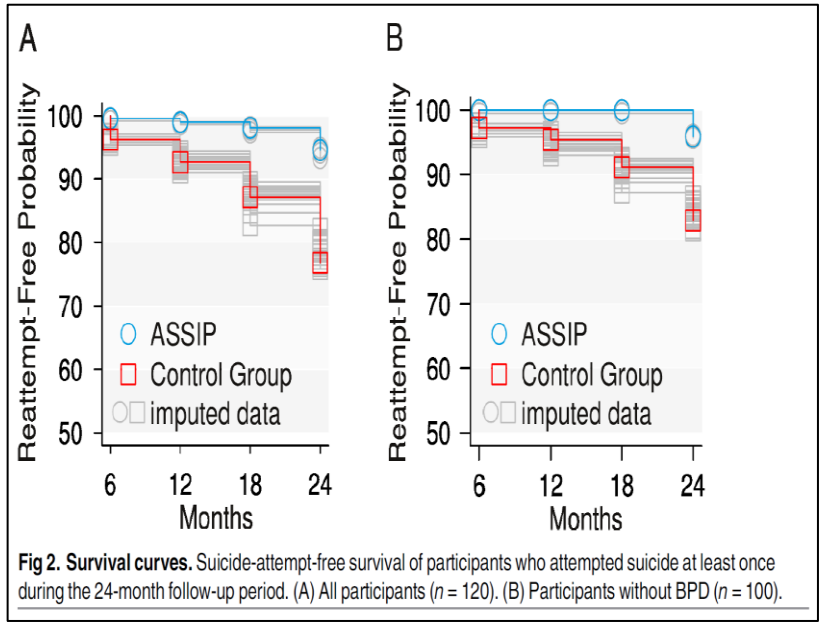
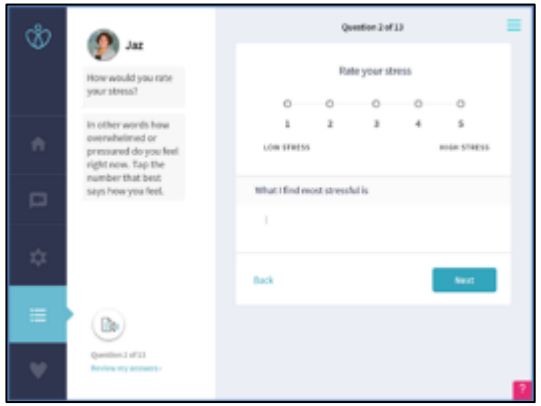
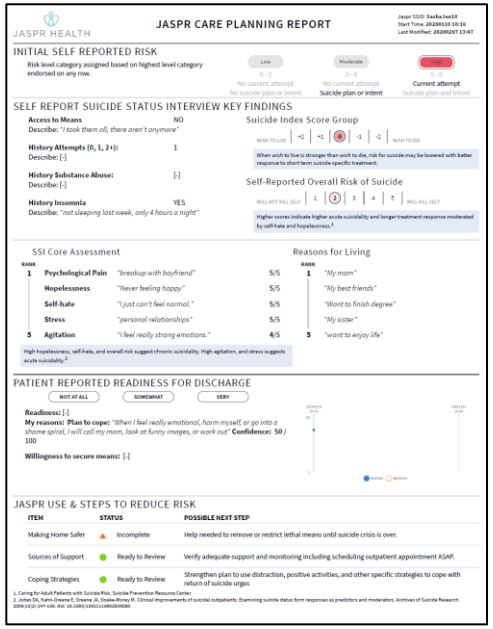


Fig 2. Survival curves. Suicide-attempt-free survival of participants who attempted suicide at least once during the 24-month follow-up period. (A) All participants (n = 120). (B) Participants without BPD (n = 100).

Developing and Studying "Jaspr Health"

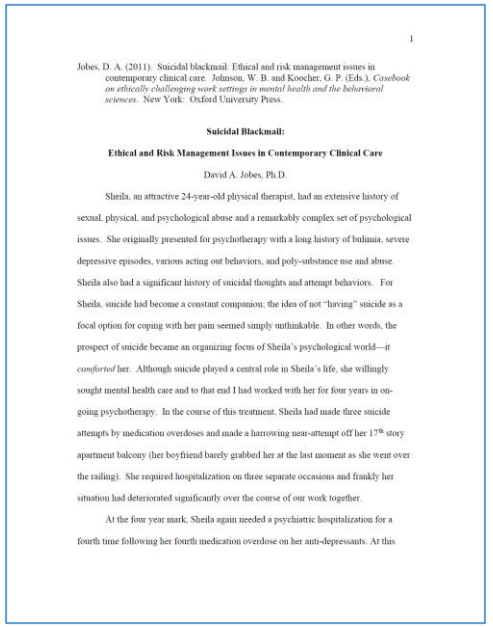




Covid compelled us to expand the use of Jaspr Health to primary care and outpatient settings...

Ethics and Suicide-Related Malpractice Liability

- Ethical considerations with suicide emphasize the importance of:
  - Informed consent and transparency
  - Clinical consultation
  - Documentation
- Malpractice tort litigation for wrongful death secondary to a patient suicide is pursued by plaintiffs (e.g., surviving family) who assert that the provide breached the “standard of care”
- The Standard of Care is operationally defined as what a reasonably prudent practitioner who is similarly trained, in a similar settings, with a similar patient would do.
- Standard of care is defined by expert witnesses who examine subpoenaed records, interrogatories, and depositions
- The plaintiff has the burden of proof to establish that the practitioner:
  - Failed to assess the risk (i.e., foreseeability)
  - Failed to appropriately treat the risk
  - Failed to follow-through on treatment



1

Jobes, D. A. (2011). Suicidal blackmail: Ethical and risk management issues in contemporary clinical care. Johnson, W. B. and Koocher, G. P. (Eds.), *Casebook on ethically challenging work settings in mental health and the behavioral sciences*. New York: Oxford University Press.

Suicidal Blackmail:

Ethical and Risk Management Issues in Contemporary Clinical Care

David A. Jobes, Ph.D.

Sheila, an attractive 24-year-old physical therapist, had an extensive history of sexual, physical, and psychological abuse and a remarkably complex set of psychological issues. She originally presented for psychotherapy with a long history of bulimia, severe depressive episodes, various acting out behaviors, and poly-substance use and abuse. Sheila also had a significant history of suicidal thoughts and attempt behaviors. For Sheila, suicide had become a constant companion; the idea of not “having” suicide as a focal option for coping with her pain seemed simply unthinkable. In other words, the prospect of suicide became an organizing focus of Sheila’s psychological world—it *comforted* her. Although suicide played a central role in Sheila’s life, she willingly sought mental health care and to that end I had worked with her for four years in ongoing psychotherapy. In the course of this treatment, Sheila had made three suicide attempts by medication overdoses and made a harrowing near-attempt off her 17th story apartment balcony (her boyfriend barely grabbed her at the last moment as she went over the railing). She required hospitalization on three separate occasions and frankly her situation had deteriorated significantly over the course of our work together.

At the four year mark, Sheila again needed a psychiatric hospitalization for a fourth time following her fourth medication overdose on her anti-depressants. At this

Psychological Psychology: Research and Practice
1993, Vol. 24, No. 1, 87-99

0735-7028/93/$3.00

Suicide and Malpractice Liability: Assessing and Revising Policies, Procedures, and Practice in Outpatient Settings

David A. Jobes and Alan L. Berman

This article broadly addresses policies and procedures as well as issues of liability and malpractice related to working with suicidal outpatients in agency and private practice settings. Issues related to ethical practice with suicidal patients are raised, general recommendations for risk management are discussed, and a step-by-step model for establishing, assessing, and/or revising suicide policies and procedures is presented. Also provided are concrete and practical suggestions to improve clinical practice with suicidal patients that may significantly decrease the risk of malpractice liability and ultimately provide better clinical care to these patients.

Case Scenarios

A psychologist schedules the first outpatient psychotherapy session of a recently discharged inpatient man who had been hospitalized for major depression with suicide ideation, 2 months after discharge. At that session, no mental status evaluation is recorded, there is virtually no inquiry about the patient's psychosocial history, and the evaluation of suicide risk is based on a simple question, "Are you still feeling suicidal?" and an answer of "No." The second outpatient session was scheduled 3 weeks later. Two days before the appointment, however, the patient hung himself in the basement of his parents' home.

A law student seeks therapy from a university counseling center, presenting with relationship problems. The assigned counselor, a graduate student in a supervised internship, does not evaluate suicide risk, and thus this consideration is not incorporated into the patient's treatment plan. One week after the intern terminated treatment on completion his internship, the student uses his father's handgun to kill himself.

Overview

Either of these case scenarios has a high probability of bereaved survivors seeking recompense for their loss through a claim of negligent care and treatment by the involved caretakers. In recent years there has been an exponential increase in the number of malpractice claims brought against clinicians who treated outpatients who completed suicide (Jobes, Berman, & Harris, 1991). Clinicians in contemporary practice must therefore consider a range of important issues to provide competent care to suicidal outpatients and simultaneously protect themselves from the increasing threat of malpractice litigation. Central to providing competent clinical care to suicidal patients are key legal and ethical questions related to adequate risk assessment and treatment planning, acceptable clinical follow-through, appropriate supervision/consultation and documentation, and clinical abandonment (see Berman, 1986; Berman, 1990; Berman & Cohen-Sandler, 1983; Knapp & Vandecreek, 1983; Pope, 1989).

DAVID A. JOBES received his PhD in clinical psychology from The American University in 1988. He is an Associate Professor of Psychology at The Catholic University of America and also the Associate Director of the university's counseling center. With research and training interests in clinical suicidology, he is the Assistant Director of the National Center for the Study and Prevention of Suicide at the Washington School of Psychiatry.

ALAN L. BERMAN received his PhD in clinical psychology from The Catholic University of America in 1970. He is an ABPP Diplomate in clinical psychology and Director of the National Center for the Study and Prevention of Suicide at the Washington School of Psychiatry. He is in private practice at the Washington Psychological Center, has written numerous articles in general and forensic suicidology, and is co-author (with David Jobes) of *Adolescent Suicide: Assessment and Intervention* (Berman & Jobes, 1991).

THIS ARTICLE WAS BASED ON a presentation given at the Annual Conference of the American Association of Suicidology (Boston, April 1991). The authors gratefully acknowledge the contributions of Eric Harris, Peter Cimbolic, and Stephanie Judd.

CORRESPONDENCE CONCERNING THIS ARTICLE should be sent to David A. Jobes, Department of Psychology, The Catholic University of America, 314 O'Boyle Hall, Washington, DC 20064.

Malpractice and the Suicidal Patient

Throughout history, traditional society has assigned blame for death. Natural and accidental deaths have been viewed as "God's will," whereas suicide and homicide have been seen as caused by humans (Litman, 1988). Thus, if someone is to blame, then someone must be punished. For example, with regard to suicide, 18th century society punished the suicide completer through desecration of the corpse, public indignity, or state confiscation of the decedent's family's property.

Cultural evolution and modern legal considerations have led to shifting perceptions of suicide. Once a punishable wrong, suicide is now viewed as a product of mental disorders requiring prevention and intervention (Berman & Jobes, 1991). It therefore follows that those who care for and treat patients with mental disorders are, de facto, charged with the task of preventing the suicide of that patient. Accordingly, blame for suicide has increasingly fallen on mental health professionals who fail to prevent the suicides of their patients. Mental health professionals have indeed become ripe targets of modern acts of retribution in the form of malpractice litigation for "wrongful

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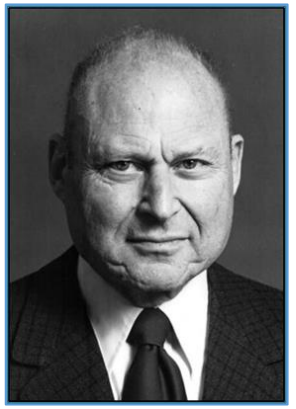
Motto's Classic Caring Letter Study:
A simple letter sent every 1-4 months for 5 years



Caring-Contact RCT Design

3,005 Depressive or Suicidal Persons Identified at 9 psychiatric inpatient hospitals

- 1,939 Received Treatment
- 843 Refused or No Treatment
- 223 Treatment Undetermined

Randomization

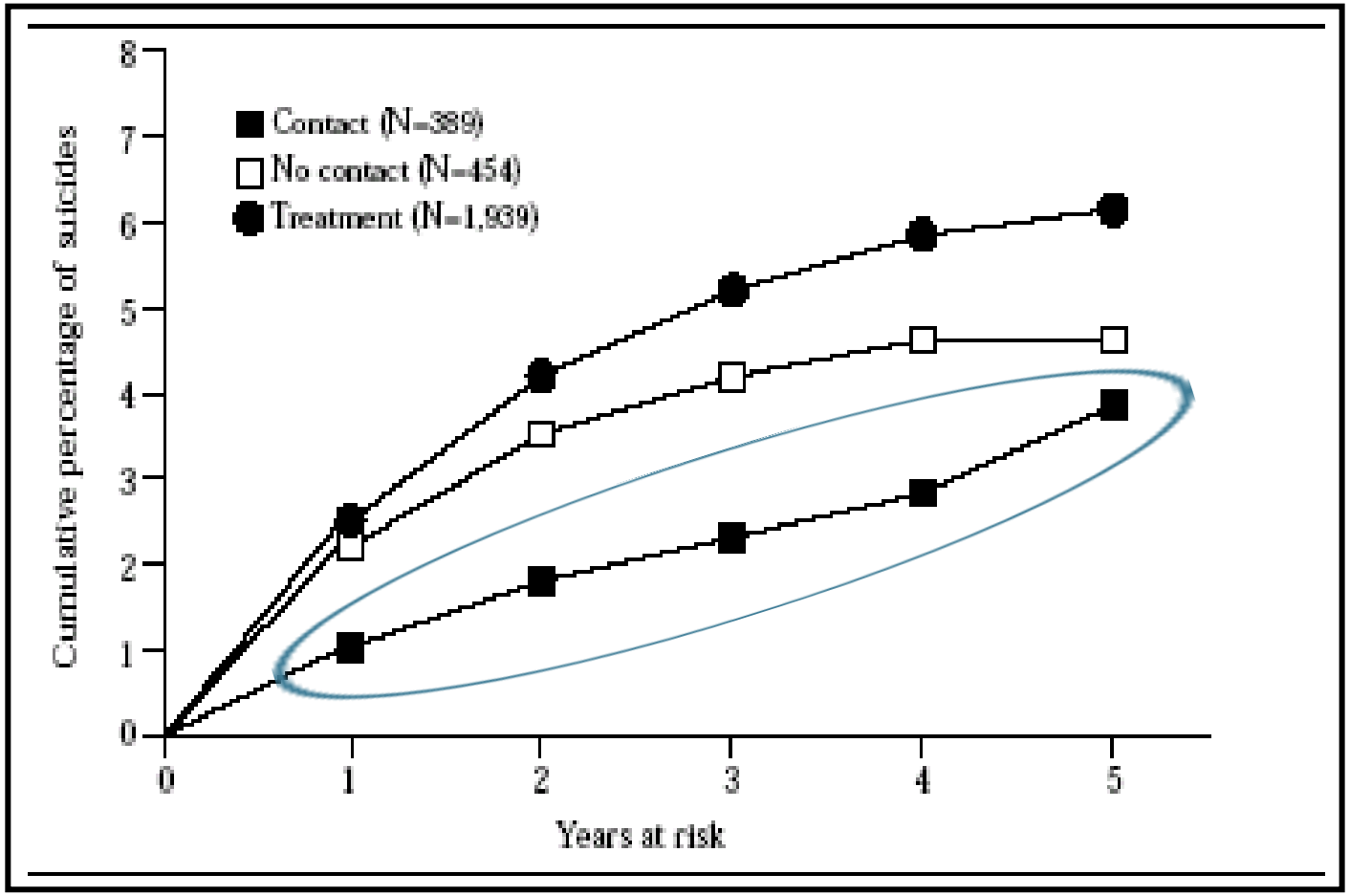
- 389 Contact
- 454 No Contact

Source: Motto & Bostrom, 2001

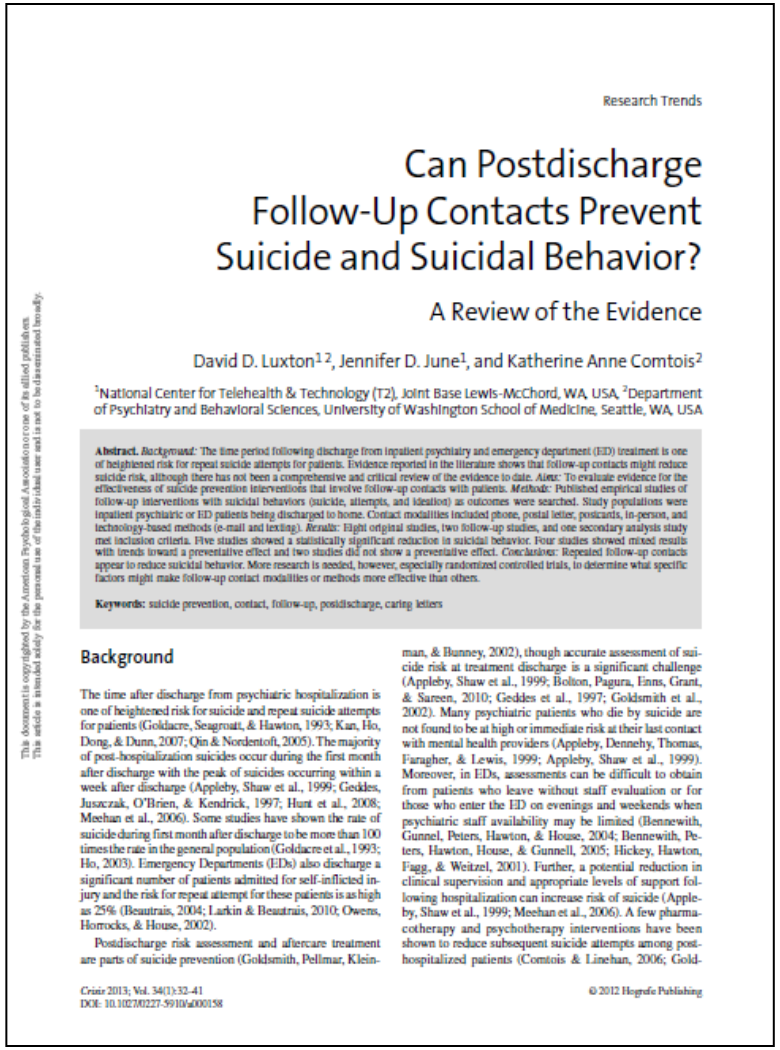
Dear *Patient's Name:*

"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. *Conclusion:* 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

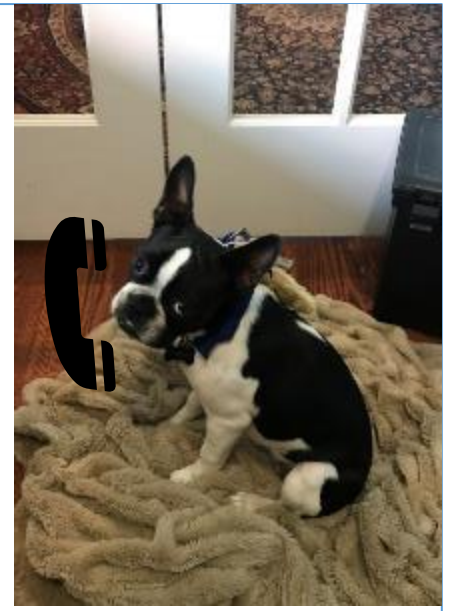
Background

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-

Crisis 2013; Vol. 34(1):32-41
DOI: 10.1027/0227-5910/a000158

- 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)



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People who are suicidal do not seek mental health care…

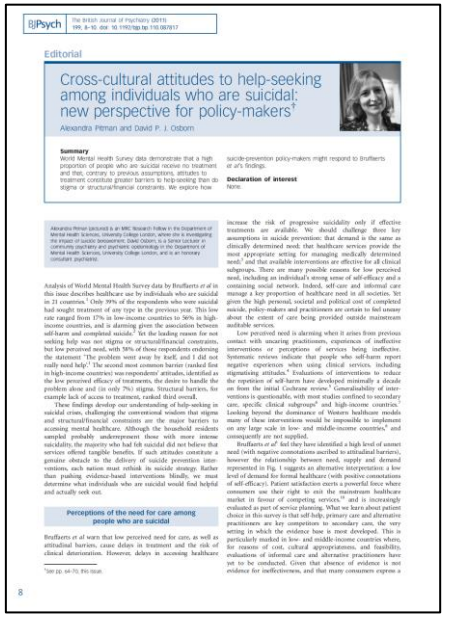
Coping With Thoughts of Suicide: Techniques Used by Consumers of Mental Health Services

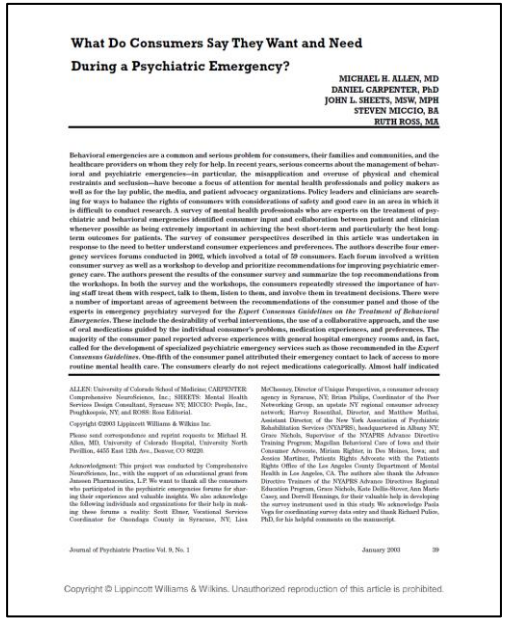
Mary Jane Alexander, Ph.D.
Gary Haugland, M.A.
Peter Ashenden, B.S.
Ed Knight, Ph.D.
Isaac Brown

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	5	18	9	7	50	7
Using peer supports	6	16	8	6	55	7
Doing something pleasurable	6	16	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.


Treatment of suicidal people around the world


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


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

- 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)

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Lived-Experience Peer-Based Support

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

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One Size Does Not Fit All: NOT a Pipe-Dream!

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.

Keywords: suicidal risk; suicide-focused clinical care; stepped care

1. Introduction to the Problem

Suicide is a major public health issue around the world that accounts for almost 800,000 deaths per year [1]. In the United States suicide is the 10th leading cause of death with approximately 47,000 total deaths in 2017 and 1.4 million American adults attempted suicide in that same year [2]. While suicidologists and public health officials are understandably preoccupied with suicide deaths and suicide attempts, Jobes and Joiner [3] have recently reflected on the massive population of people who experience suicidal ideation and all too often escape the attention of our suicide prevention research, clinical treatments, and even national health care policies. In the United States, 10,600,000 American adults experience serious suicidal thoughts [4]—a worrisome cohort which dwarfs the populations of those who attempt and die by suicide.

To fully address the many challenges to clinical suicide risk reduction we will consider: the history of mental health care and its legacy for suicidal patients, the notion of mindsets about how to best help care for suicidal people, various contemporary developments that may be changing mindsets about clinical suicide prevention, the historic pursuit of suicidal typologies, evidence-based suicide-focused treatments, and finally a stepped care public health model.

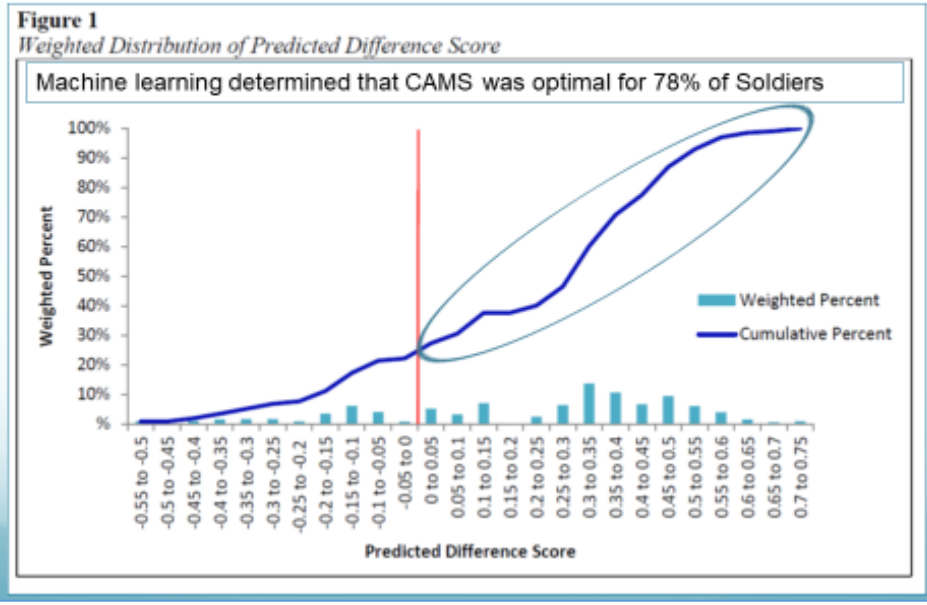
2. History of Mental Health and Suicidal Patients

The history of the field of mental health and the treatment of suicidal patients is rather sordid and includes many disturbing developments over the years. Prior to European enlightenment, the

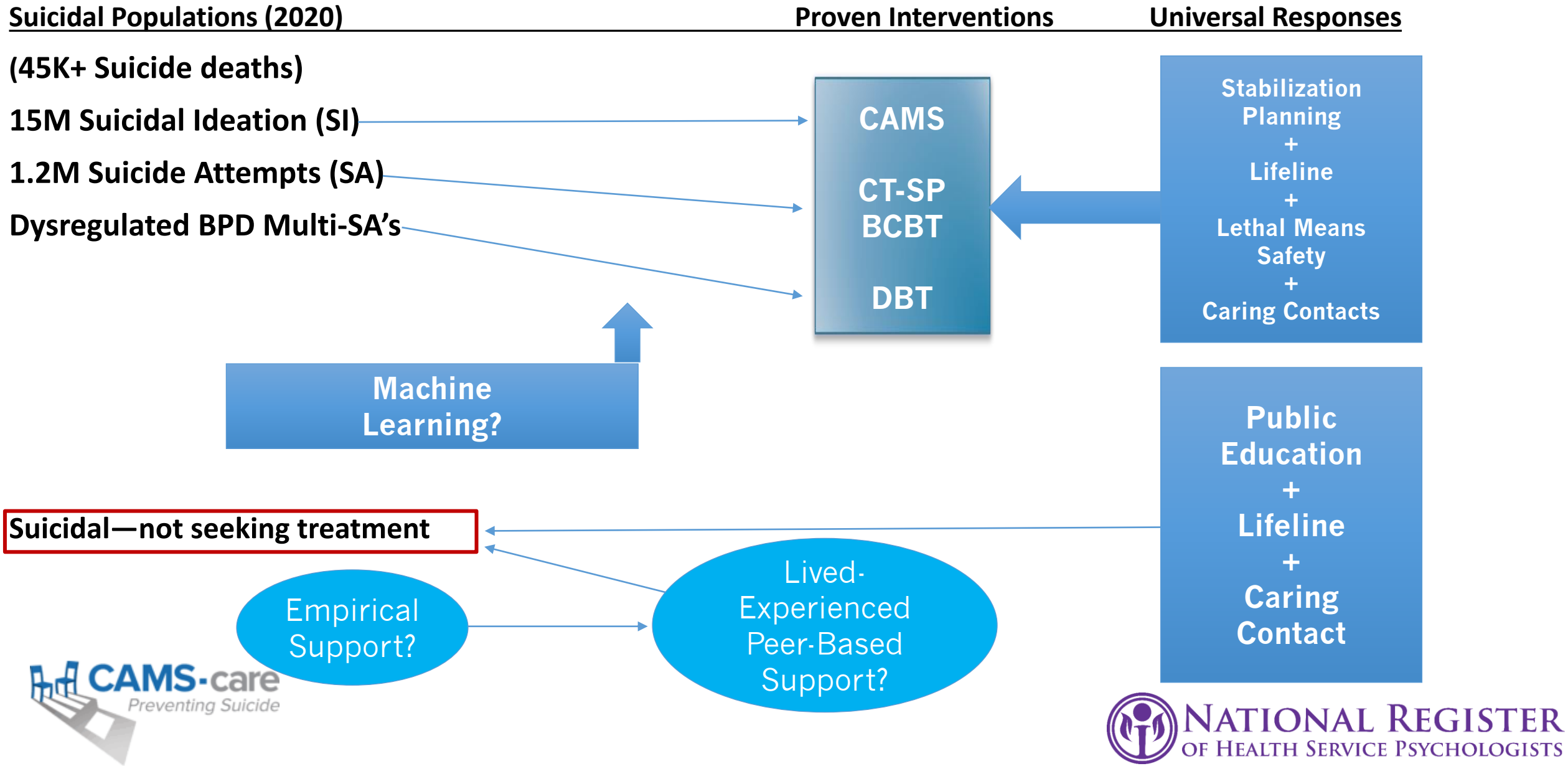
Ron Kessler's notion of the potential promise of "precision treatment rules" matching different treatments to different needs for optimal clinical outcomes and health care cost savings!

Collaboration with Ron Kessler: Machine Learning and OWL Suicidal Ideation

Figure 1
Weighted Distribution of Predicted Difference Score



Matching Interventions to Different Suicidal States



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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:

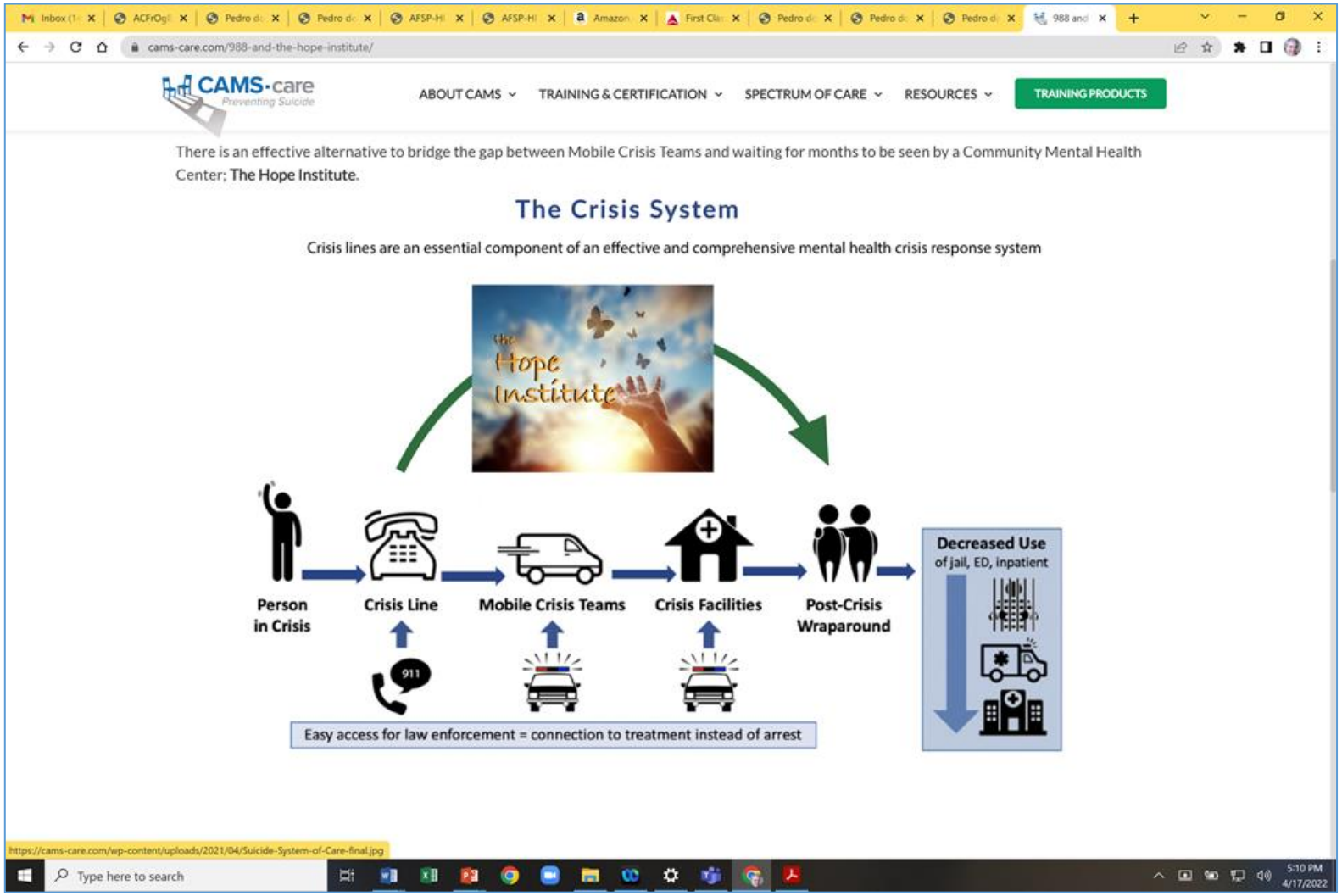
- **evidence-based**
- **least-restrictive**
- **cost-effective**

NEWS FLASH: 988 is coming!

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

The Hope Institute

Next Day Appointments of CAMS & DBT Skills Groups for 6 weeks of intensive stabilization care



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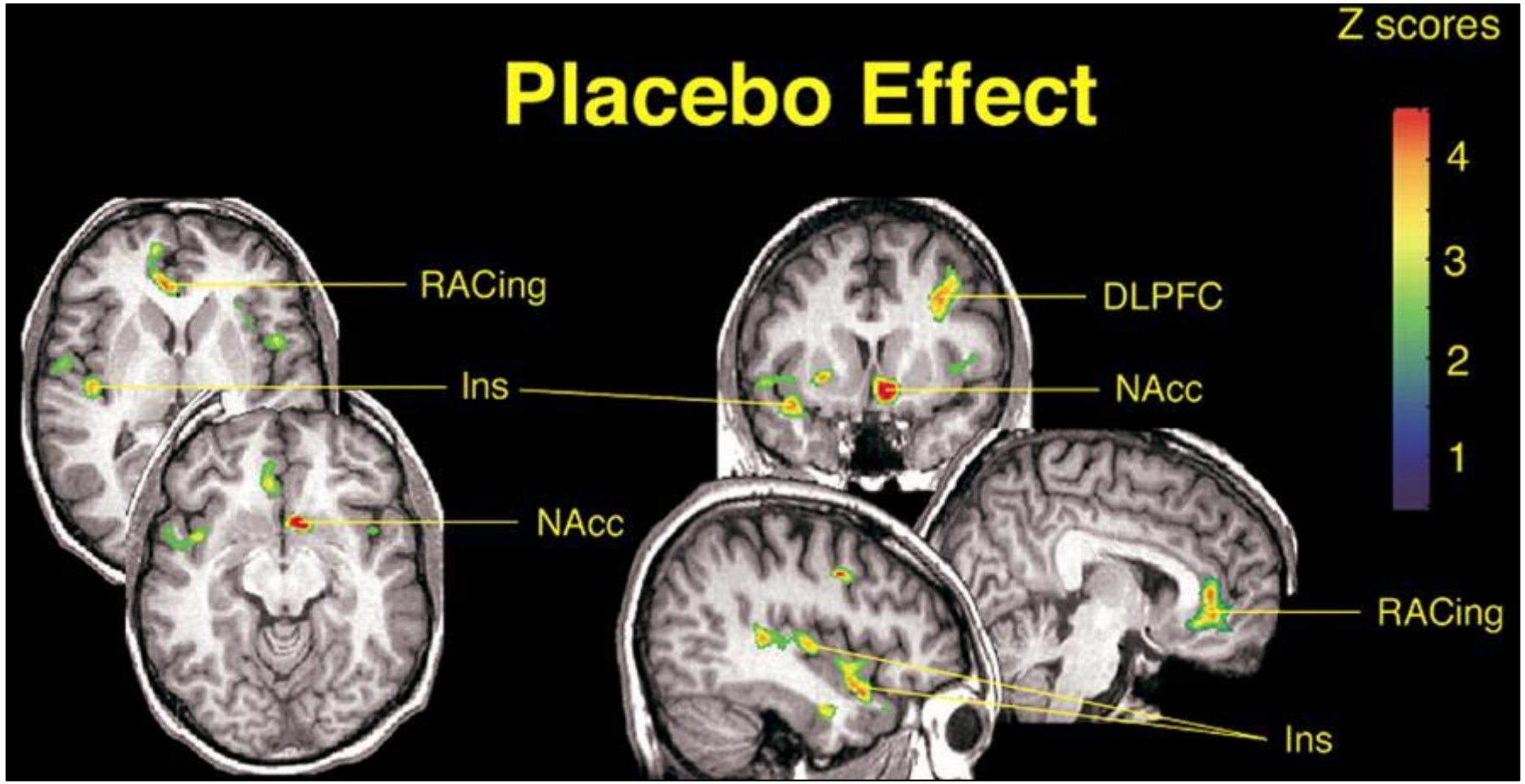
The Healing Power of Competence and Confidence!



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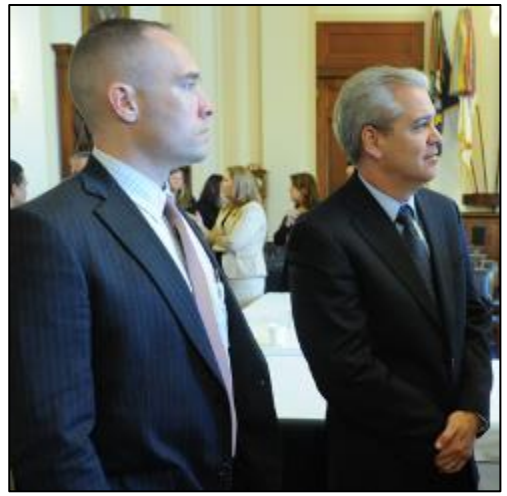
Appreciation and thanks…



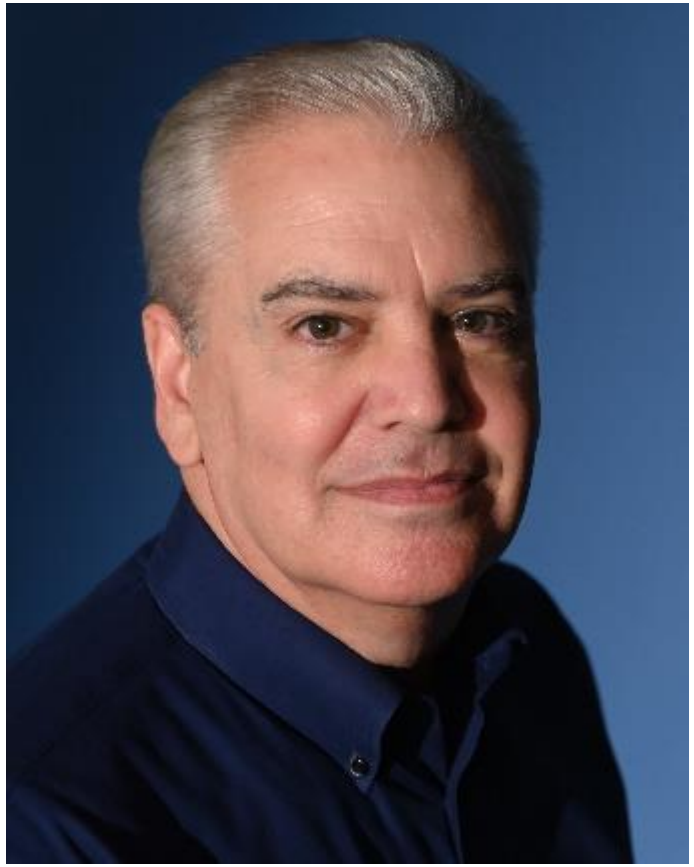










Q&A With Dr. Jobes



- Dr. Sammons will read select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.

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