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Training for Meaningful Clinical Practice Transformation & Suicide Specific Treatment

Craig J. Bryan, PsyD, ABPP

Executive Director, National Center for Veterans Studies

Associate Professor, Department of Psychology

Associate Professor, Department of Psychiatry

The University of Utah

Treatments That Reduce Suicide Risk

Treatment Modality	Duration	↓ Attempts	↓ Ideation
Multiple Clinical Trials			
Dialectical Behavior Therapy (DBT)	12 mos	√	
Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)	2-3 mos	√	
Crisis Response Plan (CRP) / Safety Planning Intervention (SPI)	1 session	√	√
Collaborative Assessment and Management of Suicidality (CAMS)	Variable		√
Caring Contacts	N/A	√	
Single Clinical Trial			
Mentalization Based Psychotherapy (MBP)	18 mos	√	
Attempted Suicide Short Intervention Protocol (ASSIP)	1 mo	√	
Post Admission Cognitive Therapy (PACT)	3 days		√



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Why Are Some Treatments Better Than Others?

Essential Ingredients of Effective Interventions

1. Based on a simple, empirically-supported model
2. High fidelity by the clinician
3. Adherence by the patient
4. Emphasis on skills training
5. Prioritization of self-management
6. Easy access to crisis services

Functional Model of Suicide

Reinforcement

Positive

Negative

Automatic
(Internal)

Adding something desirable
("To feel something")

Reducing tension or negative affect
("To stop bad feelings")

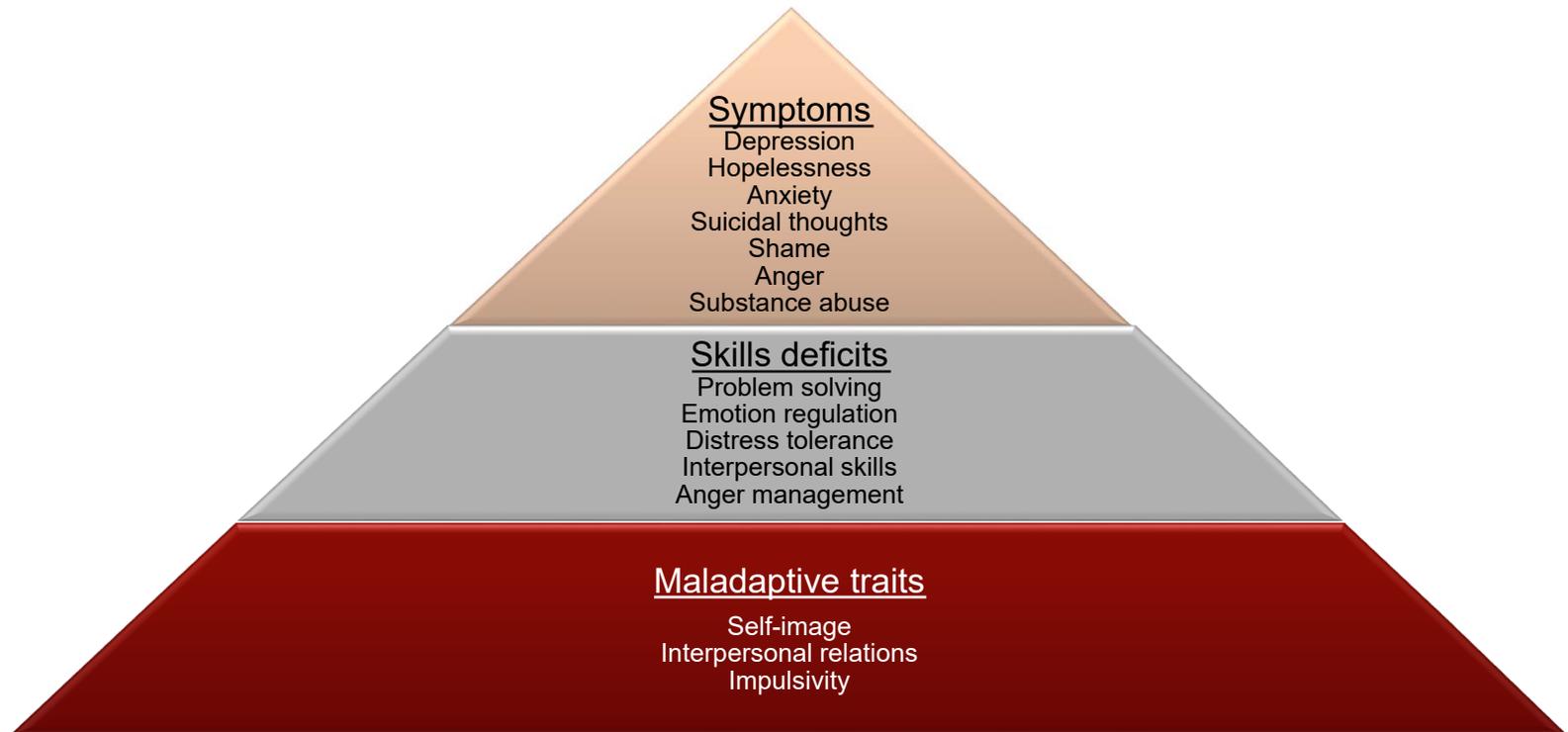
Social
(External)

Gaining something from others
("To get attention or let others
know how I feel")

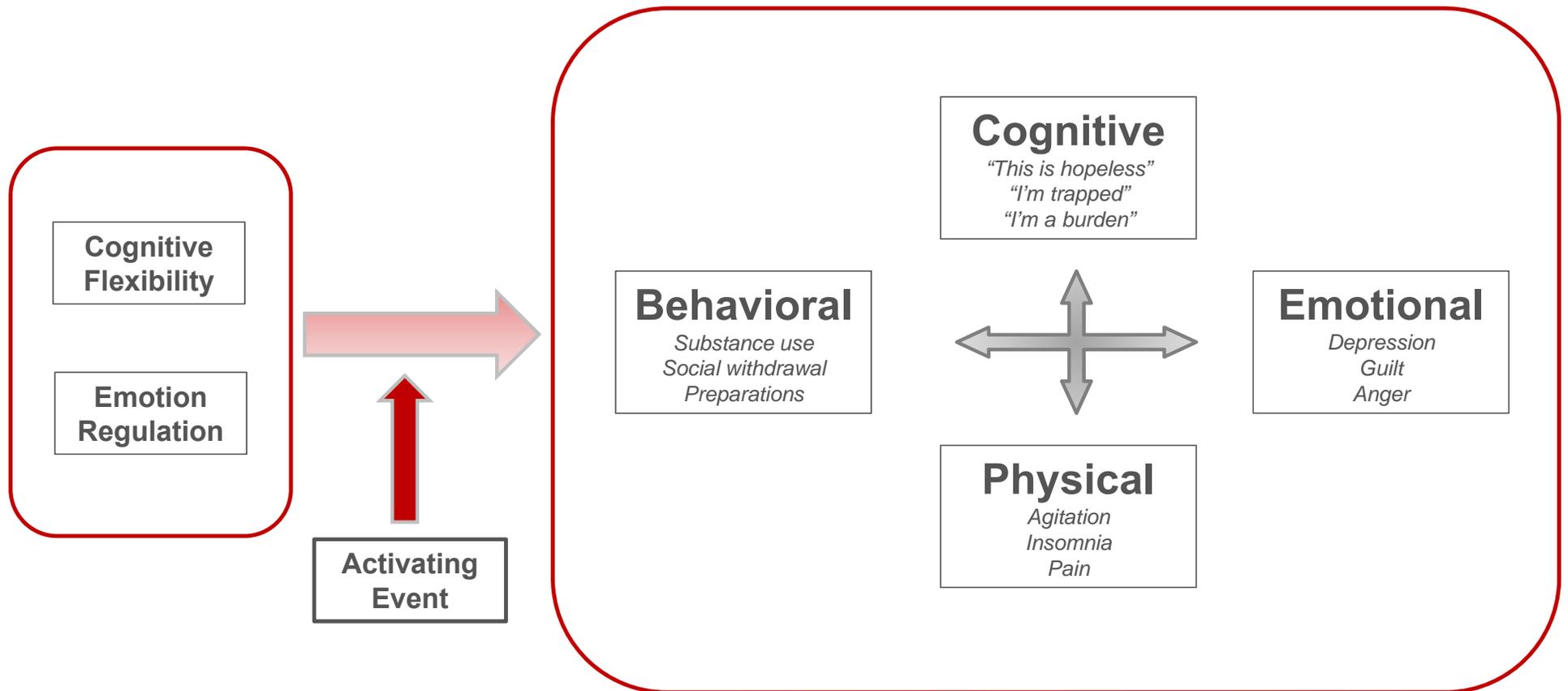
Escape interpersonal task demands
("To avoid punishment or doing
something undesirable")

Bryan, Rudd, & Wertenberger (2012, 2016); Nock & Prinstein (2004)

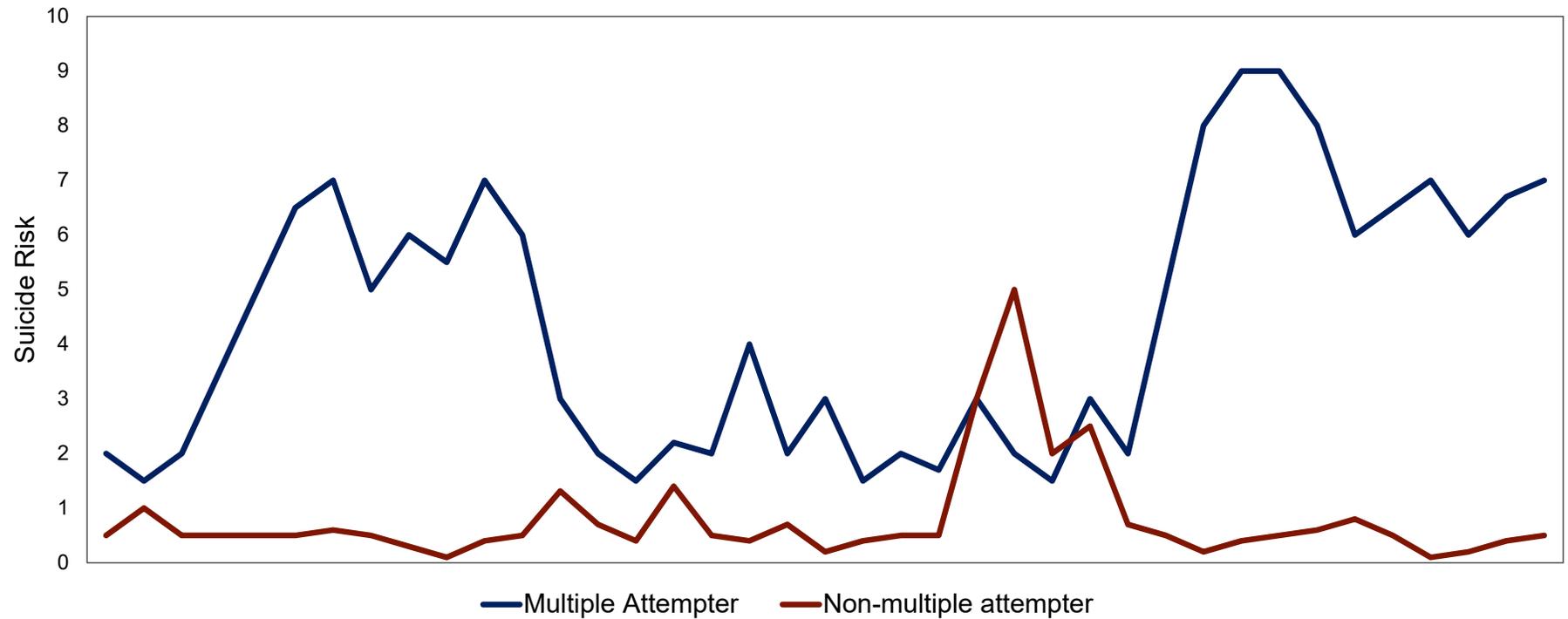
Multiple Levels of Suicide Risk



The Suicidal Mode



Fluctuations in Suicide Risk Over Time





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Which Treatment Is Right for *My Agency?*



**Recommended Standard Care
for People with Suicide Risk:**
MAKING HEALTH CARE SUICIDE SAFE

NATIONAL ACTION ALLIANCE
FOR SUICIDE PREVENTION

Primary Care

- CRP/SPI with lethal means counseling
- Make appt with MH professional
- 1 caring contact within 48 h

Outpatient Mental Health

- CRP/SPI with lethal means counseling
- Suicide-focused treatment
- Caring contacts during transitions

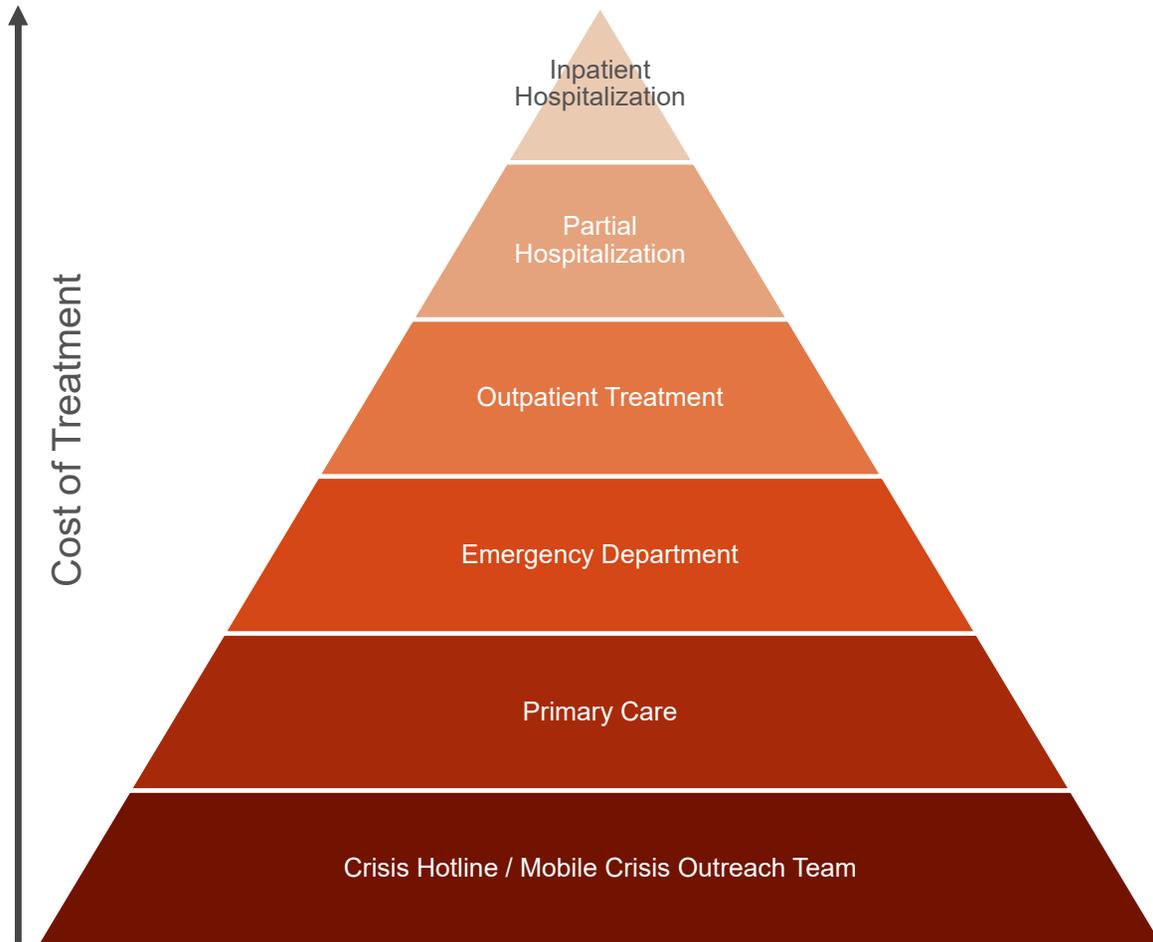
Emergency Department

- CRP/SPI with lethal means counseling
- Make appt with MH professional
- 1 caring contact within 48 h, 1 caring contact within 7 d

Inpatient Mental Health

- CRP/SPI with lethal means counseling at discharge
- Make appt with MH professional
- 1 caring contact within 48 h, 1 caring contact within 7 d

Stepped Care Model for Suicide Prevention



	CRP/SPI	Caring Contact	CAMS	CBT-SP	DBT
Inpatient Hospitalization	■	■	■	■	■
Partial Hospitalization	■	■	■	■	■
Outpatient Treatment	■	■	■	■	■
Emergency Department	■	■	■	■	■
Primary Care	■	■	■	■	■
Crisis Hotline / MCOT	■	■	■	■	■

Adapted from Jobes (2014)

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

- ① crying
- ② getting angry
- ③ wanting to hit things
- ④ argument w/ wife
- ⑤ ~~play videogames~~ photography
- ⑥ woodwork in garage
- ⑦ writing
- ⑧ go for walk
- ⑨ games on phone
- ⑩ breathing 10 mins
- ⑪ listen to ^{uplifting} music
- ⑫ talk to Bill
- ⑬ Dr. Smith: 555-555-5555 (voicemail)
- ⑭ Hotline: 1-800-273-2755
- ⑮ Hospital or 911

Reasons to live:

Mom	Photography
wife	Motorcycle rides
kids (Matt, Katie)	

What a Crisis Response Plan Is

a memory aid to facilitate early identification of emotional crises

a checklist of personalized strategies to follow during emotional crises

a problem solving tool

a collaboratively-developed strategy for managing acute periods of risk

What a Crisis Response Plan Is Not

a no-suicide contract

a no-harm contract

a contract for safety

CBT-SP Structure

Phase I:

Crisis management, distress tolerance

Phase II:

Cognitive restructuring of suicidal belief system, problem solving, cognitive flexibility

Phase III:

Relapse prevention

CBT-SP vs. Treatment As Usual (TAU)

TAU

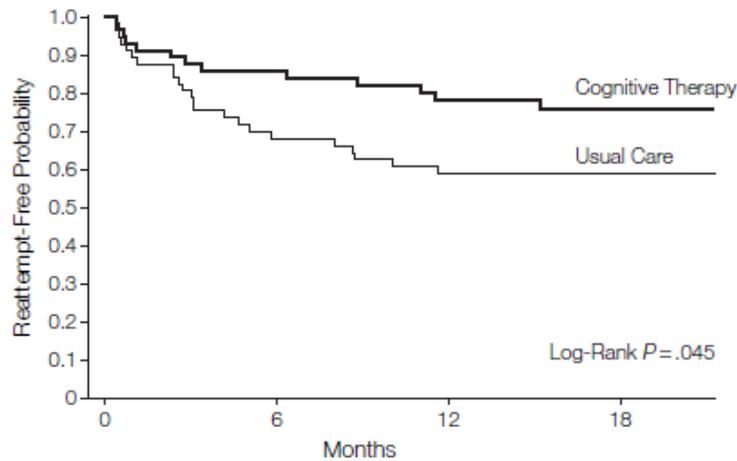
- Suicide as symptom of psychiatric diagnosis or condition
- Focus on psychiatric diagnosis
- Emphasizes external sources of self-management, including hospitalization
- Clinician responsibility for preventing suicide

CBT-SP

- Suicide as problem distinct from psychiatric diagnosis
- Focus on suicide risk
- Emphasizes internal sources of self-management to minimize hospitalization
- Shared patient-clinician responsibility for preventing suicide

Efficacy of CBT-SP vs. TAU

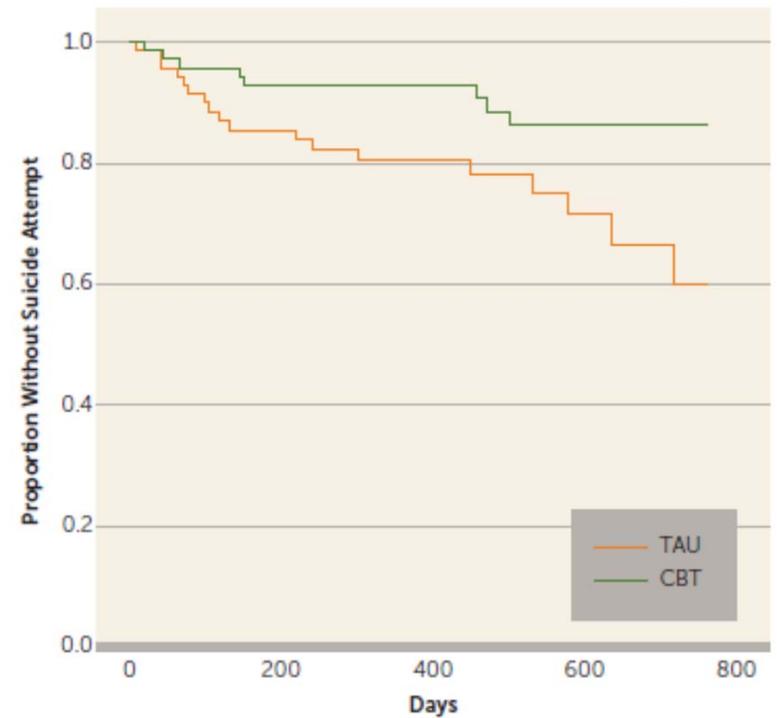
Figure 2. Survival Curves of Time to Repeat Suicide Attempt



No. at Risk

Cognitive Therapy	60	45	37	16
Usual Care	60	36	28	11

FIGURE 2. Survival Curves for Time to First Suicide Attempt^a



^aCBT=cognitive-behavioral therapy; TAU=treatment as usual (log-rank $\chi^2=5.28$, $df=1$, $p=0.02$).

Brown et al. (2005), Rudd et al. (2015)



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Considerations for Implementation

- Training workshops should be conducted by expert trainers
- Obtain follow-up consultation to support implementation
- Include leadership in training /implementation process
- Implement outcome monitoring procedures
- Think about who should get what training (not everyone should be trained to do all levels of care)
- **Remember:** Paperwork doesn't save lives; treatments do



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Questions & Discussion

craig.bryan@utah.edu