Training for Meaningful Clinical Practice Transformation & Suicide Specific Treatment

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# Treatments That Reduce Suicide Risk

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

Rudd et al. (2009)
# Functional Model of Suicide

<table>
<thead>
<tr>
<th>Reinforcement</th>
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</thead>
<tbody>
<tr>
<td><strong>Positive</strong></td>
<td><strong>Negative</strong></td>
</tr>
<tr>
<td>Adding something desirable</td>
<td>Reducing tension or negative affect</td>
</tr>
<tr>
<td>(&quot;To feel something&quot;)</td>
<td>(&quot;To stop bad feelings&quot;)</td>
</tr>
<tr>
<td>Gaining something from others</td>
<td>Escape interpersonal task demands</td>
</tr>
<tr>
<td>(&quot;To get attention or let others know how I feel&quot;)</td>
<td>(&quot;To avoid punishment or doing something undesirable&quot;)</td>
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Multiple Levels of Suicide Risk

Symptoms
- Depression
- Hopelessness
- Anxiety
- Suicidal thoughts
- Shame
- Anger
- Substance abuse

Skills deficits
- Problem solving
- Emotion regulation
- Distress tolerance
- Interpersonal skills
- Anger management

Maladaptive traits
- Self-image
- Interpersonal relations
- Impulsivity
The Suicidal Mode

Cognitive
- "This is hopeless"
- "I'm trapped"
- "I'm a burden"

Emotional
- Depression
- Guilt
- Anger

Physical
- Agitation
- Insomnia
- Pain

Behavioral
- Substance use
- Social withdrawal
- Preparations

Cognitive Flexibility

Emotion Regulation

Activating Event
Fluctuations in Suicide Risk Over Time

Suicide Risk

Multiple Attempter

- Bryan & Rudd, in press

Non-multiple attempter

- Bryan & Rudd, 2016
Which Treatment Is Right for My Agency?
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

- Inpatient Hospitalization
- Partial Hospitalization
- Outpatient Treatment
- Emergency Department
- Primary Care
- Crisis Hotline / Mobile Crisis Outreach Team

Cost of Treatment

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

Reasons to live:
- motorcycle rides
- photography
- kids (Matt, Katie)

Crying
Willing to hit things
Getting angry
Argument w/ wife

1. play videogames
2. woodwork in garage
3. go for walk
4. breathing 10 mins
5. talk to Bill
6. Dr. Smith: 555-555-5555 (voicemail)
7. Hot line: 1-800-273-2735
8. Hospital or 911
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)

<table>
<thead>
<tr>
<th>TAU</th>
<th>CBT-SP</th>
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<tbody>
<tr>
<td>Suicide as symptom of psychiatric diagnosis or condition</td>
<td>Suicide as problem distinct from psychiatric diagnosis</td>
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<tr>
<td>Focus on psychiatric diagnosis</td>
<td>Focus on suicide risk</td>
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<tr>
<td>Emphasizes external sources of self-management, including hospitalization</td>
<td>Emphasizes internal sources of self-management to minimize hospitalization</td>
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<tr>
<td>Clinician responsibility for preventing suicide</td>
<td>Shared patient-clinician responsibility for preventing suicide</td>
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</tbody>
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Efficacy of CBT-SP vs. TAU

**Figure 2. Survival Curves of Time to Repeat Suicide Attempt**

- **Cognitive Therapy**
- **Usual Care**

No. at Risk
- Cognitive Therapy: 60, 45, 37, 18
- Usual Care: 60, 36, 28, 11

Log-Rank $P = .045$

**Figure 2. Survival Curves for Time to First Suicide Attempt**

- **TAU**
- **CBT**

Proportion Without Suicide Attempt

$^{a}$CBT = cognitive-behavioral therapy; TAU = treatment as usual (log-rank $χ^2 = 5.28$, df = 1, $p = 0.02$).

Brown et al. (2005), Rudd et al. (2015)
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
Questions & Discussion

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