THE COPING LONG-TERM WITH ACTIVE SUICIDE PROGRAM (CLASP) ACROSS VULNERABLE TRANSITIONS IN CARE:

TREATMENT DESCRIPTION, RECENT DATA, AND FUTURE DIRECTIONS

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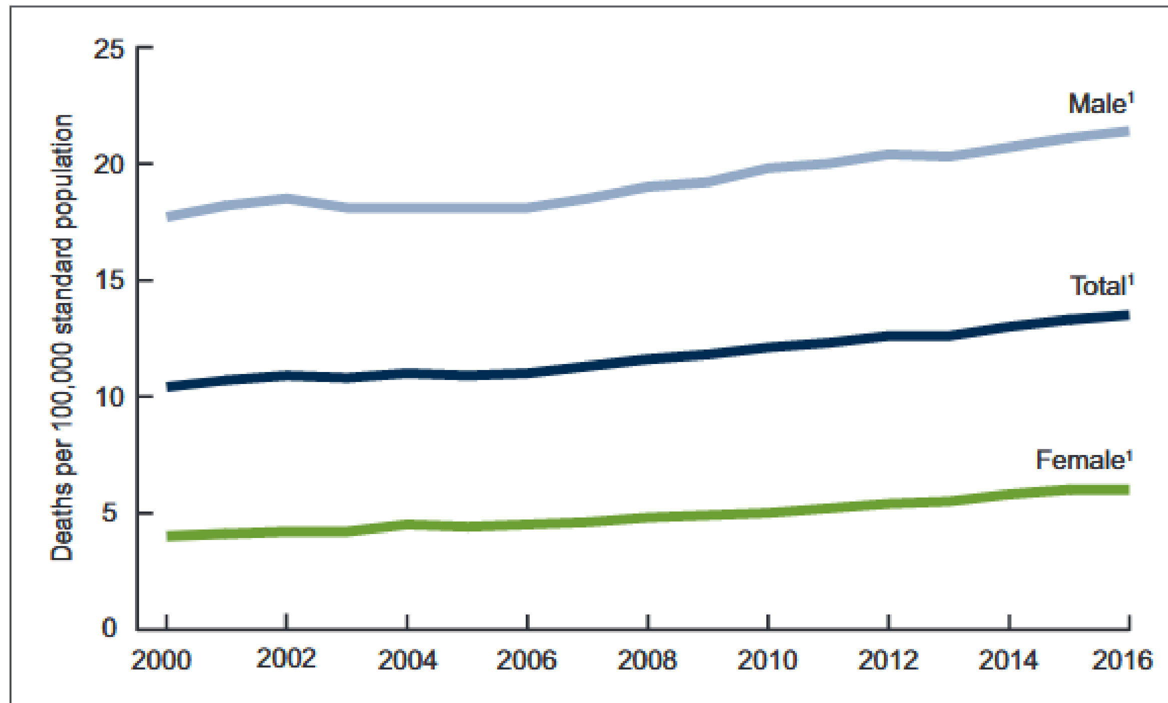
Poll Question #1

- What is your primary role in VA?
  - student, trainee, or fellow
  - clinician
  - researcher
  - Administrator, manager or policy-maker
  - Other

Poll Question #2

- Which describes your experience working with patients at high risk for suicide (select all that apply)?
  - I have frequent contact (clinical, administrative, research) with patients at high risk for suicide
  - I routinely conduct risk assessments and/create safety plans
  - I have little experience working with high risk patients
  - I rarely/never conduct risk assessments or safety plans

U.S. Suicide Rates Continue to Rise



Source:

Hedegaard, H., Curtin, S. C., & Warner, M. (June, 2018). Suicide rates in the United States continue to increase. National Center for Heatlh Statistics (NCHS) Data Brief, 309. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db309.pdf

Significant Public Health Issue

Suicide Statistics

While this data is the most accurate we have, we estimate the numbers to be higher. Stigma surrounding suicide leads to underreporting, and data collection methods critical to suicide prevention need to be improved. Learn how you can become an advocate.

Source:
American Foundation for Suicide Prevention (2019, February 27). Suicide statistics. Retrieved from https://afsp.org/about-suicide/suicide-statistics/

Suicide Risk Factors

Health Factors

- Mental health conditions
  - Depression
  - Substance use problems
  - Bipolar disorder
  - Schizophrenia
  - Personality traits of aggression, mood changes and poor relationships
  - Conduct disorder
  - Anxiety disorders
- Serious physical health conditions including pain
- Traumatic brain injury

Environmental Factors

- Access to lethal means including firearms and drugs
- Prolonged stress, such as harassment, bullying, relationship problems or unemployment
- Stressful life events, like rejection, divorce, financial crisis, other life transitions or loss
- Exposure to another person's suicide, or to graphic or sensationalized accounts of suicide

Historical Factors

- Previous suicide attempts
- Family history of suicide
- Childhood abuse, neglect or trauma

Source:
American Foundation for Suicide Prevention (2019, February 27). Risk factors and warning signs. Retrieved from https://afsp.org/about-suicide/risk-factors-and-warning-signs/

Acute psychiatric care is a key point of contact

Time-limited treatment goals

Goals of Inpatient Treatment for Psychiatric Disorders

Annual Review of Medicine
Vol. 60:393-403 (Volume publication date February 2009)
https://doi.org/10.1146/annurev.med.60.042607.080257

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Sections

ABSTRACT
KEY WORDS
INTRODUCTION
THE ACUTE UNIT FOR ADULTS IN THE GENERAL OR PSYCHIATRIC HOSPITAL

Abstract

The purpose of the psychiatric hospital changed dramatically during the twentieth century. Formerly the primary location for psychiatric treatment, the hospital now plays a more circumscribed role within a community-based system of care. Crisis stabilization, safety, and a focus on rapid discharge are the critical components of the acute inpatient stay. Subspecialized units focus on geriatrics, children, adolescents, dual diagnosis (substance abuse and mental illness), trauma disorders, eating disorders, and forensics. When integrated with the general medical system and a comprehensive base of community-delivered day treatment, residential sevices, and outpatient services, psychiatric hospitalization is a humane alternative to long-term institutional care.

Source:
Sharfstein, S. S. (2009). Goals of inpatient treatment for psychiatric disorders. *Annual Review of Medicine, 60*, 393-403. doi: 10.1146/annurev.med.60.042607.080257.

Major Challenge: Gaps in Continuity of Care Across Healthcare Transitions for Individuals at Risk for Suicide

What do Individuals and Families Face Across Transitions in Care?

- Closed vs. open healthcare systems
- Practical barriers (transportation, cost, location, timing of appointments, etc)
- Emotional barriers
- Access to proper referrals
- Brief hospitalizations and sufficient time to coordinate referrals?
- Consequences of missed appointments in an overtaxed behavioral healthcare system

Coping Long-Term with Active Suicide Program (CLASP)

- Initially developed to provide support across the transition from inpatient to outpatient treatment
- Three in-person sessions before discharge (specific focus on personal values and goals)
- One family meeting with an identified significant other (SO)
- Culminates in 6 months of telephone "check-ins" with both the patient and the SO
- Feedback letters to treatment providers

Theoretical perspective

- Risk reduction model
- Targets for relevant risk factors
  - Hopelessness
  - Isolation/Reduced belongingness
  - Impairments in problem solving skills
  - Challenges with treatment engagement
- Individual risk factors (e.g., substance use, anxiety)

Therapeutic approaches

- Multiple perspectives/strategies
  - Elucidation of values & goals (from ACT)
  - Family interventions (FITT, McMaster Model)
  - Problem solving
  - Elements of case management

Interventions mapped to risk factors

Intervention		Risk Factor
Values		Hopelessness
Family		Isolation
Problem Solving		Impaired Problem Solving
Values + Family + PS + Case Management		Treatment Engagement

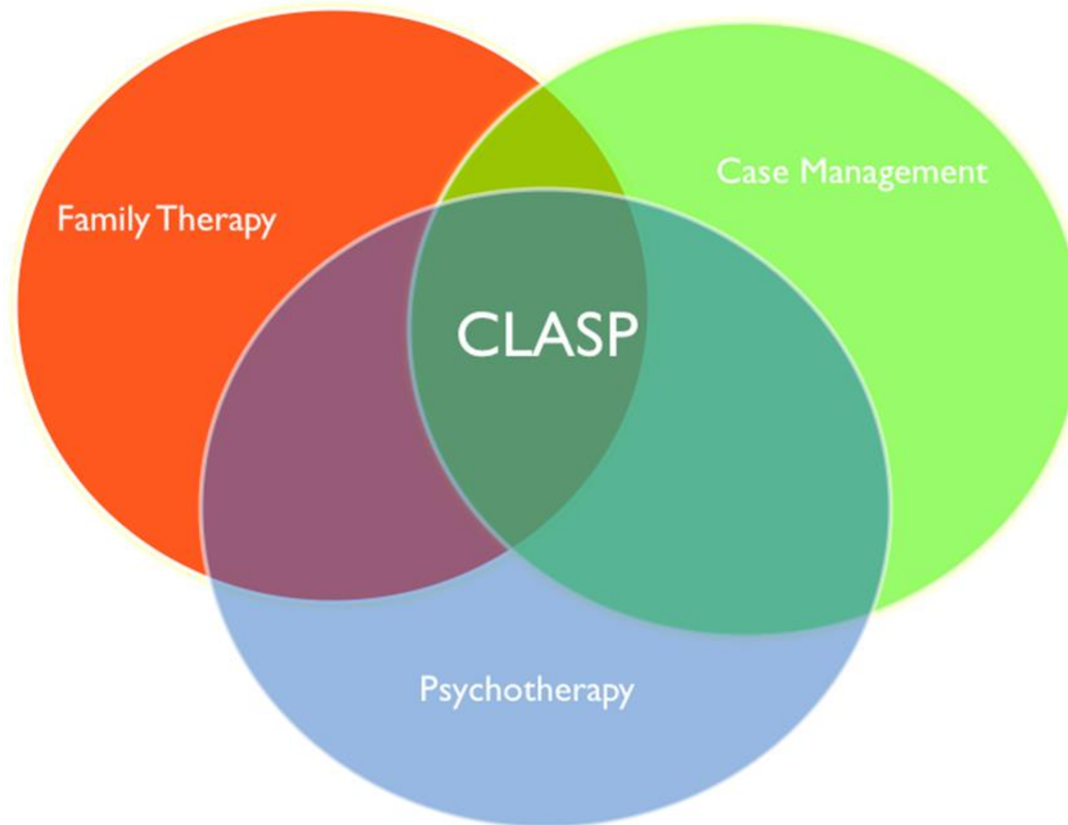
Hypothesized “meta” therapeutic goals

Strategy		Goal
Provider initiated calls		Availability + concern
Routine discussion of suicide		Reduce stigma, increase communication
Calls to both patient and SO		Increase interaction, support, joint problem solving
Problem solution focus		Models and rewards active problem solving

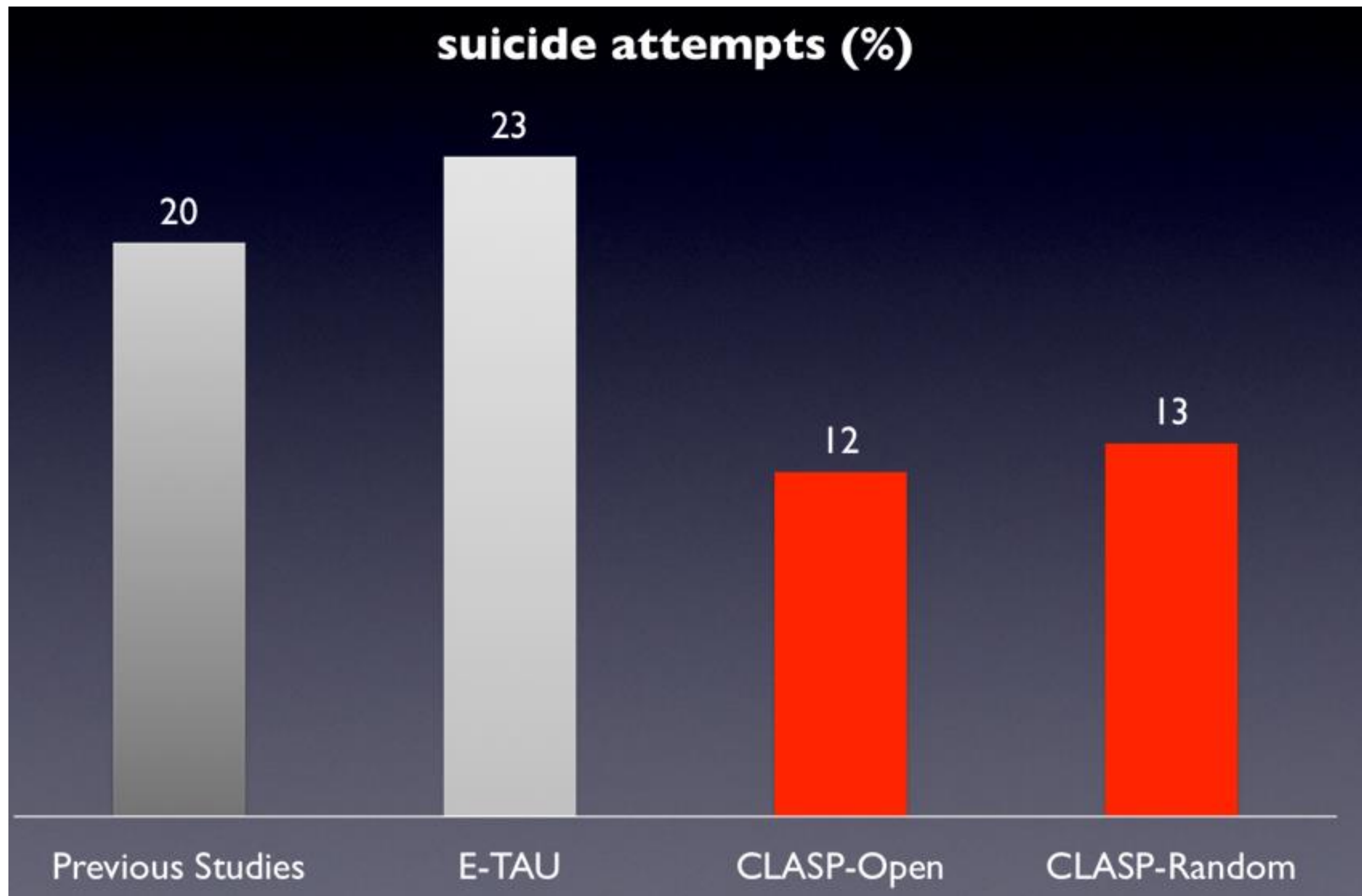
Therapeutic stance

- Different than “psychotherapist” or “case manager”
- “CLASP Treatment Advisor”
  - Monitoring
  - Facilitate values based problem solving
  - Facilitate productive patient-SO interactions
  - Case management
  - Specific psychotherapy interventions, as appropriate

The Coping Long-Term with Active Suicide Program

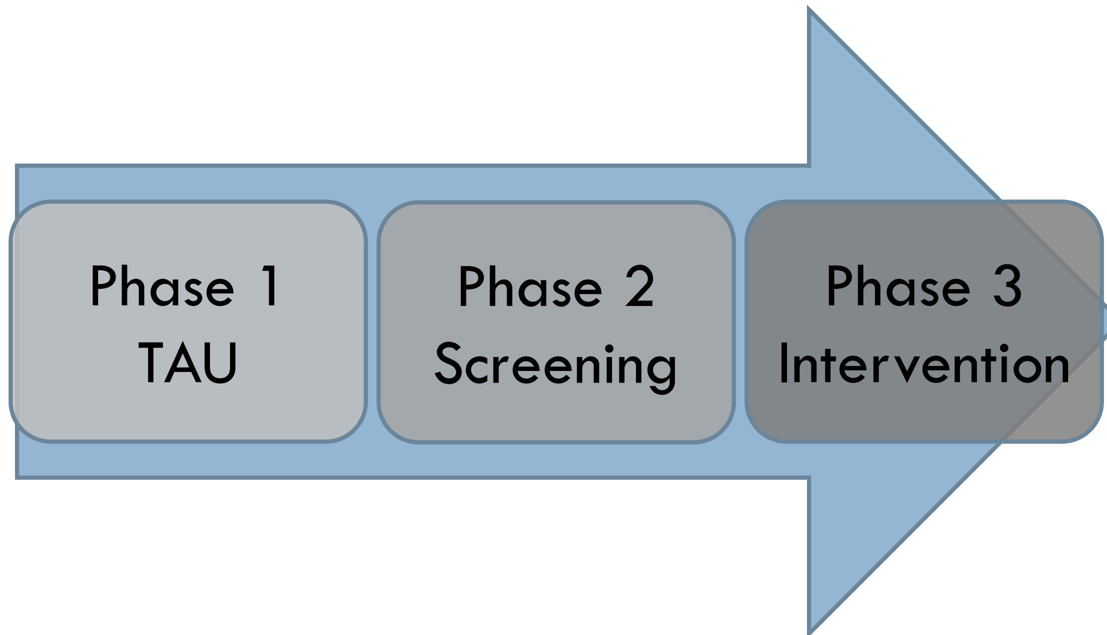


CLASP Pilot Study (N=80)



Source:
Miller, I. W., Gaudiano, B. G., & Weinstock, L. M. (2016). The Coping Long-Term with Active Suicide Program: Description and pilot data. *Suicide and Life-Threatening Behavior, 46*, 752-761. doi: 10.1111/sltb.12247

CLASP in the emergency dept setting? The ED-SAFE study (N=1376)



Source:
Miller, I. W., Camargo, C. A., Arias, S. A., Allen, M. H., Goldstein, M. B., Manton, A . P.,… Boudreaux, E. D. (2017). Suicide prevention in an emergency department population: The ED-SAFE study. *JAMA Psychiatry*, *74*, 563-570. doi: 10.1001/jamapsychiatry.2017.0678

ED-SAFE Intervention Phase

Universal screening (Phase 2)

+

Secondary risk screener for MDs (in ED)

Self-administered safety plan (in ED)

Telephone-based follow-up intervention (CLASP-ED)

Source:
Miller, I. W., Camargo, C. A., Arias, S. A., Allen, M. H., Goldstein, M. B., Manton, A . P.,… Boudreaux, E. D. (2017). Suicide prevention in an emergency department population: The ED-SAFE study. *JAMA Psychiatry, 74*, 563-570. doi: 10.1001/jamapsychiatry.2017.0678

CLASP vs. CLASP-ED

CLASP	CLASP-ED
• 3 in person sessions w/patient + 1 with SO	• Completely telephone-based
• 6 month protocol	• 12 month protocol
• 11 phone contacts with patient	• 7 phone contacts with patient
• 11 phone contacts with SO	• 4 phone contacts with SO

Overall outcomes (across phases)

Death 0.4

Suicide Attempt (n=288) 21

Suicide Behavior (n=349) 25

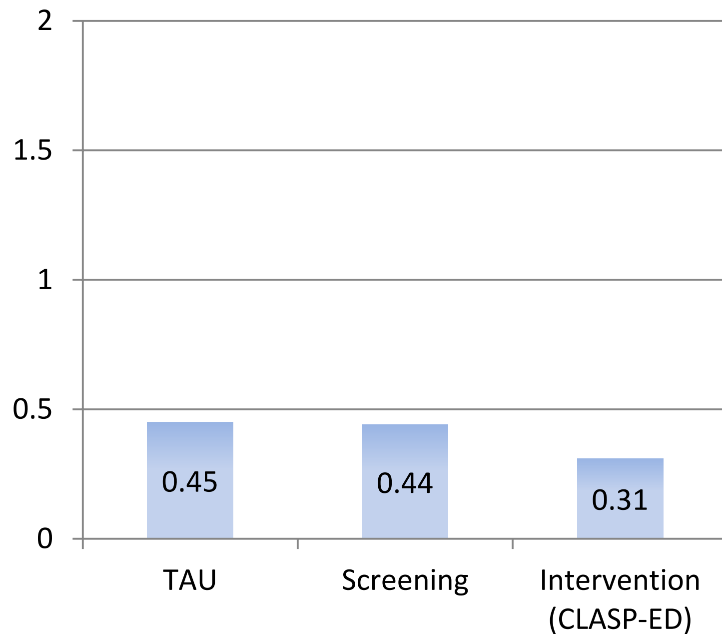
0 5 10 15 20 25 30

Percentage of Sample

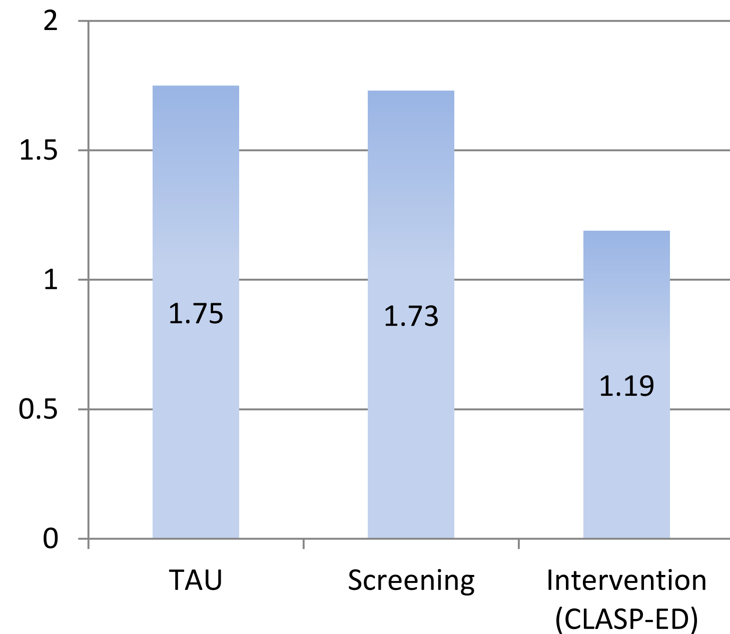
Source:

Miller, I. W., Camargo, C. A., Arias, S. A., Allen, M. H., Goldstein, M. B., Manton, A . P.,… Boudreaux, E. D. (2017). Suicide prevention in an emergency department population: The ED-SAFE study. *JAMA Psychiatry, 74*, 563-570. doi: 10.1001/jamapsychiatry.2017.0678

Suicide outcomes; average number per participant



Relative Risk Reduction = 31%



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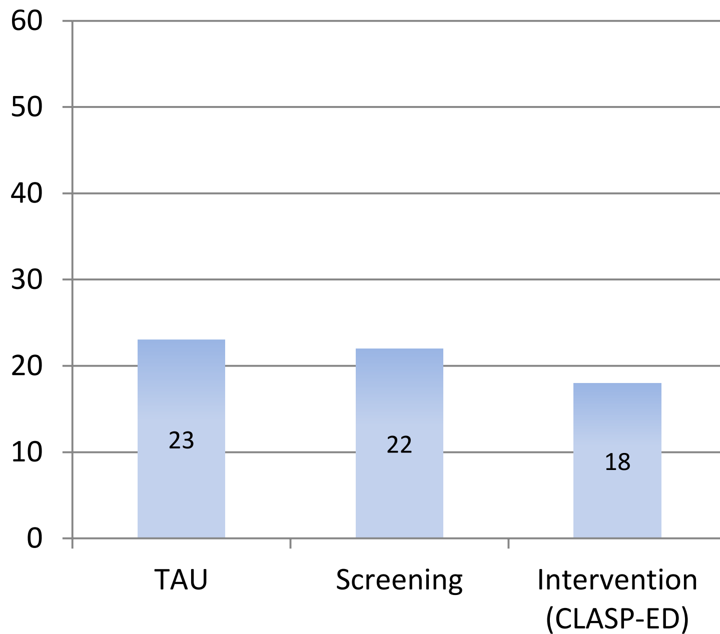
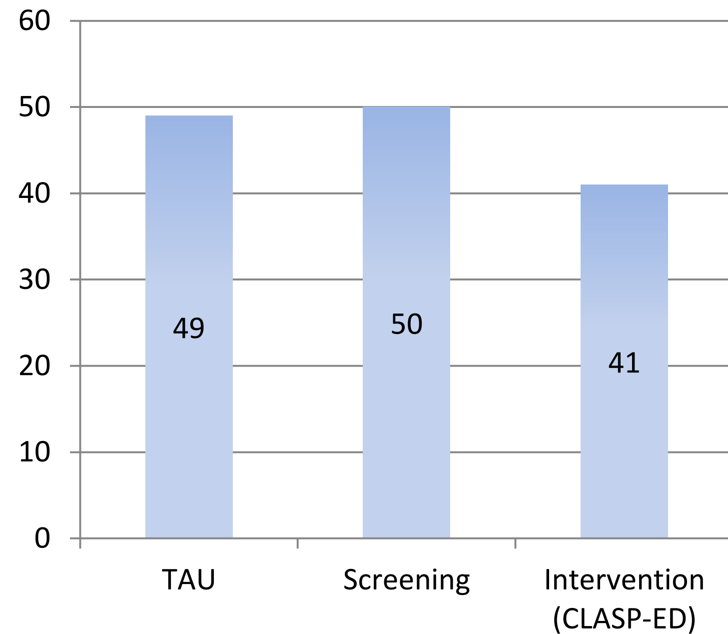
Suicide outcomes (%)





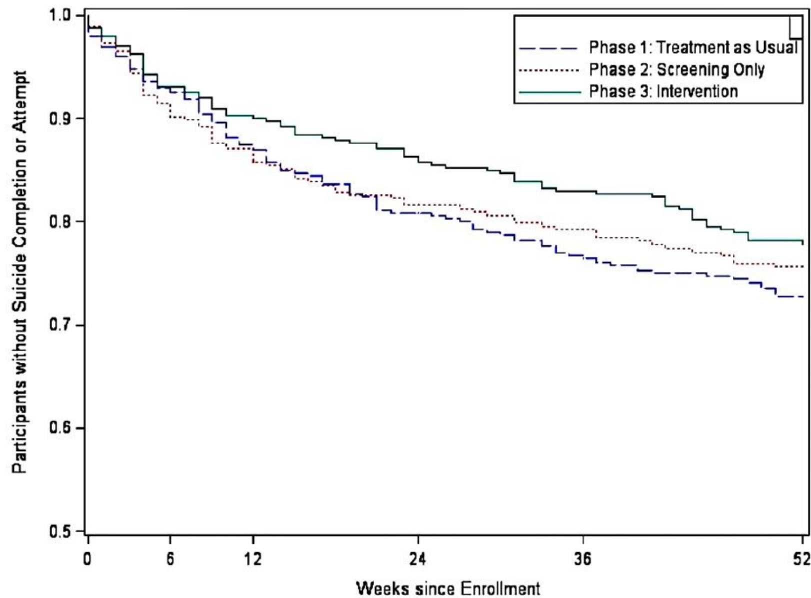
Absolute Risk Reduction = 5%
Relative Risk Reduction = 20%
Number Need to Treat = 22

Absolute Risk Reduction = 8%
Relative Risk Reduction = 15%
Number Need to Treat = 13

Source:
Miller, I. W., Camargo, C. A., Arias, S. A., Allen, M. H., Goldstein, M. B., Manton, A . P.,… Boudreaux, E. D. (2017). Suicide prevention in an emergency department population: The ED-SAFE study. *JAMA Psychiatry*, *74*, 563-570. doi: 10.1001/jamapsychiatry.2017.0678

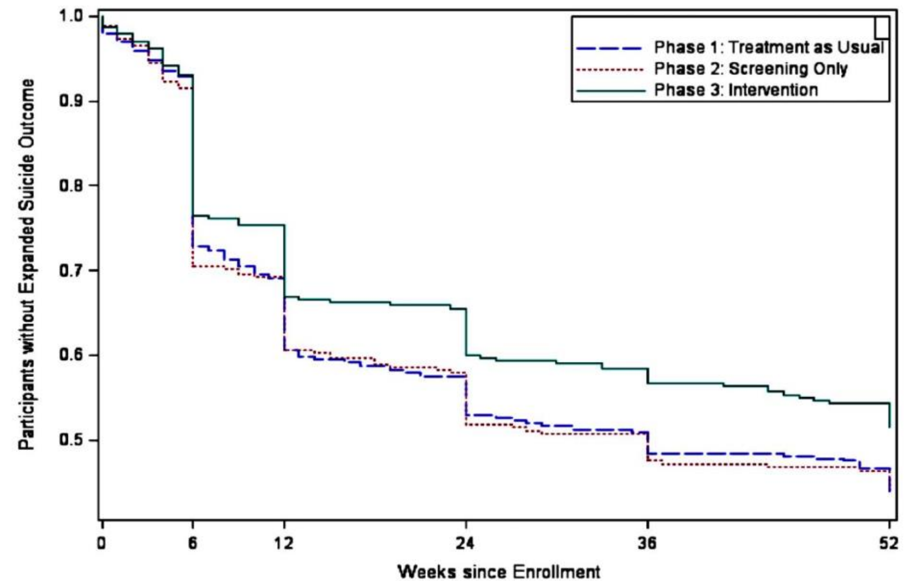
Cox multivariate models over 52 week follow-up

Suicide attempts + deaths



Log rank $p = 0.08$

Suicide composite



Log rank $p < 0.03$

Source:

Miller, I. W., Camargo, C. A., Arias, S. A., Allen, M. H., Goldstein, M. B., Manton, A . P.,… Boudreaux, E. D. (2017). Suicide prevention in an emergency department population: The ED-SAFE study. *JAMA Psychiatry, 74*, 563-570. doi: 10.1001/jamapsychiatry.2017.0678

Cox multivariate models

Comparison	Suicide Attempts+ Death		Suicide Composite	
	Hazard Ratio	p	Hazard Ratio	p
TAU vs. Screening	0.90	0.48	0.98	0.86
TAU vs. Intervention	0.73	0.03	0.78	0.01

Source:
Miller, I. W., Camargo, C. A., Arias, S. A., Allen, M. H., Goldstein, M. B., Manton, A . P.,… Boudreaux, E. D. (2017). Suicide prevention in an emergency department population: The ED-SAFE study. *JAMA Psychiatry, 74*, 563-570. doi: 10.1001/jamapsychiatry.2017.0678

Who needs CLASP?

Who needs CLASP?

AMERICAN ASSOCIATION OF SUICIDOLOGY

Suicide Prevention is *Everyone's Business*

AAS is a charitable, nonprofit membership organization

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- 52nd Annual Conference
- 31st Annual Healing Conference
- AAS Presenter Center

52nd Annual Conference

- Miller et al. (2019, April). *Who needs a comprehensive suicide prevention intervention after an emergency department visit?* To be presented Fri, 4/26, 2:30-2:45pm. Governor's Square.

Returning to inpatient care transitions: Ongoing effectiveness trials

- Miller et al. – Butler Hospital (R01 MH101129)
- Primack et al. – Providence VA (I01 HX001275)

Veterans CLASP

- Adaptation for VAMC system
  - Coordination with SPC
  - Integration into the local hospital suicide prevention clinical team
  - Increased flexibility of phone calls
  - Fewer exclusion criteria

Civilian vs. Veterans CLASP

Civilian CLASP	Veterans CLASP
• Coordination of multiple health care systems	• Centralized health care system with VHA providers
• Mailed letters to MH providers	• Integrated notes into CPRS
• Advisors are contractors	• Advisors are VA social workers
• No centralized suicide coordinator	• Coordination through SPC program

Veterans CLASP Enrollment

Approached for Study: 330

↓

Consented: 189

↓

Screened: 183

↓

Eligible: 117

↓

Baseline Assessment Completed: 107

↙ ↘

Randomized to CLASP Intervention: 52

Randomized to SAFE: 53

Veterans CLASP: Demographics

Participant Characteristics	% Sample
Gender	
Male	89.9
Female	8.2
Other	.6
Race	
Black or African Descent	9.5
White or Caucasian	86.7
Amer. Indian/Nat. Alaskan	5.7
Other	4.4
Ethnicity	
Hispanic	5.7
Not Hispanic	91.1

Military Characteristics	% Sample
Branch	
Army	35.4
Air Force	12.0
Coast Guard	3.8
Marines	16.5
Navy	12.0
National Guard/Reserves	1.9
Deployment	
Operation Enduring Freedom (OEF)	21.5
Operation Iraqi Freedom (OIF)	20.3
Persian Gulf	14.6
Vietnam	10.1
Korea	1.3
Other	17.1

preliminary data – please do not quote or cite without permission

Primack et al., in prep

Veterans CLASP: Suicide Behaviors and Ideation

Participant Characteristics	%Sample
SA in week prior to hospitalization	20
SA lifetime	63
Multiple suicide attempts?	40
Hx of suicide behavior?	79
Most commons methods (acts)?	
Overdose	
Cutting	
Hanging	

Participant Characteristics	Average
Avg CSSRS screen for week prior to hospitalization	3.81
Avg CSSRS screen for most suicidal lifetime	4.11
Most commons methods (SI)?	
Overdose	
Hanging	
Vehicular	
Firearm	
Avg. methods contemplated in week prior to hospitalzation	1.61

<u>preliminary data – please do not quote or cite without permission</u>

Primack et al., in prep

Suicidal ideation vs. behavior in Veterans CLASP

- History of suicide attempt associated with more severe lifetime ideation, with longer duration, and with less sense of controllability
- History of suicide attempt associated with reports that deterrents less likely to prevent future suicide behavior
- History of suicide attempt associated with greater likelihood that one would attribute suicidal ideation to military service

Veterans CLASP Efficacy

- Data analysis currently ongoing
  - Initial comparisons fail to show significant differences between CLASP and control condition in suicide ideation severity or attempts
  - No differences were observed in treatment utilization between CLASP and control patients

Challenges in VA CLASP

- Difficulty enrolling significant others
- Low treatment engagement/participation
- Drop out rate in assessments over 12 month period
- High percentage of patient transitioned to residential treatment following inpatient hospitalization
- VA treatment as usual offers higher standard of care for high risk patients compared to civilian hospitals (e.g., greater follow up, coordinated care system, SPC, etc.).

Current status of CLASP: Summary

- For at-risk inpatients leaving the hospital, pilot data suggest CLASP is a promising intervention
- For at-risk individuals leaving the ED, evidence that CLASP reduces risk for suicide attempts and behaviors
- Ongoing, fully powered effectiveness trials forthcoming – in both civilian and Veterans samples

Needs and future directions

- If effective, how can CLASP be implemented and disseminated successfully?
  - Health plans as a logical place for dissemination?
  - Community mental health in partnership with local health systems?
- Ongoing questions from ED-SAFE study:
  - Who will pay?
  - Who will deliver?
  - From where?
  - Questions around expectations for fidelity – CLASP vs. "telephone outreach"

Needs and future directions

- Some discussions with VA Central Office:
  - Can CLASP be integrated into SPC activities?
  - Whereas inpatient setting represents large catchment area in civilian population, is focus on inpatient transitions too narrow for VA?
  - Some suggestions that VCL may be appropriate place for roll-out?
  - Other ideas?

CLASP Study Team

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- <u>We also thank our patients and their family members for their participation</u>!

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