ISSUE 3 | APRIL 2024

CAPES

Center for Accelerating Practices to End Suicide

> Updates from the Center for Accelerating Practices to End Suicide (CAPES)

A WORD FROM OUR DIRECTORS

Welcome to the third CAPES quarterly newsletter! We are excited to share news and announcements from the NIMH-funded Center for Accelerating Practices to End Suicide (CAPES) at UMass Chan Medical School. It's been a busy quarter, with planning starting for our Summer Retreat and Fall Summit, our first Lived Experience Advisory Board meeting focused on Jaspr – and now available to all CAPES research projects and faculty, a podcast by Dr. Lourah Kelly on the Emerging Adult Avatar platform. We wish you a happy 2024 and look forward to seeing what the new year brings for our growing Center!

Sincerely,

Ed Boudreaux, PhD and Catarina Kiefe, PhD, MD
Directors, Center for Accelerating Practices to End Suicide

New Suicide and Translation Journal Articles

> Check out this study by Chitavi et al. (2024). **Evaluating the prevalence of four recommended practices for suicide prevention following hospital discharge** in *Joint Commission Journal on Quality and Patient Safety*.

> READ MORE

> Check out this study by Cullen et al., (2024). **Impact of emergency department safety planning on 30-day mental health service use** in *Psychiatric Services*.

> READ MORE

> NEWS THIS QUARTER

The launch of the CAPES signature project started in January 2024 and recruitment is well underway! We are testing clinical and implementation outcomes of Jaspr, a suicide prevention software that can be accessed on a tablet by emergency department (ED) patients, which makes therapeutic use of downtime before a psychiatric evaluation. Patients can download the Jaspr@ Home app to their smartphone and use their safety plan and tools after the visit.

The STAY Tuned Podcast within iSPARC featured Dr. Lourah Kelly and discussed her Emerging Adult Avatar project, which uses an avatar to teach young adults skills to manage drinking and suicidal thoughts during and after an ED visit. Check it out along with the other STAY Tuned podcasts here!

> LISTEN HERE

The CAPES Lived Experience Advisory Board met with the Jaspr team and provided feedback on each element of the Jaspr application and on our Research Coordinator's approach script for inviting participants to learn more about the study and participate. The board gave extensive, detailed feedback on what they liked about Jaspr, including the myriad of coping skill options and representation of persons with lived experience, techniques for ensuring privacy, and potential to reduce stigma and repetition of sensitive questions.

Themes that all technology-based suicide interventions can follow include:

1) presenting multiple options for participation and entry of information,
2) giving as much choice as possible,
3) having security options,
4) being transparent in what the intervention will offer, and
5) being transparent in what is technology-driven vs managed by a person behind a screen.

Meetings are the second Friday of each month from 230– 4PM. Contact Lourah Kelly at Lourah.Kelly@umassmed.edu to seek consultation with the Lived Experience Advisory Board. We will also have ad-hoc members with various experiences across settings (acute care, primary care/outpatient, and college settings) based on project needs.

> MEET THE CAPES FACULTY - KATHERINE DIXON-GORDON, PHD

This month, **meet Katherine Dixon-Gordon, PhD!** Dr. Dixon-Gordon is Co-Project Lead for the Leveraging "Early Mental Health Uncovering©" Risk for Suicide (LEMURS) project within CAPES, along with Dr. Elke Rundensteiner at Worcester Polytechnical Institute. She is a Clinical Psychologist and Associate Professor and Director of Clinical Training at the University of Massachusetts Amherst. She is dedicated to better understanding, predicting, and ultimately reducing self-injurious behaviors, particularly using ecologically valid methods like daily diaries, experience sampling, and momentary assessments.

Her program of research offers experiences in three relevant areas:

(1) context expertise in self-injurious behaviors and related forms of psychopathology,

(2) proficiency in multi-method paradigms to permit versatility in rigorous tests of CAPES' tools and

(3) experience conducting randomized clinical trials.

She has been an investigator in over 6 federally funded (NSF, NIH, and Canadian Institutes of Health Research) studies of the assessment and treatment of self-injurious behaviors across outpatient and emergency department-recruited samples. In addition, she is committed to dissemination of the results of CAPES work to relevant populations, via scientific publications (resulting in over 100 published works) and clinical training. Ultimately, Dr. Dixon-Gordon hopes that this work reduces suicide and aids individuals in developing lives worth living. **To learn more about her work, visit her Clinical Affective Science Lab website here!**

> CAPES TECHNOLOGY CORNER

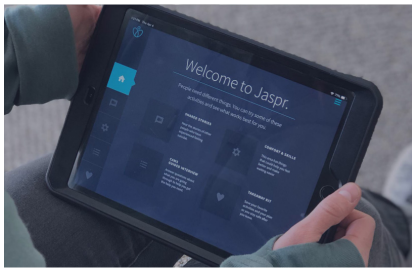
How was Jaspr designed?

We began with a pretty simple idea: *How can we transform the ED experience for people who are acutely suicidal from one that is traumatizing and prioritizes assessment, referral, and safety at all costs to one where people who are profoundly suffering reliably receive compassionately delivered evidence-based suicide care?*
The WHAT of Jaspr was easy: We looked to the research literature to see what suicide experts recommended for acutely suicidal persons seeking psychiatric crisis services in an ED. We included those domains. **The HOW was a game changer.** Inspired by NIMH, we fully included the voices and perspectives of people with lived experience every design step along the way. We recorded their stories, listened carefully to their recommendations, and made sure we were always walking in lock-step with our colleagues with lived experience. ***We fully embraced the "not about us without us" philosophy of the recovery movement.***

What is the evidence for Jaspr, such as any peer reviewed publications or presentations?

We conducted a randomized controlled trial comparing Jaspr to care as usual. Unfortunately, the study was discontinued after three months due to Covid. ***However, even with a very small sample size, we found statistically significant differences on a number of outcome variables favoring Jaspr.*** Specifically, those assigned to Jaspr were way more likely to receive evidence-based suicide care. Because patients were receiving proven care for their problems, we saw evidence of stabilization: agitation and distress decreased over time during the ED visit. ***Finally, those who received Jaspr were significantly more likely to demonstrate an increase in suicide coping.*** Findings from naturalistic studies have also found functional improvements in those patients who received Jaspr compared to those who were eligible but didn't, including significantly fewer restraint episodes and significantly more discharges home.

What are the features of JASPR - how does it advance suicide prevention?



Jaspr helps healthcare providers deliver evidence-based suicide care for acutely suicidal persons seeking help. In collaboration with Dave Jobes, PhD, ABPP, treatment developer of the Collaborative Assessment and Management of Suicidality (CAMS), we transformed the CAMS Suicide Status Form into an interview conducted by virtual chat bot. This includes a comprehensive suicide assessment, lethal means assessment, and crisis safety planning. Drawing from Marsha Linehan's Dialectical Behavior Therapy (DBT), Jaspr includes dozens of skills training videos taught by people with lived experience. Finally, and my favorite: Jaspr includes hundreds of videos by people with lived experience sharing their wisdom, hope, and insights.

> *"We fully embraced the "not about us without us" philosophy of the recovery movement."*

> UPCOMING CONFERENCES

Register **here** *for the* **FREE third annual Suicide Research Symposium, held on April 17-19, 2024**. *Sponsored by the American Foundation for Suicide Prevention, this conference focuses on recent research findings, developments in suicide research, inclusive and equitable practices in suicide research and prevention, and provides opportunities for networking across disciplines.*

On June 5th, the Massachusetts Department of Public Health is hosting a full day in-person training "Assessing and Managing Suicide Risk" led by Dr. Rachel Davis-Martin and Lourah Kelly at the Beechwood Hotel in Worcester, MA. *There are four suicide prevention trainings in May: New Developments in Understanding, Managing, and Treating Suicidal Behavior; Sustainability and Engagement of Suicide Prevention; Question, Persuade, and Refer; and Postvention: Responding to Schools, Workplaces, and Communities Following Suicide. Sign up at the Dept. of Public Health Suicide Training Prevention website linked* **here***!*

> OTHER UPCOMING EVENTS

The UMass Chan Psychiatry Department is hosting a **NAMI Walks team on May 18th from 9AM -1PM starting at the Boston Common** *to raise mental health awareness, combat stigma against mental illness, and be proud of the work we do towards improving mental health in our community.*
Click **here** *to learn more!*

NAMI Walks YOUR WAY

New Suicide Research Dissemination Resource

Dr. Celine Larkin led efforts to create a tipsheet for researchers to share findings with broader communities. **We have a duty to share out research findings responsibly by including hopeful recovery-oriented messages, pairing research with clinical resources, ensuring safe interactions on social media, using best practice language, and inviting feedback from persons with lived experience.** *Check out the resource on the last page of this newsletter.*

A poster based on this work will be shared by CAPES staff and trainees, Gwen Gould and Swashna Avneeta at the Research Symposium "Friend or Foe: Transforming Social Media and AI for a Healthy Future" organized by CAPES faculty Dr. Denise Dunlap.

> GET INVOLVED!

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CAPES Suicide Prevention

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Save the Dates for CAPES Summer Retreats: *All Admin Cores have been emailed a link to schedule a half-day retreat for a retreat for the Methods Core and a retreat for the Admin Core.* **Search your email for "CAPES Retreat for the Methods & Admin Cores: Doodle Poll" from Carolyn Kelly.**

Best Practices for Public Dissemination and Language around Suicide Research

Many of us are aware of the media guidelines for responsible media reporting around suicide.[1,2,3]

Irresponsible communication around suicide in the media has been shown to increase risk and can even contribute to higher suicide rates.[4,5]

As researchers, we have a part to play in responsible reporting and sharing of suicide research findings with the public. As you share any suicide-related research, please keep these simple guidelines in mind.

DON'T:

- **Don't** include methods of suicide in publication titles[6]
- **Don't** provide detailed description of methods or describe novel methods of suicide[1]
- **Don't** provide simplistic explanations of suicide, such as single "triggers" or "causes" of suicide[6]
- **Don't** harp on statistics: citing lots of numbers without also balancing with hope or resources can reinforce hopelessness
- **Don't** use sensational language, such as "surge," "crisis," "tsunami,"or "epidemic" [6]
- **Don't** use images that depict methods or stereotypes, like the classic "head-clutcher" image[7]
- **Don't** publicize celebrity suicides or suicide clusters; publicize resources instead
- **Don't** use stigmatizing language, such as "commit suicide" or referring to suicide as "successful," "unsuccessful" or a "failed attempt." [1]
- **Don't** dehumanize a person by saying "suicidal patient" or "suicide attempter". Rather, use person-first narrative (e.g. "patient who struggles with suicide").

DO:

- Include **messages and narratives of hope and recovery**
- List **resources** that can support those experiencing suicidal thoughts/behaviors and suicide bereavement
- Use **carefully selected images** that represent a variety of lived experience and communities[7]
- Assume that any content can go **viral**[8]
- **Monitor interactions** with your posts; consider disabling comments for certain posts[8]
- **Invite input of those with lived experience**, while prioritizing safe messaging. What's validating for persons with lived experience may not be an ideal message or visual for the broader public and could instead be shared in specific settings (e.g., settings for persons with lived experience with suicidal thoughts/behaviors)
- **Use appropriate language**, like "died by suicide", "attempted suicide" or "took their own life" [1]
- When talking about someone who struggles with SI and SA, **please use "person first" language** (e.g. "a person who struggles with suicide", "a person who has attempted suicide").

REFERENCES

[1] https://reportingonsuicide.org/wp-content/uploads/2022/12/ROS-One-PagerUpdated2022.pdf
[2]https://iris.who.int/bitstream/handle/10665/372691/9789240076846-eng.pdf?sequence=1
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[4]Niederkrotenthaler, T., Fu, K. W., Yip, P. S., Fong, D. Y., Stack, S., Cheng, Q., & Pirkis, J. (2012). Changes in suicide rates following media reports on celebrity suicide: a meta-analysis. J epidemiol community health, 66(11), 1037-1042.
[5]Niederkrotenthaler, T., Braun, M., Pirkis, J., Till, B., Stack, S., Sinyor, M., ... & Spittal, M. J. (2020). Association between suicide reporting in the media and suicide: systematic review and meta-analysis. Bmj, 368.
[6]Knipe, D., Hawton, K., Sinyor, M., & Niederkrotenthaler, T. (2021). Researchers must contribute to responsible reporting of suicide. BMJ, 372, n351-n351.
[7]https://training.cochrane.org/sites/training.cochrane.org/files/public/uploads/Images%20Check-list%20for%20Evidence%20Dissemination%20-%20Final%2C%20version%201.0_2.pdf
[8]https://www.orygen.org.au/chatsafe/Resources/International-guidelines/US-English

If unsure, check with CAPES suicidologists to make sure your messaging is safe.

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