



Evidence-based treatment for suicidality

Why include this strategy in LifeSpan?

People living with mental illness are up to 30 times more likely to die by suicide than the general population ¹. Although not all people who die by suicide have a mental health problem, and not all people with mental illness are affected by suicidal behaviour, access to excellent mental health treatment represents an important strategy for suicide prevention. This strategy aims to improve access to evidence-based treatments for suicidality by equipping mental health professionals with information and guidance about identifying the best treatment options and upskilling.

Psychosocial therapies have been shown to significantly reduce suicidal thoughts and behaviours ^{2,3}. Randomized controlled trials indicate that different types of behavioural therapy have shown effectiveness in certain groups of people. For instance, Cognitive Behavioural Therapy (CBT) and the Collaborative Approach to Management of Suicidality (CAMS) have shown good outcomes in adults ^{4,5}, including military personnel ^{6,7}. Group-, family-, and mentalisation-based therapies have shown benefits for adolescents ⁸⁻¹⁰. Mentalisation-based therapy has also shown positive results for adults with borderline personality disorder (BPD), while dialectical behaviour therapy (DBT) has shown good outcomes for both adolescents and adults with BPD ¹¹⁻¹³. Interpersonal psychotherapy has shown positive results for adults with depression ¹⁴ and older people ¹⁵. Narrative therapy by clinicians with appropriate cultural awareness may be helpful for Aboriginal or Torres Strait Islanders ^{16,17}, though further research is required to confirm possible benefits.

Notably, improved outcomes have also been found for psychosocial treatment delivered on digital platforms. Indeed, e-Mental Health, including tools available on the internet or a mobile device, have shown benefits for the management of depression and anxiety ¹⁸⁻²¹, both associated with increased risk of suicidality. Internet-delivered therapy for depression is reported to be as effective as face-to-face therapy for reducing suicidal ideation ²². Certain medications may also reduce the risk of self-harm in individuals with mental disorders ²³, however pharmacotherapy is only recommended as an adjunct to behavioural therapy for mental illness and not for suicidal behaviour by itself ²⁴. Finally, enhancing communication between clinical services and psychoeducation of carers has been shown to correspond to better patient mental health outcomes ^{25,26}.

What is happening in LifeSpan NSW trial sites?

While most mental health professionals will have completed extensive training in one or more of the therapies outlined above, LifeSpan recommends several ways for mental health professionals to further expand their capacity to address the specific needs of patients who are suicidal or who may be at risk of suicide.

Advanced Training in Suicide Prevention

This interactive, accredited workshop builds skills in identifying and assessing suicidality, needs-based safety



planning, collaborative treatment planning and management, as well as skills in managing people bereaved by suicide. Developed at the Black Dog Institute by GPs, psychologists, and allied health professionals, the workshop provides an opportunity for mental health professionals to strengthen connections with local primary health providers (e.g. GPs) to help integrate pathways for referral and shared care. The Black Dog Institute has demonstrated promising evaluation of the program in the Australian context. Paired t-tests showed a significant increase in participant confidence and knowledge recognising and managing suicide risk from pre- to post-training. By comparison, other programs currently show no known evidence in terms of participant evaluation or any other measure relating to clinical practice.

CAMS (Collaborative Assessment and Management of Suicidality)

CAMS is a flexible therapeutic framework in which patient and provider work together to assess the patient's risk of suicidality, and use that information to plan and manage suicide-specific, patient-centred treatment. The associated multi-purpose clinical tool, the Suicide Status Form (SSF), guides the patient's assessment and treatment and is developed collaboratively between the patient and the practitioner over the course of therapy. CAMS is atheoretical, and can be used by mental health clinicians from a range of different therapeutic backgrounds. Treatment with CAMS has been associated with a reduction in suicide-related behaviours following attempt in people across hospital inpatient and outpatient contexts^{5,27-29}. This includes one randomized controlled trial of CAMS that showed a reduction in suicidal ideation one year after treatment⁵. In patient self-reports, CAMS has also been identified as a key factor in reducing suicidal behavior, though these studies did not use a comparison group^{30,31}.

eMental Health in Practice

e-Mental Health in Practice (eMHPac) is a suite of resources, workshops, training modules, and webinars designed to introduce mental health professionals to programs and tools to support mental health assessment, management, and information via digital platforms. eMHPac is an initiative of the Australian Government led by Queensland University of Technology in collaboration with National Institute for Mental Health Research, Menzies School of Health Research, and Black Dog Institute. Internet-delivered therapy has been found to be as effective as face-to-face therapy for reducing suicidal ideation²² in addition to showing good outcomes for the treatment of depression and anxiety²⁰, both risk factors for suicide^{32,33}.

How will this be evaluated?

Research will assess the effect of these interventions on the way mental health professionals care for people at risk of suicide. Advanced Training in Suicide Prevention will be evaluated by surveys focused on identification, referral, and treatment of suicidality, in addition to knowledge and attitudes around suicide. Data will be collected before and after training, as well as follow-up (6, 12 months).

Medicare Benefits Scheme (MBS) data will measure changes in the use of psychological services. These data will be collected for periods before, during, and at the conclusion of the LifeSpan trial.



Qualitative data from the Cohort Study conducted as part of **Improving emergency and follow-up care for suicidal crisis** will assess the patient journey through mental health services following discharge from hospital. This data will be collected throughout the duration of the LifeSpan trial.

Relevant documents and resources

https://blackdoginstitute.secure.force.com/forms/bdi_EducationCourseLanding > Advanced Training in Suicide Prevention
<https://cams-care.com/>
<http://www.emhprac.org.au/>
<http://www.healthpathwayscommunity.org/About.aspx>
<http://graphc.anu.edu.au/graphc2017/graphc.html>

Key References

1. Pompili M, Innamorati M, Raja M, et al. Suicide risk in depression and bipolar disorder: Do impulsiveness-aggressiveness and pharmacotherapy predict suicidal intent? *Neuropsychiatric Disease and Treatment*. 2008;4(1):247-255.
2. Hawton K, Witt KG, Salisbury TLT, et al. Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis. *The Lancet Psychiatry*. 2016;3(8):740-750.
3. Calati R, Courtet P. Is psychotherapy effective for reducing suicide attempt and non-suicidal self-injury rates? Meta-analysis and meta-regression of literature data. *Journal of psychiatric research*. 2016;79:8-20.
4. Tarrier N, Taylor K, Gooding P. Cognitive-behavioral interventions to reduce suicide behavior: a systematic review and meta-analysis. *Behavior modification*. 2008;32(1):77-108.
5. Comtois KA, Jobes DA, S SOC, et al. Collaborative assessment and management of suicidality (CAMS): feasibility trial for next-day appointment services. *Depress Anxiety*. 2011;28(11):963-972.
6. Jobes DA, Wong SA, Conrad AK, Drozd JF, Neal-Walden T. The Collaborative Assessment and Management of Suicidality versus Treatment as Usual: A Retrospective Study with Suicidal Outpatients. *Suicide and Life-Threatening Behavior*. 2005;35(5):483-497.
7. Rudd MD, Bryan CJ, Wertenberger EG, et al. 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. *The American journal of psychiatry*. 2015;172(5):441-449.
8. Wood A, Trainor G, Rothwell J, Moore A, Harrington R. Randomized trial of group therapy for repeated deliberate self-harm in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2001;40(11):1246-1253.
9. Diamond GS, Wintersteen MB, Brown GK, et al. Attachment-based family therapy for adolescents with suicidal ideation: a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2010;49(2):122-131.
10. Rossouw TI, Fonagy P. Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2012;51(12):1304-1313.e1303.



12. Linehan MM, Comtois KA, Murray AM, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Arch Gen Psychiatry*. 2006;63(7):757-766.
13. Verheul R, Van Den Bosch LM, Koeter MW, De Ridder MA, Stijnen T, Van Den Brink W. Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomised clinical trial in The Netherlands. *Br J Psychiatry*. 2003;182:135-140.
14. Weitz E, Hollon SD, Kerkhof A, Cuijpers P. Do depression treatments reduce suicidal ideation? The effects of CBT, IPT, pharmacotherapy, and placebo on suicidality. *Journal of Affective Disorders*. 2014;167:98-103.
15. Bruce ML, Ten Have TR, Reynolds IC, et al. Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: A randomized controlled trial. *JAMA*. 2004;291(9):1081-1091.
16. Bacon V. What potential might Narrative Therapy have to assist Indigenous Australians reduce substance misuse? *Australian Aboriginal Studies*. 2007;1(1):71-82.
17. ATSIPEP. *Solutions That Work: What The Evidence And Our People Tell Us* School of Indigenous Studies University of Western Australia: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project;2016.
18. van Straten A, Hill J, Richards DA, Cuijpers P. Stepped care treatment delivery for depression: a systematic review and meta-analysis. *Psychol Med*. 2015;45(2):231-246.
19. Hedman E, Ljotsson B, Lindefors N. Cognitive behavior therapy via the Internet: a systematic review of applications, clinical efficacy and cost-effectiveness. *Expert Rev Pharmacoecon Outcomes Res*. 2012;12(6):745-764.
20. Andrews G, Cuijpers P, Craske MG, McEvoy P, Titov N. Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: a meta-analysis. *PLoS One*. 2010;5(10):e13196.
21. Griffiths KM, Farrer L, Christensen H. The efficacy of internet interventions for depression and anxiety disorders: a review of randomised controlled trials. *Med J Aust*. 2010;192(11 Suppl):S4-11.
22. Wagner B, Horn AB, Maercker A. Internet-based versus face-to-face cognitive-behavioral intervention for depression: a randomized controlled non-inferiority trial. *J Affect Disord*. 2014;152-154:113-121.
23. Hawton K, Witt KG, Taylor Salisbury TL, et al. Pharmacological interventions for self-harm in adults. *Cochrane Database Syst Rev*. 2015(7):CD011777.
24. Carter G, Milner A, McGill K, Pirkis J, Kapur N, Spittal MJ. Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. *Br J Psychiatry*. 2017.
25. Dixon L, McFarlane WR, Lefley H, et al. Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric services (Washington, DC)*. 2001;52(7):903-910.
26. Fuller JD, Perkins D, Parker S, et al. Effectiveness of service linkages in primary mental health care: a narrative review part 1. *BMC Health Serv Res*. 2011;11:72.
27. Andreasson K, Krogh J, Wenneberg C, et al. Effectiveness of Dialectical Behavior Therapy Versus Collaborative Assessment and Management of Suicidality Treatment for Reduction of Self-Harm in Adults with Borderline Personality Traits and Disorder-a Randomized Observer-Blinded Clinical Trial. *Depress Anxiety*. 2016;33(6):520-530.
28. Ellis TE, Rufino KA, Allen JG. A controlled comparison trial of the Collaborative Assessment and Management of Suicidality (CAMS) in an inpatient setting: Outcomes at discharge and six-month follow-up. *Psychiatry Res*. 2017;249:252-260.



29. Ellis TE, Rufino KA, Allen JG, Fowler JC, Jobes DA. Impact of a Suicide-Specific Intervention within Inpatient Psychiatric Care: The Collaborative Assessment and Management of Suicidality. *Suicide Life Threat Behav.* 2015.
30. Arkov K, Rosenbaum B, Christiansen L, Jonsson H, Munchow M. [Treatment of suicidal patients: The Collaborative Assessment and Management of Suicidality]. *Ugeskrift for laeger.* 2008;170(3):149-153.
31. Nielsen AC, Alberdi F, Rosenbaum B. Collaborative assessment and management of suicidality method shows effect. *Dan Med Bull.* 2011;58(8).
32. Hawton K, Casañas i Comabella C, Haw C, Saunders K. Risk factors for suicide in individuals with depression: A systematic review. *Journal of Affective Disorders.* 2013;147(1–3):17-28.
33. Sareen J, Cox BJ, Afifi TO, et al. Anxiety disorders and risk for suicidal ideation and suicide attempts: a population-based longitudinal study of adults. *Arch Gen Psychiatry.* 2005;62(11):1249-1257.