SUICIDE RISK ASSESSMENT AUSTRALIA™

WSPD WEBINAR SERIES 2020

Evidence Based Practice in Suicide Prevention

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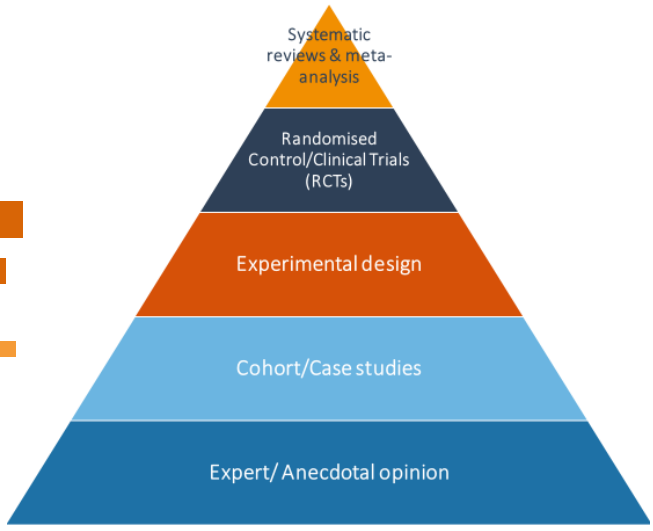
Why we need research

When a person seeks support for distress, behavioural challenges and mental health difficulties, the hope that they will access the best support available. If a person approaches a clinician for support – and the clinician assumes the duty of care to 'treat', then it is reasonable to assume that the clinician, whether a psychologist, psychiatrist, counsellor or otherwise, will provide the best approach for their needs. In the context of suicide prevention, selecting interventions and strategies that have an identified evidence base is critical. In fact, it may save a life.

It can be difficult is to differentiate between what is good marketing of an intervention and what is genuinely scientifically sound interventions. For this reason, we offer some helpful insights in this webinar.

Levels of evidence in research



Systematic literature reviews & meta-analysis

Evaluates research findings within a set evaluation criterion (which can be stringent) to establish efficacy of the constructs/research presented. Research that is outside the evaluation criteria are excluded from analysis.

This is classified as the 'top' level of evidence.

Randomised Control/Clinical Trials (RCTs)

This involves the analysis of intervention constructs or components, where at least two conditions are under examination. Only three suicide prevention interventions have undergone RCT analysis.

Experimental design

These may be controlled clinical trials, though without treatment groups being randomised (so participants know what treatments they are receiving, for example). If the study is randomised, it moves to the 'RCT' level. Designs vary, however, they typically involve evaluating different variables (factors that may be dependent and independent) or undertaking before and after comparisons (pre- and post-) test of variables (their scores before the intervention and after the intervention). For example;

Variables identified ➔ pre-test ➔ deliver intervention ➔ post-test ➔ evaluate extent of change

Cohort/Case studies

These are studies are often aimed at understanding the 'real life' situation at greater depth. This can include qualitative exploration of circumstances, experiences or phenomena. It may involve monitoring people's progress over time or performing retrospective studies, to evaluate whether conditions implemented influence identified outcomes in a given cohort or case. In suicide prevention research, this can be a valuable approach, in light of unique situations or experiences, particularly where suicide is a 'low base rate' phenomenon. The

following article is an example of this type of study design *Perspectives from paramedics responding to deaths by suicide*

Expert/Anecdotal opinion

Studies using the Delphi method are founded on the survey and/or interview of experts in the subject matter, providing their opinion, where those opinions are collated and synthesised to recommend a way forward. This is sometimes done when alternate research methods may be ethically inappropriate or unfeasible. It is the 'lowest' level of evidence but remains an important alternative when examining topics that are extremely difficult to implement more rigorous experimental designs – as is demonstrated by the excellent Delphi Study by Hill and colleagues (2017) providing Guidelines for integrated suicide-related crisis and follow up care in Emergency Departments and other acute settings.

What is the difference between "evidence-based" and "evidence-informed" practice

Evidence-based practice is described as "…the conscientious, explicit and judicious use of current evidence in making decisions about care of individual patients…"

Evidence-informed practice is described as the integration of research evidence with clinical judgement and expertise, together with a client's values, expectations and the circumstances of their care

(Sackett, Richardson, Rosenberg, & Haynes (1997) in Melnyk (2014), p.34)[1]

Although often used interchangeably and as though they are essentially the same thing, they are not. From a technical perspective, evidence-based practice is often the manualised application of a treatment modality, consistent with how it would be applied in a research setting. Importantly, in the research setting, the client values and preferences are often not evaluated in the same way as in a non-research context as it may influence the variables being assessed or researched.

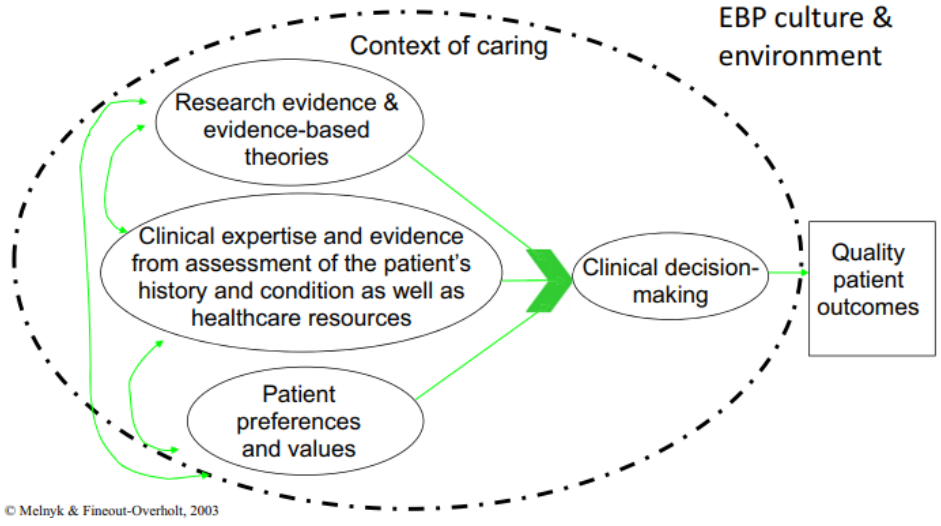


Diagram 1 – Evidence Based Practice, (Melnyk, 2014)

[1] Melnyk (2014) Evidence-based practice versus evidence informed practice: A debate that could stall forward momentum in improving healthcare quality, safety, patient outcomes and costs, *Worldviews on Evidence Based Nursing*, 11(6), 347-349

When considering the real-world interventions, and while adopting a person-centred approach, clinicians are more likely to engage at a deeper level with how a client understands and feels about what is described of an intervention. Clinical decision making is informed by a range of factors, outside the actual evidence base. This can include a clinician's aversion to certain approaches (such as recommending a referral for medication review or second opinion) or preferences for other approaches (such as in-direct suicide prevention interventions). How a clinician presents the evidence for an intervention will influence the client's interpretation – these factors relate to clinician bias, parallel processes and knowledge of suicide prevention models.

Difficulties emerge when clinicians weight factors more heavily than the evidence base.

What is the evidence in suicide prevention?

There are critical limitations in our existing workforce in identifying how we provide evidence based and evidence informed care. We must acknowledge that overall, suicide prevention/intervention practice is 'evidence-informed' when we are delivering treatments that are truly collaborative and responsive to a person's preferences and previous experiences with therapy and intervention. We are not providing treatments in a vacuum, and often not rigidly adhering to a manual. Within this acknowledgement, we should still aim to deliver interventions according to the evidence base, which prioritises direct suicide prevention therapies as the critical and primary approach.

That is:

1. Direct psychotherapy, of which there are only three – Cognitive Behavioural Therapy – Suicide Prevention (CBT-SP), Collaborative Assessment and Management of Suicidality (CAMS) & Dialectical Behaviour Therapy (DBT) are the only therapies evidenced to reduce suicidal behaviours within 12 months[2]
2. Indirect psychotherapies, such as Acceptance and Commitment Therapy (ACT), Interpersonal psychotherapy etc are effective, however, evidence is it is in the long term (beyond 12 months)[3]
3. Brief psychotherapeutic interventions, such as Suicide Safety Planning & Crisis Response Planning, have some immediate effectiveness but must be integrated into longer term therapy[4] (either direct or indirect)
4. Nonclinical / peer workforce roles including sharing stories of recovery may offer strong messages of hope[5]

Risks and opportunities in suicide prevention research

Better understanding of 'what works' means there is greater opportunity to make meaningful differences to peoples lives.

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[2] Meerwijk, E., Parekh, A., Oquendo, M., Allen, E., Franck, L. & Lee, K. (2016). Direct versus indirect psychosocial and behavioural interventions to prevent suicide and suicide attempts: A systematic review and meta analysis. *Lancet Psychiatry*, http://dx.doi.org/10.1016/S2215-0366(16)00064-X

[3] Khangura, S., Kanga, I., Seal, K & Spry, C. (2018). *Suicide-specific psychotherapy for the treatment of suicidal crisis: A review of clinical effectiveness*. CADTH rapid response report: summary with critical appraisal. Ottawa: CADTH.

[4] Betterridge, C. (2018). *Safety Planning, Crisis Response Planning and Coping Planning – What's the evidence?* https://suicideriskassessment.com.au/coping-planning/

[5] Huisman, A. & van Bergen, D. (2019). Peer Specialists in suicide prevention; possibilities & pitfalls. *Psychological Services* DOI: 10.1037/ser0000255

Risks	Opportunities
Research into suicide is difficult to evaluate according to RCT design, from an ethical perspective	Research continues to grow in person-centred approaches, which is growing the evidence base across intervention designs
Deviations from the evidence-base may unwittingly introduce risk to the intervention as the deviation is untested	Lived experience is enhancing the quality of insight and understanding of interventions and design
Only adhering to the top tiers of research design can lose sight of the narratives and individual experiences which enrich our understanding of what is helpful from alternate research methods	Funding and community support and acceptance of suicide specific research has continued to increase in recent years

5 tips in evidence based and evidence informed practice

1. Know the evidence

Critically, we encourage you to work with 'direct' suicide interventions that integrate Brief Psychotherapeutic Interventions, such as Safety Planning (Stanley & Brown, 2012) before potentially moving to indirect therapies as suicidality reduces.

2. Know your skillset, capabilities and blind-spots

While your competence may be increasing, it is essential that when working with someone that has disclosed suicidality (or if you have assessed suicidality), you approach the person's care with strong knowledge of the evidence base – as per above. If you are developing these skills, ensure your supervisors and workplace support you in delivering evidence informed care.

We all have blind-spots that supervision can assist us to overcome, but this should not place a client at risk. As such, it may be important to refer clients to a more skilled clinician if you are in your infancy in working with people experiencing distress generally.

3. Work with the client to understand why any given intervention is not their preference

It may be that the client presents and says they do not want to undertake Cognitive Behavioural Therapy for Suicide Prevention, or another evidence-based approach. This feedback is extremely valuable – and may inform how you work with them going forward. In understanding this, it may be that the person didn't gel with the clinician rather than the therapy being a poor fit – similarly – it may be that the person has had a negative experience with that type of therapy and are specifically looking to trial something else.

4. Follow a sound formulation process

All treatment approaches should be based on a sound formulation process. Importantly, SRAA have developed a strong formulation tool, that is collaborative with the client in identifying both their needs and strategies for meeting those needs. Further, this is only harnessed through a sound psychosocial assessment that integrates in depth suicide risk assessment components.

5. Ensure you have supervision

Supervision is an essential aspect to the delivery of sound care – whether for suicide prevention or otherwise. Supervision that is specific to working with a client experiencing suicidality, must support evidence-based practice in those direct therapies described. This can be difficult, when CAMS specifically, is not widely practiced (yet) in Australia.

NOTES