# TREAT

ZERO Suicide IN HEALTH AND BEHAVIORAL HEALTH CARE | INSTITUTE

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## Treat Suicidal Thoughts and Behaviors Directly.

Utilize evidence-based treatments that focus explicitly on reducing suicide risk to keep patients safe and help them thrive.

## Overview: Treating Suicidal Thoughts and Behaviors Directly

Clinicians have historically focused on treating mental health problems, such as depression, substance use, or anxiety with the assumption that a patient's suicidal thoughts and behaviors would cease once other issues resolved. Recent research strongly supports targeting and treating suicidal ideation and behaviors specifically and directly in the least restrictive environment. These findings were independent of diagnosed mental health or substance abuse issue.[1,2] The Joint Commission states that care teams should utilize problem-focused clinical interventions targeting skills training and suicidal "drivers."[2]

Several empirically-based models of suicide treatment have emerged that effectively reduce suicidal thoughts and attempts, as outlined in the section below. In organizations using the Zero Suicide approach, all staff who treat patients at risk for suicide are trained to use these models of evidence-based treatments regardless of the setting. Additionally, patients should be supported in the least restrictive setting possible.

## Recommendation: Use Effective, Evidence-Based Care

Controlled trials demonstrated that Cognitive Behavioral Therapy for Suicidal Prevention (CBT-SP), Dialectical Behavior Therapy (DBT), and Collaborative Assessment and Management of Suicidality (CAMS) are more effective than treatment as usual in reducing suicidal thoughts and behaviors.[1]

CBT is based on the theory that individuals with issues like depression lack skills for coping effectively with troubling thoughts or feelings. CBT teaches them to recognize these thoughts and provides alternative ways to cope. Studies have demonstrated CBT's effectiveness with conditions such as depression and anxiety.[3,4,5] Research showed that CBT-SP has resulted in reductions in suicide attempts and symptoms.[6,7]

DBT is an adaptation of CBT developed to help patients with chronic suicidality and other behavior problems. DBT has four components: 1) a skills training group, 2) individual treatment, 3) phone coaching, and 4) consultation team meetings. Studies have demonstrated that DBT is effective in reducing suicidal behavior. Linehan, et al. found that those receiving DBT were significantly less likely to drop out of treatment, attempt suicide, visit psychiatric emergency departments, or be hospitalized. Evidence suggested the skills training component of DBT is particularly significant for patients who are suicidal.[8]

CAMS is an intensive psychological treatment that is suicide-specific, helping patients develop other means of coping and problem solving to replace or eliminate thoughts of suicide as a coping strategy. One of the core values of CAMS is that most suicidal patients can be treated effectively in outpatient settings. Studies of CAMS have shown reductions in suicidal ideation, depression, hopelessness, and visits to primary care and emergency departments.[9]

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Along with an emphasis on treating suicide risk directly with evidence-based interventions, newer models of care suggest that treatment and support of persons with suicide risk should be carried out in the least restrictive setting appropriate for the individual and their risk. Interventions should be designed—and clinicians should be sufficiently trained—to work with the person in outpatient treatment with an array of support and avoid hospitalization if at all possible. A recent article recommended a stepped care pathway in which patients are "offered numerous opportunities to access and engage in effective treatment, including standard in-person options as well as telephonic, interactive video, web-based, and smartphone interventions."[10]

Engagement in treatment can increase the efficacy of interventions and can reduce suicide risk.[11] Research shows that reaching out to those patients not engaged in treatment through caring letters—communicating support and concern for the patient—may reduce rates of suicide.[12] This is particularly true during care transitions or discharge from a more restrictive setting such as inpatient hospitalization. For those patients currently engaging in care, follow-up interventions such as phone calls, postcards, and caring contacts in between scheduled appointments may help to reduce suicide deaths, repeat attempts, and keep a patient engaged in treatment. Participants who received intensive follow-up treatment had fewer repeat suicide attempts than those who received treatment as usual.[12]

## Conclusion: Target Suicidal Ideation & Behaviors

Treatment for those at risk for suicide must target suicidal ideation and behaviors specifically, directly utilizing evidence-based treatments, and should be carried out in the least restrictive setting possible for that patient. Treatment will include a robust suicide care management plan that educates the patients and families about their care. Most behavioral health providers will need additional training in utilizing evidence-based treatments for suicide.

### Citations


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