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Morton M. Silverman, M.D. is the Senior Advisor to the National Suicide Prevention Resource Center and was its first director. He is a Clinical Associate Professor of Psychiatry at the University of Chicago, and an Assistant Clinical Professor of Psychiatry at the University of Colorado at Denver. He serves as a Senior Medical Advisor to The Jed Foundation and Education Consultant to the Denver VA VISN 19 MIRECC, both focusing on suicide prevention. He has served as a Temporary Advisor to the Department of Mental Health and Substance Dependence of the World Health Organization and consulted on the development of national suicide prevention programs.

Dr. Silverman served as the first Chief of the Center for Prevention Research at the National Institute of Mental Health (1983-1985), and then served as the first Associate Administrator for Prevention in the Alcohol, Drug Abuse, and Mental Health Administration (1985-1987). From 1987-2002, he was an Associate Professor of Psychiatry, Associate Dean of Students in the University, and Director of the Student Counseling and Resource Service, all at the University of Chicago. Dr. Silverman served as the Senior Scientific Editor and Writer for the National Strategy for Suicide Prevention: Goals and Objectives for Action. From 1996-2009 he was the Editor-in-Chief of *Suicide and Life-Threatening Behavior*, the scientific journal of the American Association of Suicidology.

Dr. Silverman is the co-author, co-editor, or author of over 30 peer-reviewed publications, and over 25 book and monograph chapters on the topics of college student mental health, disease prevention, alcohol and other drug abuse, suicide, and standards of care. He is a recipient of the Louis I. Dublin Award from the American Association of Suicidology, for “outstanding service and contributions to the field of suicide prevention as evidenced by leadership, devotion and creativity.”

Evidence-based Practices

Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice.

Evidence-based medicine assumes that scientific evidence is only one important component of decision-making. A second involves including the patient’s values, goals, preferences, and participation in shared decision-making. A third is the sum of local circumstances: the availability of hospitals, specialists, programs, insurance, supports,

and other resources that affect health care decisions. All of these must be considered to make optimal decisions.

Critics of evidence-based medicine point out that researchers often disagree about the scientific evidence, that the scientific evidence is often limited to specific types of patients or settings, and that there is no strong research evidence (e.g., randomized controlled trials) to inform many common clinical decisions. All of these arguments are valid. The best external clinical evidence can be obtained only if a hierarchy of evidence is taken into account.

This hierarchy is as follows, with the evidence at the top of the list being the most reliable: Systematic reviews and meta-analyses (discussion of validity and confidence intervals); Randomized controlled trials (discussion of validity, magnitude, and clinical significance of results); Cohort studies; Case-control studies; Cross-sectional surveys; and Case reports.

A systematic review of suicide prevention strategies described five key areas on which prevention strategies were focused: education and awareness; screening for at-risk individuals; treatment of psychiatric disorders; restricting access to lethal means; and media reporting of suicide (Mann et al., 2005). Preventive interventions in these domains span the population (education and awareness, media reporting, and means access), institutional and professional (education and awareness, screening), and individual levels (treatment of psychiatric disorders) and may be multilevel. Evidence for many commonly accepted prevention strategies is sometimes sparse or absent, particularly for the key but less common outcome of suicide.

One of the reasons for the dearth of evidence is the methodological difficulties involved in evaluating prevention interventions using suicide as a primary outcome due to its low base rate. Nonfatal suicide attempt and suicidal ideation are more frequent and therefore more amenable to investigation, although there is considerable variability across interventions and studies in the definition and method of data collection for both these outcomes. Moreover, the relationship between ideation and even nonfatal suicide attempts with suicide varies across the lifespan. For these reasons, support for intervention efficacy often draws on suicidal ideation or nonfatal attempts or even secondary or intermediate outcomes, including help-seeking behavior, identification of at-risk individuals, entry into treatment, and antidepressant prescription rates. Hence providing “evidence” that an intervention actually reduces or prevents suicide in a population is difficult.

This presentation will address these issues in more detail, and explore how best practices in suicide prevention can be applicable across cultures.