Improving Emergency and Follow-up Care

Why include this strategy in LifeSpan?

Suicide is a significant and increasing problem in Australia, with rates of suicide in 2015 being the highest in the past decade[1]. One of the strongest predictors of a suicide attempt or suicide death is a previous suicide attempt[2]. This clearly suggests that it is vital to offer effective medical and psychological care when a person identifies as at-risk of suicide or attempts suicide. The risk of a further suicide attempt is greatest immediately after discharge from an emergency department or psychiatric ward and remains high for up to 12 months following the attempt[2-5]. For this reason, access to high quality emergency and follow-up care (also known as aftercare) is essential for suicide prevention initiatives. The available evidence clearly demonstrates that access to high quality crisis and follow-up care is protective against further suicidal behaviour[4,6-8], with a recent review estimating that coordinated assertive aftercare has the capacity to decrease suicide attempts by 19.8% and suicide deaths by 1.1% [9].

Evidence supporting the recommended interventions in LifeSpan

Emergency care or crisis care for suicide-related presentations (thoughts and attempts) occurs after the immediate medical response and stabilisation. Effective emergency care for suicidal crisis includes the provision of a comprehensive psychosocial assessment. This assessment includes establishing a person's level of ongoing risk for suicide (risk assessment), conducting a comprehensive interview with the person to gain a thorough understanding of the person's life circumstances, and working in conjunction with the person to link them to appropriate ongoing care. The evidence suggests all three of these components are important for emergency care. Although a risk assessment is not effective in decreasing suicide attempts or deaths by itself [10], it is a key first step for keeping a person safe during a suicidal crisis. Following this initial assessment, a comprehensive interview and link to follow-up care have been identified as critical components for reducing further suicide attempts and deaths from suicide [6,7]. Follow-up care is essential for anyone who is at-risk of suicide. The evidence suggests that it is crucial to establish a good therapeutic alliance and work with the person to choose the ongoing care they receive, and ensure this referral is established[11,12]. Establishing this referral includes the staff at the hospital clearly communicating with the follow-up service and setting up an appointment within 24-72 hours of discharge from hospital[13].

For many different reasons, people at risk of suicide have varying levels of motivation to engage with follow-up treatment services. Consequently, there are four different options for follow-up once a person is discharged from hospital.

Brief contact interventions: It is well-recognised that not all patients who have made a suicide attempt will be ready to engage in face-to-face treatment[14]. In such cases, brief contact interventions for follow-up have received considerable attention and have appeal because of the comparatively low levels of resourcing required to implement [15].

Brief contact interventions include supportive short letters, phone calls, post-cards or the provision of an emergency or crisis card, which encourages help-seeking or offers on-demand crisis admission or help. They are designed to maintain long-term contact and offer re-engagement with services if needed. Brief contact interventions are not individually-tailored, but follow a structured schedule. Brief contact interventions have been found to be successful in reducing the frequency at which individuals re-attempt, rather than the proportion of people that engage in self-harming behaviours or suicide attempts or who die by suicide [16].

Coordinated assertive aftercare: Coordinated assertive aftercare[17-23] typically involves four components (1) immediate and assertive follow-up after the person is discharged from the emergency department, (2) ongoing risk assessment and planning, (3) encouragement and motivation to adhere to treatment, and (4) problem solving / solution focussed counselling. This aftercare is provided in the form of home visits, phone calls, voice messages, texts, letters or a combination of these forms of contact. The contact is made by a mental health professional or a person trained in mental health. Where possible the contact is provided by the same person over the duration of 6 to 12 months. The evidence suggests these programs decrease the frequency of suicide attempts[17-20,23,24], with one program, the OPAC programme, also demonstrating decreases in the proportion of people who reattempt suicide [17,18,23].

Brief therapy combined with brief contact interventions: These therapies typically focus on helping a person who has recently attempted suicide to understand the circumstances that led them to feel that way, and develop more adaptive coping strategies to help them in the future. These brief therapies are combined with a brief contact intervention which has the aim of maintaining contact and linking people to referral options if required. The number of therapy sessions ranges from a single session [25] to as many as 10 sessions[26] followed by brief contact interventions. The single session intervention was largely psychoeducation on suicidal behaviour, alternatives to suicide and referral options[25]. Whereas the longer brief therapy interventions are person-centred[26,27]; dealing with the issues specific to that person. The evidence shows these interventions reduce suicidal behaviour[25-27], with some impacting on the proportion of people who reattempt[26,27] and in one study the number of deaths by suicide[25]. Some of these interventions have also been successful in decreasing depression and hopelessness[28].

Evidence-based treatments: For people who are more willing and able to engage with ongoing treatment, they may also be referred to their GP or other mental health professional for ongoing care. The evidence for these treatments and recommendations for LifeSpan have been included in the brochure on ***Using evidence-based treatments for suicidality***.

What is happening in LifeSpan NSW trial sites?

LifeSpan trial sites have been provided with recommendations for emergency and follow-up care which are based on the existing evidence.

Emergency / Crisis care - recommendations

Emergency / crisis care should include three components:

1. Risk assessment (for the purpose of triage alone)
2. Comprehensive psychosocial assessment
3. Coordination of referral to follow-up or aftercare.

Follow-up / Aftercare - recommendations

There are three evidence based options recommended to sites:

1. Brief contact interventions
2. Coordinated assertive aftercare, and
3. Brief therapy combined with brief contact interventions

Based on the overall effectiveness of the three different strategies and the resources required, LifeSpan recommends implementing a 'coordinated assertive aftercare / continuity of care' model which includes the following four components:

1. Immediate and assertive follow-up after the person is discharged from the emergency department,
2. Ongoing risk assessment and planning,
3. Encouragement and motivation to adhere to treatment, and
4. Problem solving / solution focussed counselling.

It is recommended that this follow-up aftercare is provided in the form of home visits, phone calls, voice messages, texts, letters or a combination of these forms of contact and is tailored to the needs of the individual. The contact is made by a mental health professional or a person trained in mental health. Where possible the contact is provided by the same person over the duration of 6 to 12 months. It is recognised that the duration of follow-up may have to be rationalised based on resources, keeping in mind that the period immediately after the index attempt, up to 90 days post is the highest risk period for repetition and suicide [2,29].

It is well-recognised that these interventions will need to be tailored to the local needs of the different sites. Consequently, a tool-kit of advice on the different evidence-based programs has been supplied to sites to empower the creation of localised solutions.

How will this be evaluated in LifeSpan?

The emergency and follow-up care will be evaluated by following up people (i.e. a cohort) who have attended the emergency department for a suicide-related presentation and assessing if their care changes after the LifeSpan Emergency and Follow-up care has been implemented. Specifically, we will compare the experience, mental health outcomes and suicide rates (attempts and deaths) for people who have received the LifeSpan intervention, with those who have not received the intervention. This evaluation will use three sources of data: data-linkage of primary care data, self-report questionnaires and qualitative interviews.

The evaluation will also explore the experience of health care workers (i.e emergency department staff, community mental health and other mental health professionals) to determine if the factors which hinder or assist their care of those at-risk of suicide change over time. Additionally, the experience of carers and those bereaved by suicide will also be evaluated to determine if the implementation of the LifeSpan intervention equips them with the necessary information and resources to care for those at-risk of suicide and provides them with the care and support required whilst caring, or after losing a loved one to suicide.

The person at-risk, health care workers, carers and those bereaved by suicide will be followed-up every 6 months for a two-year period to gain an in-depth understanding of their experience over time.

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