1. LIFELINE SOUTH COAST SUPPORT TELEPHONE CALL PROGRAM –

LIFELINE SOUTH COAST'S "LIFELINK"PROGRAM

TARGET GROUP:

People at risk of suicide in the Illawarra/Shoalhaven who have been assessed by a Mental Health professional, and whose risk has been determined to be due to a situational issue rather than a serious mental health issue. These people would also have been assessed by a Mental Health professional as being appropriate for, and likely to benefit from follow-up support from Lifeline South Coast to assist them to identify and access other community services.

BRIEF DESCRIPTION:

Once a client has been assessed as being suitable for the "Lifelink" Program, the Mental Health professional contacts Lifeline South Coast via the 13 11 14 number, and gives the consenting client's details. The client's details are recorded on an intake form by the answering Telephone Counsellor at Lifeline South Coast.

The client is then contacted by the "Lifelink" Program Supervisor, a Clinical Psychologist, who makes an assessment of the client's interest in being involved in the Program, their intention to access other community care services, and their overall suitability for the Program.

If suitable, the client then receives regular phone calls from the service's telephone counsellors that are of a referral and support nature, geared towards encouraging and assisting the client in identifying and accessing other available community care services, for a period of approximately four to six weeks.

During the period of time that the client is part of the "Lifelink" Program, their file will remain open with the Community Mental Health Team, effectively keeping them as an active mental health client until discharge notification is received from "Lifelink". This will help to facilitate the referral of the client back to the Community Mental Health Team if necessary at any stage during their participation in the "Lifelink" Program.
The goal of the "Lifelink" Program is to empower and support clients during the transition period between their assessment by a mental health professional or discharge from the Mental Health Service, and identification of and access to other community care services (e.g. relationship counselling).

AIM:

To improve continuity of care for people at risk of suicide who do NOT have a serious mental illness through the provision of a support telephone call program.

OBJECTIVES:

- To increase the provision of immediate crisis care/support available for people at risk of suicide who do not have a serious mental illness
- To decrease the amount of people at risk of suicide being discharged from Mental Health Services with no follow-up care arrangements
- To increase the access of people at risk of suicide to other community care services
- To decrease the amount of time an individual at risk of service is left unsupported during the transition phase from one service to another.
- To increase the level of networking and collaboration between service providers in the Illawarra and Shoalhaven.

RATIONALE:

Identified Continuity Of Care Issues:

In addition to the issues identified from consultation with service providers, consumers, carers and community representatives reported in Phase One, the following relevant issues were identified in a review of the literature in the first phase of the Project:

Appleby, M. & Lawson, K. (2002) ***Lifeline's suicide buddy scheme*****. Presentation at 9th Annual National Conference on Suicide Prevention, Suicide Prevention Australia, Sydney**

- The authors note the evidence from previous researchers of the importance of people at risk of suicide being supported by key 'helpers' who have made a real connection with them.
- They highlight the critical nature of the relationship between the 'helper' and the person at risk of suicide.
- The authors note that the availability of the 'helper' appears to be of importance, with the period when a 'helper' is unavailable having been noted to be a common period for suicidal acting out, as the lack of contact can agitate fears and feelings of abandonment that can generate suicidal impulses.
- Previous research by Lovett and Maltsberger is cited, who suggest that many of those at risk of suicide do not possess the inner resources required to sustain and internal sense of coherence and wellbeing. Such people therefore rely on exterior resources to achieve comfort and maintain self-cohesion and self-esteem. Inability to attain these exterior resources can result in feelings of loneliness and self-hatred. As long as these exterior resources are available on a consistent basis, suicide is not a threat. The loss of such resources, however, can result in a suicidal regression.

Auditor General Western Australia (2001) ***Performance Examination – Life Matters: Management of Deliberate Self-Harm in Young People*****. Office of the Auditor General Western Australia: West Perth.**

The report states:

- For individuals at risk of suicide, "there may be a considerable gap in time between leaving the Emergency Department and the next contact with health professionals…" (p.29).
- "Opportunities for patients to 'slip through the gaps' occur at a number of places throughout the patient's contact with the hospital, particularly during the waiting periods between services" (p.21)
- This waiting period between services can disrupt a patient's continuity of care, and can potentially result in an increase in suicide risk.
- Community mental health and other services vary in their follow-up practices for clients who do not attend appointments or are unable to be contacted. "Follow-up practices range from a 'three strikes and you're out' approach to highly assertive strategies that involve multiple telephone calls, home visits, and follow-up with people within the young person's support network, including parents, teachers, school psychologists, friends, and general medical practitioners" (p.38).
- "It is imperative that waiting times are kept to a minimum and appropriate plans and appointments are in place before the patient leaves hospital… Appropriate follow-up arrangements would include such things as a discharge plan, informing the patient's GP, establishing contact with a community based support agency or the use of follow-up appointment cards" (p.22).
- Evidence shows that improving continuity of care between hospitals and community support services requires patients to be provided with a follow-up treatment plan prior to discharge, to be engaged in follow-up treatment, according to assessed risk, within at least 3 days, and to be assertively followed up by services when they do not attend appointments.

Barclay, W. (2000) ***Report of external review*****. Illawarra Area Health Service, Mental Health Service: Wollongong, NSW**

The review found:

- GPs and carers both identified a need for more psychological support and counselling services within the Illawarra Area.
- GPs commonly reported that while the Mobile Treatment Team were good managers of patient medication, inadequate attention was paid to psychological needs. "There seems to be little alternative offered if medication does not appear to be effective" (p.27).
- Carers commonly reported a lack of confidence in the capacity of the Mobile Treatment Team to appropriately handle post-discharge care, blaming an overload of work which resulted in workers having insufficient time to provide anything more than superficial attention to problems.
- Community Mental Health Teams have staff with heavy caseloads, some at a level of 40-50 clients. However, the size of the caseload was not as significant as the frequency of contact and the task being performed with each client.
- Lifeline South Coast and Illawarra Mental Health Service have a shared client base of some 200 clients at any time, many of whom have complicated issues. There is an interaction between Lifeline South Coast Telephone Counsellors and Illawarra Mental Health Service Case Managers with respect to these clients.
- There is a group of Lifeline South Coast clients who do not wish to become clients of the Illawarra Mental Health Service. Lifeline South Coast becomes the de facto case manager for these clients simply by default, with little in the way of resources. Barclay recommends a better organised joint management of clients between Lifeline South Coast and the Illawarra Mental Health Service, which would require the active involvement of Mental Health Case Managers.

- Lifeline South Coast has a group of clients who do not have a diagnosable mental illness, but would benefit from early intervention. A typical client from this group may have recently lost their partner, whereby early counselling intervention can help reduce the risk of that client decompensating for the loss. Illawarra Mental Health Service unfortunately does not have the capacity to provide resources for the care of such individuals.
- "The unit cost of a Lifeline call is $14.70 per call. The Area contribution to that cost is $2.95. The value of Lifeline as a diversion service and as a low cost effective alternative to face to face professional counseling would suggest that Lifeline is a service with a favourable benefit to cost ratio" (p.17).

Burgess, P., Pirkis, J., Morton, J. & Croke, E. (2000) Lessons from a comprehensive clinical audit of users of psychiatric services who committed suicide. ***Psychiatric Services*** **51 (12) 1555-1560**

- The study found that excessive times between appointments with a continuing care team was responsible for 13% of the suicides considered by the clinicians auditing cases to have been preventable.
- The authors cite Bongar et al (1998), who note the transition period as being a time of increased vulnerability for the mental health patient, and emphasise the importance of carefully managing transitions between services and between staff.

Chipps, J. & Katrakis, E. (1998) ***Circular 98/31 – Policy guidelines for the management of patients with possible suicidal behaviour for NSW health staff and staff in private hospital facilities*****. NSW Health Department: North Sydney**

- The guidelines state that each Area Health Service needs to ensure that there is "…a balanced range of interventions available for the management of patients with suicidal behaviour including

psychological, social and physical treatment in community or hospital settings" (p.3).

- If a patient who presented to a health service with suicidal behaviour or suicide risk factors is not being admitted, or is being discharged, staff must ensure:

  1. That an appointment is made for follow-up with a relevant health provider (case manager, mental health service, general practitioner, psychologist/therapist, private psychiatrist or other) within 24 hours if intermediate to high risk or within 24-48 hours if low risk.

  2. That before the patient leaves the service facility they should be given a treatment plan including written information about how to seek further help, including a 24-hour telephone number and the name of a contact person.

Churchward, D. & Smith, J. (1998) ***A report on suicide, and parasuicide activity in the Southern Shoalhaven, and associated referral processes and networks*****. Southern Shoalhaven Suicide Prevention Service (unpublished): Ulladulla**

- Results of this study showed that 43 (63%) of the 68 discrete incidents reported were referred for, or were receiving, ongoing counselling and 35 (61%) of the 57 individuals identified in the study were referred for, or were receiving ongoing counselling.
- The authors surmise that as follow-up counselling is voluntary, these figures suggest a relatively high uptake rate for ongoing counselling.
- They also surmise that this rate could be increased if follow-up counselling was made mandatory following presentation to the hospital, mental health, community health, or GP following suicidal behaviour. The authors suggest that this may require "…an active and direct referral procedure whereby the individual is informed that they will be followed up and that their contact details will be passed on to an appropriate health professional for follow-up".

- There were 11 individuals identified in the study who made multiple presentations during the reporting period. In only 4 cases was a logical and progressive referral pattern identified. The remaining cases showed sporadic contact with health and community services: despite referrals being made to the appropriate services, the clients continued to make sporadic contact with the health system, indicating a continuing risk of suicide.
- Of the 4 cases where a referral pattern was identified, only one case continued to make sporadic contact with the health system. The authors postulate that this finding may suggest that informed and logical referral processes reduce the risk of representation for suicidal behaviour.

Consumer Focus Collaboration (2001) ***The evidence supporting consumer participation in health*****. Commonwealth Department of Health and Aged Care: Canberra**

- Consumer participation in individual care leads to improvements in health outcomes.
- Access to quality information facilitates decision-making and supports an active role for consumers in managing their own health.
- There is growing recognition that consumers have enormous potential to influence their own health outcomes if they are involved actively in shared decision-making and provided with quality information and appropriate self-management tools.
- Shared decision-making is gaining more and more support as a strategy for increasing the effectiveness of treatment.

Groom, G. Hickie, I. & Davenport, T. (2003) ***Out of hospital, out of mind! A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008.*** **Mental Health Council of Australia: Canberra**

- This nationwide review of mental health service providers and consumers documents that current community-based systems fail to provide adequate services. The authors state that these services are characterised by "restricted access; variable quality; poor continuity; lack of support for recovery from illness; and protection against human rights abuses" (p.1).
- The difficulty in accessing specialist psychology and other allied health services due to the lack of government and private insurance support is highlighted. The review found that many respondents in both the public and private sectors recommended improving access to a range of counselling services and psychological therapies, potentially through the funding of more positions, and the inclusion of psychological therapies under the Medical Benefits Schedule.
- Respondents also reported the need for more holistic treatment, including support groups, counselling and advocacy, through better utilisation of counsellors, social workers, community and housing workers, nurse practitioners, and generalist telephone counselling services.

Illawarra Area Health Service (2001) ***Illawarra Area Health Service six-year health plan 2000/01 – 2005/06*****. Illawarra Area Health Service: Port Kembla, NSW**

Priorities for service development are noted as following:

- providing more counsellors to deal with the areas of depression, anxiety, stress, drug and alcohol issues, and adult survivors of child sexual abuse, bilingual counsellors and specialised counselling for refugees;
- providing more crisis services and supporting further those provided by non-government organizations like Lifeline and ARAFMI;
- increase resources for mental health strategies in the Shoalhaven;

- implementing health promotion and early intervention strategies to reduce depression particularly in people from culturally and linguistically diverse backgrounds.

Illawarra Area Health Service (2003) ***Illawarra Mental Health Program Strategy 2003-2005.*** **Illawarra Area Health Service**

Strategic Direction #4 of the Strategy looks at developing productive partnerships throughout the Illawarra Area Health Service with others to better deliver a spectrum of services proven to improve the mental health status of the population. The priority is to enure access to appropriate services as they are needed.

Mitchell, P. (2000). ***Crisis intervention and primary care: Evaluation of the National Youth Suicide Prevention Strategy.*** **Australian Institute of Family Studies: Melbourne**

Recommendations include:

- 3.1 "In any future expansion or development of telephone counselling services, priority should be given to the following:
    - the place and role of telephone counselling services in relation to the other services in youth suicide prevention, and the linkages between these services;
    - …strategies for supporting an active and systematic approach to referral and follow-up of young callers at risk of suicide including the improvement and updating of electronic referral databases and skills in engaging young males" (p.110).

Mitchell notes that telephone counselling services could be utilised as a 'safety net' for catching individuals who are using a variety of other services which are unable to meet all their needs, and for those "falling over the edge" (p.106).

It is recommended that telephone counselling services could investigate ways of developing more active and systematic approaches to referral and follow-up of callers at high risk of suicide.

Mulquiney K (2002) Survey of Discharge and Alternatives to Hospital Care in the Shoalhaven. Mental Health Integration Project – Illawarra Area Mental Health Service.

- This survey found Mental Health consumers concerns were the lack of opportunity to discuss discharge plans with staff, and the possibility that they may not be well enough to care for themselves.
- Carers concerns were reported to be the lack of opportunity to discuss discharge plans and follow-up care, not being informed of discharge, the patient not being well enough to be discharged in the first place, and the lack of suitable follow-up services to provide after-care.
- Mental Health staff concerns included the lack of communication between inpatient and community services, the lack of joint participation and opportunity to participate in discharge planning, not being informed of an impending discharge, the brevity of the admission, the likelihood that the patient may not be able to care for themselves and may have little support on discharge, the lack of follow-up care, and the failure to consult with and inform the patient's family/carers. These concerns were also cited as reasons for a patient's readmission.

NSW Health Department (1999) ***Suicide: We can all make a difference. NSW Suicide Prevention Strategy: Whole of Government Approach.*** **NSW Health Department: Sydney**

There are five strategic directions in the NSW Suicide Prevention Strategy. Of relevance to the Lifeline South Coast Telephone Support Phone Call Program are:

- *Strategic Direction 2:* Connect and Care – Providing outreach and support for groups at higher risk; and
- *Strategic Direction 3:* Suicide, an emergency – enhancing the effectiveness of services in suicide prevention.

Strategy 1.5 – Link telephone hotline services to relevant local health services – "To enable people in need to reach relevant local mental health services, a collaborative effort with hotline services might link people with mental health problems and suicidal intentions to relevant local services" (p.13).

Perusco, A. & Westley-Wise, V. (1995) ***Illawarra Suicide Prevention Council 1995 Suicide Questionnaire Report – Draft*****. Illawarra Suicide Prevention Council, unpublished.**

The survey found that respondents reported the following gaps/needs within and between Illawarra and Shoalhaven services:

- Improved crisis services, through increasing after-hours availability of services, back up for crisis calls received by non-Mental Health Services, and more crisis counsellors;
- Appropriate follow-up of people who are at risk of suicide or self-harm, particularly adolescents, and particularly following discharge from hospital;
- Development of networking and encouragement of interagency cooperation;
- Appropriate assertive follow-up mechanisms and improved support links between services;
- Case management collaboration between services, particularly mental health and drug and alcohol services.

Spirito A, Boergers J, Donaldson D, Bishop D, Lewander W. (2002) An intervention trial to improve adherence to community treatment by adolescents after a suicide attempt. ***Journal of the American Academy of Child and Adolescent Psychiatry*****, 41 (4), 435-8**

- Spirito et al found that long delays in gaining appointments, and being placed on a waiting list ranked among the top six problems classified as service barriers.
- They found that service delivery characteristics such as the lack of long-term follow-up past the crisis phase, and barriers to service such as cost, were the most formidable obstacles to patients who were obtaining treatment.
- The study identified that being told by a therapist or agency that no further treatment was needed despite the patient's (or carer's) desire for further treatment ranked among the top six problems classified as service barriers.

Swedo, S.E. (1989) Postdischarge therapy of hospitalised adolescent suicide attempters. ***Journal of Adolescent Health Care*****, 10, 541-544**

Swedo states that Bogard (1970) found that only 35% of patients treated in Emergency Departments for suicide attempts received follow-up care. More than a decade later, Litt et al (1983) found that this figure to be 39%.

Tatz, C. (1999) ***Aboriginal suicide is different – Aboriginal youth suicide in New South Wales, the Australian Capital Territory and New Zealand: Towards a Model of Explanation and Alleviation.*** **Criminology Research Council CRC Project 25/96-7**

Tatz states that of the NSW Aboriginal suicides and parasuicides that he investigated, "…it is doubtful whether anything like 90% (as in New Zealand) or even 50% were suffering from a mental disorder" (p.72).

Tobin, M. et al (1999) ***Reducing repeated deliberate self harm amongst youth – Youth at Risk of Deliberate Self Harm (YARDS): Evaluation Report*****. South Eastern Sydney Area Health Service.**

The authors cite Hansagi et al (1991), who report that frequent Emergency Department users have been found to be a high risk group in regard to

morbidity and mortality, especially with respect to suicide if not properly followed up.

Turley, B. (2000) ***Lifeline Youth Suicide Prevention Program: Findings of a Follow-Up Study of Young At-Risk Callers to Lifeline*****. Lifeline Australia: Melbourne**

- The Study aimed to determine how callers under the age of 25 years with suicidal or self-harm ideation fare after they call Lifeline. It attempted to determine the ongoing needs to young people in crisis, and the care pathways that they are able to access following contact with Lifeline. It also attempted to determine caller's perceptions of the helpfulness of the telephone counselling and their experiences in seeking follow-up care.
- Callers gave consent to receive follow-up calls at one, five and twelve weeks after the initial call to Lifeline.
- Results showed that at the time of their call, 82.3% of callers were accessing some form of support – family, friends, GP, psychiatrist, counsellor, youth worker or other. Male callers were less likely to be accessing support than female participants. The majority were considered to be of moderate to high risk of suicide or self-harm. Referrals were given to 80.3% of the callers upon their initial contact.
- Follow-up contacts made at one, five and twelve weeks after the initial call found that 81% of callers stated that they had taken some form of additional action since contacting Lifeline, the most common form of which was to access professional support. Counsellors and GPs were the most commonly accessed professionals, with psychologists and psychiatrists accessed less commonly. Other participants acted by contacting a support service such as drug rehabilitation, counselling or support groups.
- Reasons for failing to access support at week one as reported by participants were mainly motivational, such as being lazy or not

allowing self to access support. Other reasons were a lack of resources such as money or time.

- At week one, only 43% of participants reported that the problem they had called about had been resolved or had improved.
- Of the 39 participants who completed all of weeks one, five and twelve questionnaires, the overall reporting of suicidal ideation by participants increased slightly between weeks one and five, but changed little between weeks five and twelve.
- At the end of the follow-up period, 43% stated that their problem had stayed the same, and 15% stated that their problem had worsened since their initial call to Lifeline. The overall reporting of thoughts of self-harm or suicide was found to have increased slightly in participants between weeks one and five, but changed little between weeks five and twelve following their initial call.
- Turley recommends the implementation of a case management system for all callers, and the establishment of a call back system for at risk callers to all Lifeline centres.

Vastag B (2001) Suicide Prevention Plan Calls for Physician's Help. ***The Journal of the American Medical Association*****. 285 (21) 2701**

Vastag cites the following:

- In America, it has been estimated that for every person who dies of suicide, 22 others visit emergency departments for suicidal behaviour, and these patients often do not receive appropriate follow-up care. One Rhode Island study found that fewer than 50% of adolescent suicide attempters were referred for treatment following an emergency department visit" (RI Med J 1989).
- American studies have shown that a large proportion of suicide risk patients who attend Emergency Departments and are given referrals for follow-up care do not attend their appointments (J Consult Clin Psycho 1995).

The Evidence Base for a Telephone Support Call Program:

The idea of a support phone-call program as an intervention to be piloted as part of the Project first arose during the investigative phase of the Project.

It was suggested as a concept by several service staff and professionals (notably in Emergency Departments, and Community Care services which offer counselling) as well as several consumer, carer and community representatives.

A gap identified during the first phase of the Project was for people whose suicide risk was more related to situational issues rather than a serious mental illness. These people would normally receive only brief contact with the Community Mental Health Team, and would then often experience a lengthy waiting period to access other community services such as counselling.

An application was submitted to the University of Wollongong/IAHS Ethics Committee for approval for a pilot phase of the Program, where clients would be referred from Emergency Departments once they had been assessed as not requiring further mental health follow-up. This application was rejected by the Illawarra Area Health Service component of the Ethics Committee as Illawarra Area and NSW Health policy states that all individuals presenting to Emergency Departments at risk of suicide will receive mental health follow-up. While the Project Coordinator understood this, the concern was that many of those consulted with during the first phase of the Project reported that this was not always the case in practice. In fact, quite often, the provision of a mental health assessment alone is deemed as enough to constitute this 'mental health follow-up' referred to in Illawarra Area and NSW Health policy.

To satisfy Illawarra Area Health management, while still providing a service that could address this gap in continuity of care, it was decided by Lifeline South Coast and the Illawarra Mental Health Service to target clients who have been assessed by a Community Mental Health Team professional, and deemed appropriate for the Program. The suicide risk of these clients will

have been assessed as being due to situational issues rather than a serious mental illness, which means that their contact with the Community Mental Health Team will be brief and they will soon be discharged. These clients are frequently left in a position of having to wait lengthy periods of time (sometimes up to 8 weeks) to access other community services such as Relationship Counselling without any other support. These clients may also have to rely on their own initiative to identify and gain access to these services.

The service staff and consumer, carer and community representatives consulted with during the first phase of the Project, felt that the concept of a Support Phone-Call program would ideally provide an assertive 'safety-net' stretching from one service (eg. Community Mental Health Team) to the community care services available (eg. Relationship Counselling). This concept was also in keeping with the goal of the Project overall, being "To improve suicide prevention continuity of care for people at risk of suicide in the Illawarra region, based on existing resources".

A review of the literature supports the concept of the Support Phone-Call as being effective in reducing the rate of repeated suicidal behaviour, in improving continuity of care, and increasing compliance with follow-up care for people deemed to be at risk of suicide:

Appleby, M. & Lawson, K. (2002) ***Lifeline's suicide buddy scheme.*** **Presentation at 9th Annual National Conference on Suicide Prevention, Suicide Prevention Australia, Sydney**

- In April 1998 Lifeline Manly Warringah Pittwater commenced a support phone-call program known as the suicide Buddy Scheme. The program was initially funded by a grant from Lifeline Australia's Youth Suicide Prevention project. A general impression of the program's worth saw the Lifeline Manly Warringah Pittwater decide to continue funding the program after the grant ceased.

- People at risk of suicidality, and family and friends supporting someone at risk of suicidality access the program either by referral from another service, from a friend or family member, from a Lifeline Manly Warringah Pittwater Telephone Counsellor, or can refer themselves.
- The program consists of a Telephone Counsellor being assigned to clients as a "buddy", and making regular phone calls in a support capacity over a period no longer than four weeks. The goal of the phone call contact is to support the client through the crisis period, and to encourage and assist them in gaining entry to another service.
- To date, evaluation of the program has not extended past the process evaluation level.

De Leo, D., Carollo, G. & Buono, M.D. (1995) Lower suicide rates associated with a tele-help/tele-check service for the elderly at home. ***The American Journal of Psychiatry*****, 152 (4) 632**

- An Italian telephone service designed to provide elderly people with home assistance was examined for its effect on the suicide rate of this population.
- The Tele-Help program consisted of providing elderly people with a portable device that let them send alarm signals in an emergency, activating a pre-established network of assistance.
- The Tele-Check program consisted of trained staff members at the centre contacting each client on an average of twice a week to monitor their condition through short, informal interviews and offering emotional support. Clients were also able to contact the centre themselves.
- It was noted that the criteria for accessing the program are actually similar to that for suicide risk clients. This program has been shown to reduce the number of suicides among elderly people. It was also

shown that the program was effective in reducing the occurrence of appointments with other services/professionals.

Donaldson D, Spirito A, Arrigan M & Weiner Aspel J (1997) Structured Disposition Planning for Adolescent Suicide Attempters in a General Hospital: Preliminary Findings on Short-Term Outcome. ***Archives of Suicide Research*****, 3 (4) 271-282**

- An experimental group of 23 adolescents, who had received medical treatment and a standard psychiatric evaluation in an Emergency Department following a suicide attempt, also received a psychotherapy compliance enhancement intervention, which also involved the parents/guardians of the adolescent.
- This intervention also included a verbal agreement between the adolescent and parent/guardian to attend at least four sessions of psychotherapy as aftercare.
- After discharge from the hospital, each of the experimental subjects also received three telephone interviews spread over an 8-week period, utilising a problem-solving approach around suicidal ideation and psychotherapy compliance.
- When compared to a control group of 78 patients of the same hospital, the experimental group showed a greater compliance with psychotherapy aftercare, increased number of sessions attended, and no further suicide attempts.

Harris, M. (2003) ***Tele-Check Suicide Prevention Program*****. (Information brief) University Department of Rural Health, University of Tasmania: Launceston**

- The University Department of Rural Health was funded through the National Suicide Prevention Strategy to design a model for service delivery that is adapted to the local context.

- The two-year program commenced in April 2003, and involves the recruitment and training of Tele-Check staff and the development of referral, assessment and feedback protocols.
- People at risk are referred through the Tele-Check screening process by community service providers. Assertive contact is made via regular telephone calls made by trained staff members of health service providers in the target area, aiming at checking on the general health of the clients.
- The result of this is anticipated to be "a strengthened social contact network; a constant check on the treatment plan; inter-agency linking for further referral or crisis response; and an improvement of the community capacity to respond beyond the clinical setting".
- The program involves numerous contributing health professionals because of its interagency nature, involving collaborative partnerships between health service providers with a view to improving community capacity to respond to suicide risk.

Lifeline Hornsby Ku-ring-gai (2003) ***Policy and procedure manual.*** **(Internal document) Lifeline Hornsby Ku-ring-gai: Gordon, NSW**

- Lifeline Hornsby Ku-ring-gai also conducst a 'Suicide Buddy Program'. The Program targets people at risk of suicide within the Sydney telephone region who do not have adequate support in place, or are temporarily without adequate support.
- Callers to the 24-hour telephone counselling service deemed appropriate by counsellors can be informed of the Program's existence and thus enter the Program if willing.
- Clients are contacted on a regular basis by a 'Buddy' for a period of 2 to 4 weeks. The connection with the client is one of support only, with a focus on encouraging the client to connect with an appropriate face-to-face counsellor or other appropriate support service. Once this has

occurred, the Buddy promotes loyalty to this service and decreases contact.

- Evaluation of the Program has mostly consisted of process and impact measures.

Lifeline Newcastle & Hunter Life Matters Program (Connell 2003)

- Lifeline Newcastle & Hunter's Life Matters Program, the development of which has been funded by the Department of Health & Aged Care as part of the National Suicide Prevention Strategy, offers face-to-face counselling and telephone counselling for people who have attempted, contemplated or are at risk of suicide.
- The aim of Life Matters if to support people at risk of suicide for a period of three months. Lifeline Newcastle & Hunter's trained face-to-face counsellors work with the client on a weekly basis, while a telephone counsellor can also be assigned to the client as a 'buddy', calling the client whenever they need some extra support, up to three times a week.
- Clients are unsuitable for the program if they have a history of mental illness, and are referred to the local mental health team.
- Clients can access the program directly or can be referred to the program by mental health and other service providers.
- The Life Matters Program was piloted from October 2002 to February 2003 in conjunction with the Psychiatric Emergency Centre and the Mater Misericordiae Hospital. The aim of the pilot was to establish and evaluate a follow-up support package for people at risk of suicide.
- Results of the pilot showed that during this period, 10 clients were referred to the Program, 7 of which undertook the Program. Five of these clients undertook ongoing counselling for at least 6 weeks. Four of these clients chose the support of a buddy. The face-to-face counsellors conducted a total of 44 counselling sessions for these

clients, and the telephone counsellors (buddies) made a total of 22 care-calls to clients.

- Evaluation of the pilot showed that at the end of the Program, clients exhibited a reduction in frequency of suicidal thoughts and plans.

Lifeline South Coast – Self-Help for Depression Project (Phipps 2003)

- Lifeline South Coast has recently developed a self-treatment package aimed at people with depression, and are currently running a study on its effects. The package is aimed at people who are mild or moderately depressed, rather than those with acute depression who are largely addressed by existing mental health programs. The package takes a cognitive behavioural perspective, and aims to help people to help themselves before they reach the severe depression stage.
- The client is assessed, and if appropriate is sent the self-help package. For the next 8 weeks the patient is contacted once weekly on the phone for a half hour session with a psychologist who assists them in their progress through the self-help package, providing cognitive behaviour therapy, coaching, and solution-focused counselling.
- It is the goal of Lifeline South Coast that, based on the findings of this study, this program will be adapted accordingly, and offered in its adapted form as a permanent service.

Litman, R.E. (1995) Suicide prevention in a treatment setting. ***Suicide & Life-Threatening Behaviour*****, 25 (1) 134**

- Litman and colleagues (Litman 1989; Litman & Wold 1976) provided 'relationship maintenance' for patients at high risk of suicide from the Suicide Prevention Centre in Los Angeles.
- The intervention consisted of a volunteer worker calling on the telephone and talking with the client at least once a week as a 'befriender'. The outcome of these interventions, however, should be noted. Clients who had been depressed and suicidal appeared to like

the program and benefit from being involved. However, some suicidal alcoholic clients appeared to resent what they regarded as an intrusion, and exhibited increased suicide rates.

- These results emphasise the need for interventions to be designed to uniquely suit each individual client.

Mental Health Branch, Commonwealth Department of Health and Family Services (1997) ***Youth suicide is Australia – A background monograph 2nd edition*****. Australian Government Publishing Service: Canberra**

- Hamilton et al (1994) at the Western Australian Institute for Child Health undertook a two-year study of the effectiveness of providing extended counselling and support services for patients hospitalised following attempted suicide.
- The efficacy of the interventions were gauged by comparing the number of subsequent suicide deaths among this group with those recorded for patients from another hospital who were not given similar assistance.
- The study demonstrates the value of continued community care for patients at risk of suicide and self-harm, and supports the appointment of increased social work resources in Emergency Departments of larger hospitals.

Mitchell, P. (2000). ***Crisis intervention and primary care: Evaluation of the National Youth Suicide Prevention Strategy.*** **Australian Institute of Family Studies: Melbourne**

- The Blacktown Youth Suicide Prevention Project is examined in the evaluation report. Factors contributing to the development of the Project are stated to be the perceptions of increasing numbers of young people in the area attempting suicide, and an identified gap in the service provided to them, particularly for those who were not identified as having a mental illness. In fact, a key rationale for the

project was the observation that people identified as at risk of suicide but not diagnosed with a mental illness appeared to experience poorer continuity of care and poorer compliance with recommended after care than those linked directly into mental health services.

- The major aims of the Project were to improve the care of young people at risk of suicide presenting to Emergency Departments and develop protocols.
- The major interventions trialled by the Project were routine comprehensive assessment of all young people presenting with deliberate self-harm, and the implementation of an assertive coordinated care plan for each young client following departure from the Emergency Department.
- Clients were followed up and monitored for six months following their presentation to the Emergency Department. The Project appears to have reduced reattempt rates through the provision of long-term supportive follow-up.
- The Project team (Fry et al 1999) suggest that the precise social supports and problem solving skills required tend to be indicated by the factors that precipitated the suicidal and self-harm behaviour. The immediate precipitants are noted to usually be acute psychosocial stressors that are commonly alleviated by through short-term problem solving. Therefore, appropriate follow-up care includes referral to therapy which focuses on the particular problem involved, for example, relationships counselling.
- Mitchell cite Janosik (1994) in noting that the value of assertive follow-up is also consistent with the key basis of crisis theory, being that people in crisis tend to become occupied with attempting to alleviate internal distress rather than focusing on rational problem-solving. Mitchell postulates that if this premise is true, then it could be expected that people in crisis may find it difficult to apply themselves to the task of identifying and arranging appointments for appropriate follow-up

care. "Assertive follow-up by the ongoing care agency or some other provider could act as a stabilising and guiding influence during periods of disorganisation" (p.52).

- The prospective follow-up research conducted by the Central Sydney Project found that only one of the nine young people who were given a phone number to initiate their own aftercare did so. Eventually 44% of the group given phone numbers did receive further professional help but this was only sought after being followed up by the Project social worker/researcher. A total of eight young people were not provided with any referral when they left the Emergency Department. During the follow-up phone call three of these young people requested assistance from the social worker, as they did not know where to seek help.
- Some of the young people contacted by the researcher expressed how pleased they were to receive further help. Vajda & Steinbeck (1999) interpret these results as indicating that assertive follow-up is acceptable to young people and may help improve rates of attendance at after care. They state that further research is warranted to explore the utility of assertive follow-up in this regard. The draft Critical Pathway recommended by the Central Sydney Project specifies that all clients should be followed up within three working days to establish whether or not they had attended the follow-up appointment or contacted the service provider. They also recommend that protocols should specify who is responsible for follow-up, what the response should be if the client has not attended, and that information systems should be designed to ensure client outcomes are reported back to the hospital staff involved in their care.
- Mitchell states: "Some research data suggest that risk for suicide following treatment for an attempt is very high in the first day or two. This suggests that it may be important to initiate contact and seek to secure engagement within one day of the young person leaving the

hospital. Other research indicates that risk for completed suicide is highest in the first 6-12 months following an initial attempt (Hawton & Fagg 1988; Isometsa & Lonnqvist 1998); this suggests that follow-up should continue for at least six months and perhaps 12 months for those at greatest risk." (p.51)

Motto, J.A. & Bostrom, A.G. (2001) A randomised controlled trial of post-crisis suicide prevention. ***Psychiatric Services*** **52 (6) 828-33**

- Patients who had been hospitalised because of depressive or suicidal behaviour were contacted by letter initially 30 days after discharge, and subsequently at least four times a year for five years about follow-up treatment.
- Patients in the experimental group had a lower suicide rate in all five years of the study. Formal survival analyses revealed a significantly lower rate in the experimental group for the first two years. Differences in the rates of suicide gradually diminished and towards the end of the study period no differences between the groups were observed.
- The authors conclude: "A systematic program of contact with persons who are at risk of suicide and who refuse to remain in the health care system appears to exert a significant preventive influence for at least two years"(p.828).

Preston, W., Morrell, S., Blackmore, K. & Elkington, J. (1999) ***National Youth Suicide Program, final report: Shoalhaven Combined Services, best practice in suicide management*****, Mental Health Branch, Commonwealth Department of Health and Family Services: Canberra**

The evaluation of the Combined Services practice found:

- The greatest negative predictor, that is, the least likelihood for further suicidal or self-harm behaviour, was shown to be referral for follow-up and continued case management.

- The implementation of the policies, protocols and procedures of the Combined Services practice, which helped facilitate after-care and implemented assertive follow-up strategies to ensure such after-care occurred, resulted in a highly significant reduction in the mean number of suicidal and self-harm presentations per patient.
- Suggestions made to Emergency Department patients that they make their own follow-up arrangements subsequent to a suicide or self-harm risk presentation decreased the likelihood of that client seeking follow-up or ongoing case management.

Spirito A, Boergers J, Donaldson D, Bishop D, Lewander W. (2002) An intervention trial to improve adherence to community treatment by adolescents after a suicide attempt. ***Journal of the American Academy of Child and Adolescent Psychiatry*****, 41 (4), 435-8**

- Spirito et al (1992) conducted a compliance enhancement intervention focused on adolescents at risk of suicide. Part of the intervention was comprised of follow-up phone calls, made at one, two, four, and eight weeks post-discharge regarding their participation in outpatient care.
- A total of 83% of adolescents completed all four telephone calls. The follow-up phone calls were a structured process, not psychotherapy, designed to provide support, facilitate problem solving, and help with any obstacles in obtaining care. A specific procedure was followed with each call, in an effort to review psychotherapy attendance and suicidal ideation. Potential compliance problems were identified, and the adolescent and parents were assisted in generating solutions. Interventions were provided as needed and included information distribution, task directives when necessary (e.g. 'call your therapist'), problem reframing, and support for treatment-seeking behaviours.
- The 3-month follow-up calls found that the compliance enhancement group receiving the follow-up calls attended an average of 7.7 sessions

compared with 6.4 sessions for the control group, but this difference was not statistically significant.

Turley, B. (2000) ***Lifeline Youth Suicide Prevention Program: Findings of a Follow-Up Study of Young At-Risk Callers to Lifeline*****. Lifeline Australia: Melbourne**

- Turley cites Spirito et al's (1992) follow-up of adolescents who had been seen in hospital following a suicide attempt. The follow-up was conducted by telephone at 1, 2, 4 and 8 weeks after discharge. Spirito et al (1992) express concern that telephone interviews might limit the adolescent's willingness to speak openly about personal information.
- However, Turley notes that Reich and Earls (1990) report that telephone interviews with adolescents can provide similar results to face-to-face interviews, and are a suitable alternative when face-to-face interviews are difficult or impossible to obtain.
- Turley also notes that Woodard & Zimmerman (1995) suggest that telephone follow-up can be effective because it has the ability to produce higher response rates, adolescents may feel more comfortable as the telephone is a familiar mode of communication for them, and it is a cost-effective and labour-effective use of a researcher's time.

Van Heeringen, C., Jannes, S., Buylaert, W., Henderick, H., De Bacquer, D. & Van Remoortel, J. (1995) The management of non-compliance with referral to out-patient after-care among attempted suicide patients: A controlled intervention study. ***Psychological Medicine*** **25, 963-970**

- Non-compliant patients in Belgium (who had originally presented to the Emergency Department, had been referred for outpatient after-care and were then non-compliant with this after-care) in the experimental group were visited in their homes by a community nurse.
- During the visit, the nurse assessed reasons for non-compliance, needs for treatment, and matched these needs with the supply of outpatient

treatment. Home visits were repeated if the patient was not at home, or if the initial home visit was not followed by attendance at the outpatient facility.

- Results of the study showed (1) a significant increase in compliance with referral for outpatient after-care of attempted suicide patients; and (2) a non-significant decrease in the occurrence of repetition of suicidal behaviour.