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Community care of individuals at risk of suicide: the Life Promotion Clinic model

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Abstract

Assistance to suicidal patients is problematic both at the hospital and community care level. Inadequacy of facilities, pressured personnel, long waiting time, and professional and social stigmatization are just some of the many issues that interfere with successful treatment. The goal of this paper is to present the functioning of the Life Promotion Clinic (LPC), Australia, and describe its users. The LPC is the first specialized outpatient service in Australia dedicated to the treatment of individuals with suicidal thoughts and behaviors. A description of the service and characteristics of its clients (demographic, psychopathology, risk of suicide) are herein presented. Data were collected for 63 male and 175 female patients who attended the LPC over a three-year period. Patients were mostly single females, aged up to 44 years, poorly educated, unemployed or on a pension/benefit. The majority of patients reported at least one suicide attempt, severe depression and anxiety scores, moderate-severe feelings of hopelessness, and high impulsiveness scores. Compared to females, male patients presented with more active desire to kill themselves and higher level of suicidal ideation. We can conclude that establishing a specialist service for treatment of individuals at increased risk for suicide requires consideration of both patient and clinicians needs. The LPC presents an innovative model of community service, capable of engaging patients with serious mental health issues, while making the service accessible to people from various social categories.

Introduction

Poorly perceived need for treatment and attitudinal/cultural barriers in help seeking, prevent many people, especially males, from receiving treatment after a suicide attempt. An analysis of 22 nationally representative samples worldwide, showed that less than half of people with suicidal behavior in the previous year had received some form of treatment. The receipt of treatment was especially low in middle- and low-income countries, where the perceived need for treatment was the most often reported reason for not seeking help. In contrast, in high-income countries the primary reasons for not seeking treatment were related to attitudinal barriers (e.g., trying to handle the problem on their own). In all countries, structural barriers, such as limited finances, lack of availability of treatment, transportation problems, and inconvenience of attending the treatment, were also reasons for not receiving care.

A review of studies on attitudes towards clinical service underlined the importance of patient involvement in treatment, and also showed that many service users reported negative experiences with the discharge and referral to after-care services. These perceptions were supported by Lizardi and Stanley, who found that the transition from emergency to outpatient services is a crucial but often neglected step in treating suicidal people.

Difficulties with engaging in treatment are also likely to be complicated by high risk of repeated attempts after discharge. General hospital staff most often hold negative attitudes towards people who self-harm. These attitudes (often charged with feelings of irritation, anger, frustration, and helplessness) were found to be particularly expressed towards patients who repeatedly self-harmed—a group at highest risk of subsequent suicide.

Notwithstanding these issues, the majority of people with suicidal ideation or behavior are willing to accept help in managing and minimizing their risk of suicide. Recognizing the need of suicidal individuals for specialist care, and considering that history of suicidal behavior is the most important predictor of subsequent self-harming behaviours, the Australian Institute for Suicide Research and Prevention (AISRAP) established the Life Promotion Clinic (LPC). The LPC was the first Australian community-based clinic specialized in assessing and treating individuals with suicidal ideation and behavior. The aims of this paper were to present the model of care of the LPC, and to describe its patients.

Materials and Methods

The Life Promotion Clinic: background and development

The rationale for establishing the LPC came from increased demand from community, government and non-government organizations for a specialized clinical service to provide comprehensive treatment to suicidal people (i.e., a service that is not routinely provided by EDs, psychiatric inpatient settings or general hospital settings, or community mental health services).

This was supported by research showing that negative perceptions regarding hospital treatment and attitudes of hospital staff strongly influence help-seeking behavior. In fact, in a community survey performed in Queensland, 52.5% of people who have planned suicide, and 29.8% of people who have made a suicide attempt, did not seek professional help. Most of them refer to attitudes of hospital and community services personnel as reasons for not seeking help.

An additional motive for the implementation of the LPC was represented by the need for a treatment environment facilitating clinical research on protocols for suicidal people, able also to constitute a specialized training setting for psychiatry registrars and clinical psychologists.

On these grounds, AISRAP, in 2004, initiated the establishment of the LPC, by locating it in its main building at Mt Gravatt campus of Griffith University. The clinic employs consult-
The clinic pursues the following objectives: i) to provide an appropriate outpatient service to people with suicidal ideation and behavior; ii) to collect data regarding treatment outcomes, so as to develop effective protocols; iii) to provide a setting for clinical training of psychiatry registrars and other post-graduate students in the field of suicide prevention; and iv) to raise awareness of suicide and its prevention in the wider community.

Operational budget

The clinic operates on a cost-recovery basis, with Medicare client fees representing the most relevant source of funding. Services are provided through the Medicare system making all visits bulk-billed. This was made possible with the Better Outcomes in Mental Health Care Program, implemented in Australia in 2003. One of the components of the program was the Better Access initiative, which aimed to improve community access to mental health professionals by enabling general practitioners (GPs) to refer their patients to allied health professionals (e.g., psychiatrists, clinical psychologists, registered psychologists). Through Better Access, patients can receive up to 10 (14 in exceptional cases) clinical interventions – individual and/or group therapy sessions – within a calendar year. The mental health nurse is supported by the national Mental Health Nurse Incentive Program.

Referral pathways

Patients are in most cases referred to the clinic following a presentation to ED, or discharge from mental health inpatient facilities in South East Queensland. Patients are also referred by GPs, and in some case their family or friends.

Client selection criteria and consent procedures

Patients are always informed about the research nature and operation of the clinic, as well as available treatment options provided. This is in agreement with Taylor et al. (2009, data not cited), who found that especially suicidal patients are generally provided with insufficient information about their care.

A few selection criteria apply for acceptance to treatment at the LPC. These include: age of 18 years and over, and current suicidal ideation or recent attempt(s). Exclusion criteria concern imminent risk of suicide, acute psychosis, and severe alcohol/substance abuse disorders.

Clients consent in writings to treatment and research participation. The Ethics Committee of Griffith University approved the functioning of the LPC.

Treatment

The clinic offers a variety of psychotherapeutic approaches depending on clinical needs, including individual and group psychotherapeutic treatment (based on dialectical behavior therapy, cognitive behavioral therapy, mindfulness, psychodynamic psychotherapy), nearly always supplemented by pharmacotherapy. The aim of the LPC is to develop innovative approaches of clinical practice to counteract suicidal behaviors. Currently, evaluation of one such treatment is in place at the clinic (Emotion Modulation Therapy). Particular care is taken in creating a nurturing and supportive environment for clients in order to facilitate the treatment process.

Follow-up

Patients are contacted at 6, 12, and 24 months after the end of their treatment. Each patient consents to this agenda of contacts at the beginning of treatment. Follow-ups include a phone call by a clinician (not the treating one) treating the patient, and involves assessment of health and well being, including possible re-occurrence of suicidality. A battery of tests (described below) is sent to patients to complete and return in a reply-free envelope.

An intention to treat approach inspires the follow-ups, which are primarily planned to guarantee continuity of attention/care to clinic clients. Intention to treat designs permit collection of data on the non-response and dropout figures, which are useful in evaluating outcomes.

Life Promotion Clinic patients

From September 2008 (when the clinic was equipped as described above) to August 2011, 63 men and 175 women attended the LPC (patients that did not commence treatment are excluded from these figures). Their mean age was 33.6 years; 35.6 years (range 19-61 years)

Table 1. Demographic characteristics of patients, by gender.

| Characteristic                              | Males N | % | Females N | % | Total N | % |
|--------------------------------------------|---------|---|-----------|---|---------|---|
| Aboriginal and Torres Strait Islander status* | 3       | 4.9 | 10        | 5.9| 13      | 5.6|
| Other Australian                           | 58      | 95.1| 160       | 94.1| 218     | 94.4|
| Country of birth**                         |         |    |           |    |         |    |
| Australia                                  | 46      | 73.0| 145       | 82.9| 191     | 80.3|
| Other country                              | 17      | 27.0| 30        | 17.1| 47      | 19.7|
| State***                                   |         |    |           |    |         |    |
| Queensland                                 | 61      | 96.8| 172       | 98.3| 233     | 97.9|
| Other state                                | 2       | 3.2 | 3         | 1.7 | 5       | 2.1|
| Living arrangement*                       |         |    |           |    |         |    |
| With friend/other relative                 | 27      | 44.3| 79        | 45.7| 106     | 45.3|
| Alone                                      | 15      | 24.6| 34        | 19.7| 49      | 20.9|
| With spouse/partner/children               | 14      | 23.0| 39        | 22.5| 53      | 22.6|
| Other shared/institutional                 | 5       | 8.2 | 21        | 12.1| 26      | 11.1|
| Marital status**                           |         |    |           |    |         |    |
| Single                                     | 40      | 64.5| 103       | 59.2| 143     | 60.6|
| Married/De facto                           | 15      | 24.2| 39        | 22.4| 54      | 22.9|
| Divorced/Separated/Widowed                 | 7       | 11.0| 32        | 18.0| 39      | 17.0|
| Education level**                          |         |    |           |    |         |    |
| Post-school (Under/Postgraduate)           | 16      | 25.8| 42        | 24.6| 58      | 24.9|
| TFE/Trade                                  | 8       | 12.9| 23        | 13.5| 31      | 13.3|
| Year 12 or less                            | 38      | 61.3| 106       | 62.0| 144     | 61.8|

Employment status*

| Employed (any modality)                     | 21      | 34.4| 55        | 31.6| 76      | 32.3|
| Unemployed receiving pension/benefit        | 11      | 18.0| 37        | 21.3| 48      | 20.4|
| Unemployed                                 | 25      | 41.0| 60        | 34.5| 85      | 36.2|
| Out of the labor force (student/retired)    | 4       | 6.6 | 22        | 12.6| 26      | 11.1|

Fisher exact test =1.000, missing=7 (2.9%). **χ²=1.47, df=1, P=0.59; *** Fisher exact test = 0.30, ** Fisher exact test = 0.154, df=2, P=0.673, missing=1 (1.1%). 
**χ²=1.07, df=1, P=0.31, missing=2 (0.8%). ***χ²=1.04, df=2, P=0.579, missing=5 (2.1%). χ²=2.38, df=3, P=0.497, missing=1 (1.3%).
for males and 32.8 years (17-65 years) for females (t=1.68, NS).

Assessments
Routinely, the first appointment lasts approximately two hours. As said, patients are aware that LPC is a research clinic. Before meeting with a clinician (a consultant psychiatrist or a psychiatry registrar), patients are requested to sign consent form, and to fill in a number of self-report questionnaires. These include: i) the Beck Scale for Suicide Ideation (BSS);11 ii) the Beck Hopelessness Scale (BHS);12 iii) the Depression Anxiety and Stress Scales (DASS);13 and, iv) the Impulsiveness Questionnaire (IVE).14

Demographic profile of clients
During the three years considered, 238 patients attended the LPC; most of them (58.4%) were 15-34 years old. Main demographic characteristics are presented in Table 1. There were no significant differences between male and female patients in terms of Aboriginal and Torres Strait Islander status, country of birth, living arrangements, marital and employment status, and education.

Referral and clinical profile of clients
Of the 238 patients, 127 (53.4%) were referred by a hospital-based mental health professional; 91 (38.2%) by a GP. Small numbers of patients were referred by a non-governmental organization (n=11; 4.6%), or a family member or friend who attended the clinic previously (n=9; 3.8%).

All diagnoses were formulated by the aid of the Structured Clinical Interview for DSM Disorders (Out-Patient Version).15 Most patients presented with co-morbidities: 43.7% (n=104) had two psychiatric diagnoses; 12.2% (n=29) had three; and 3.8% (n=9) had four diagnoses, while 40.3% (n=96) had one diagnosis only. There were no significant differences in the number of diagnoses by gender (t=0.18, NS). Uni-polar depression was the most frequent diagnosis in both genders, followed by anxiety and personality disorders (Table 2). Personality disorders were significantly more frequent in female patients, while psychotic disorders being prevalent in males. The majority of patients (n=203, 85.3%) were prescribed medications, in more than two-thirds of cases antidepressants (Table 2). There were no significant differences by gender. More than three-quarters (78.7%) of patients reported they had self-harmed at least once in their life, with intention to die during the most recent attempt (Table 3). Male patients appeared significantly more determined to kill themselves than females (Table 4). The average BSS score of suicide ideators was 20.0 (SD=7.1), close to detect a significant difference between sexes (t=1.98, P=0.051).

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According to DASS scores, the majority of the patients reported severe level of depression (n=158, 78.6%) and anxiety (n=144, 72.7%), while 128 patients (64.3%) reported a severe level of stress (Figure 1). There were no significant differences between male and female patients in the average scores of depression (t=0.73, NS), anxiety (t=1.55, NS) or stress (t=1.22, NS).

The patients of the LPC were found to have relatively high impulsiveness scores (9.9, SD=4.0), with no significant differences between male and female patients (t=0.87, NS).

Discussion and Conclusions
A few limitations should first be acknowledged. People who seek specialized help from the LPC might not represent the general population of suicidal individuals. Furthermore, given the research nature of the clinic, a number of patients whose symptoms affect mental concentration may have found it difficult to attend the LPC, due to the extent of the protocol required for initial assessment. The effective management of the clinic has been affected by insufficient number of staff, which is still reflected in the limited operating time for clients (i.e., two days per week). The increasing number of referrals shows the need for an expansion of services. Given the characteristics of the clientele, it would be inappropriate to impose waiting time beyond two weeks from referral. The LPC is a public outpatient service

Table 2. Psychiatric diagnoses and prescribed medications of patients (multiple diagnoses and medications allowed).

| Psychiatric diagnoses* | Males | %   | Females | %   | Total | %   | χ² (df=1) | P     | F     |
|-----------------------|-------|-----|---------|-----|-------|-----|----------|-------|-------|
| Unipolar depression   | 43    | 68.2| 112     | 64.0| 155   | 65.1| 0.37     | 0.543 |
| Anxiety (incl PTSD and trauma) | 25 | 39.7| 73 | 41.7| 98 | 41.2| 0.08 | 0.779 |
| Personality disorder  | 17    | 27.0| 72     | 41.1| 89    | 37.4| 3.97     | 0.046 |
| Substance use disorder| 11    | 17.4| 20     | 11.4| 31    | 13.0| 1.49     | 0.223 |
| Bipolar depression   | 5     | 7.9 | 11     | 6.3 | 16    | 6.7 | 0.20     | 0.654 |
| Psychotic disorder   | 6     | 9.5 | 3      | 1.7 | 9     | 3.8 | -        | -     |
| Other or vague disorder | 2 | 3.2 | 6 | 3.4 | 8 | 3.4 | - | 1.000 |
| Eating disorder      | 1     | 1.6 | 6      | 3.4 | 7     | 2.9 | -        | -     |
| Developmental disorder | 0 | -   | 1     | 0.6 | 1    | 0.4 | -        | -     |

| Prescribed medications | Males | %   | Females | %   | Total | %   | χ² (df=1) | P     | F     |
|------------------------|-------|-----|---------|-----|-------|-----|----------|-------|-------|
| Any prescribed medications | 56 | 88.8| 147 | 84.0| 203 | 85.3| 0.88     | 0.347 |
| Antidepressant         | 50    | 79.4| 136    | 77.7| 186  | 78.2| 0.74     | 0.786 |
| Sedative and/or anxiolytic | 23 | 36.5| 50 | 28.6| 73 | 30.7| 1.37     | 0.241 |
| Antipsychotic          | 18    | 28.6| 41     | 23.4| 59   | 24.8| 0.66     | 0.418 |
| Other mood stabilizer  | 6     | 9.5 | 22     | 12.6| 28   | 11.8| 0.41     | 0.520 |
| Lithium                | 2     | 3.2 | 8      | 4.6 | 10   | 4.2 | -        | -     |

*All the patients had at least one psychiatric diagnosis. PTSD, Post Traumatic Stress Disorder; P, P-value; F, Fisher’s ex test.

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Table 3. Past suicide attempts and intention to die during the most recent attempt, by gender.

|                | Males |   | Females |   | Total |   |
|----------------|-------|---|---------|---|-------|---|
|                | N     | % | N       | % | N     | % |
| Past suicide attempta |       |   |         |   |       |   |
| Never           | 15    | 27.3 | 29      | 19.1 | 44    | 21.3 |
| Once            | 12    | 21.8 | 27      | 17.8 | 39    | 18.8 |
| Two or more times | 28    | 50.9 | 96      | 63.2 | 124   | 59.9 |
| Wish to die during past suicide attemptb |       |   |         |   |       |   |
| Low             | 2     | 5.0 | 7       | 5.7 | 9     | 5.6 |
| Moderate        | 6     | 15.0 | 34      | 27.9 | 40    | 24.7 |
| High            | 32    | 80.0 | 81      | 66.4 | 113   | 69.8 |
| Not applicable* | 15    | 23.8 | 29      | 16.6 | 44    | 18.5 |

*aχ² = 2.64, df= 2, P=0.267, missing=31 (13%). bχ² = 2.76, df= 2, P=0.252, missing=32 (13.5%). *Patients with no prior suicide attempt.

Table 4. Active and passive suicidal ideation (items 4 and 5 of the BSS), by gender.

|                | Males |   | Females |   | Total |   |
|----------------|-------|---|---------|---|-------|---|
|                | N     | % | N       | % | N     | % |
| Passive desire to kill oneself* |       |   |         |   |       |   |
| No desire      | 22    | 40.7 | 52      | 34.9 | 74    | 36.5 |
| Weak desire    | 18    | 33.3 | 69      | 46.3 | 87    | 42.9 |
| Moderate desire | 14    | 25.9 | 28      | 18.8 | 42    | 20.7 |
| Active desire to kill oneself** |       |   |         |   |       |   |
| No desire      | 13    | 24.1 | 49      | 32.0 | 62    | 30.0 |
| Weak desire    | 19    | 35.2 | 69      | 45.1 | 88    | 42.5 |
| Moderate desire | 22    | 40.7 | 35      | 22.9 | 57    | 27.5 |

*χ² = 21.80, df=2, P=0.023, missing=26 (14%). **χ² = 4.33, df=2, P=0.191, missing=31 (13.5%)

Figure 1. Patients by levels of depression, anxiety and stress. Missing: Depression: 37 (15.5%), Anxiety: 40 (16.8%), Stress: 39 (16.4%)
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