POST DISCHARGE CARE FOR PATIENTS PRESENTING TO EMERGENCY DEPARTMENTS WITH DELIBERATE SELF HARM OR SUICIDE ATTEMPT
Post discharge care for patients presenting to emergency departments with deliberate self harm or suicide attempt

• Three year initiative funded under the Commonwealth National Suicide Prevention Project (two phases)
• Collaboration between DoHA, Queensland Health/Department of Health, local Medicare Locals and General Practice Networks and CheckUP (previously known as General Practice Queensland)

Aim - to prevent suicide by:
• addressing the need for improved discharge planning,
• engaging consumers with a GP
• providing referral and community support for people who present to ED with self harm or suicide attempt
Acknowledgements

The Post Discharge Care for Patients Presenting to Emergency Departments with Deliberate Self Harm or Suicide Attempt Evaluation was conducted by the Mater UQ Centre for Primary Health Care Innovation.

CheckUP would like to acknowledge the contribution of Ms Donata Sackey and Ms Caroline Nicholson to the development of this final evaluation report.
Objectives

1. provide appropriate assertive follow up services to support eligible patients who present with self harm or suicide attempt
2. establish and implement agreed written protocols, procedures, communication and governance processes for management of this patient group between tertiary and primary care
3. establish and implement clear and effective linkages between MLs, general practice, specific clinical staff within hospital EDs and relevant community based services
4. increase the capacity of the primary care sector to deliver multidisciplinary education to GPs and primary health care professionals
5. explore the need for 24 - 48 hour follow up, access to a 24 hour service for crisis support, and compulsory education for allied health professionals
Two sites:
- Metro North - Royal Brisbane and Women’s Hospital
- Metro South - Princess Alexandra Hospital

Each site:
- 1 Suicide Prevention Officer (SPO):
  - clinical role
  - assess patients
  - refer to project
  - follow up after discharge
- 1 Project Officer – ML/GPN
  - coordination of referrals to primary health care
  - Educational offerings across disciplines
  - Raising awareness of the services/program
- CheckUP – overarching coordination, contracting, Project Governance Committee and reporting

Project Model
The research team evaluated:

- The model of care implemented at the two sites
- The role of the SPO
- The role of the DGP/ML Project Officer
- The management of referrals to primary care providers

Collaborative approach to the development of the evaluation plan and criteria

Qualitative and quantitative data collected
## Key evaluation areas

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<th>Key area</th>
<th>Criteria</th>
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| Clinical care - Access         | • Facilitate processes for identification, screening, assessment and referral of target group  
|                                | • Promote evidence based treatment options                                 |
|                                | • Develop and utilise clinical care pathways                                |
| Clinical care - Information transfer | • Implement clinical tools including referral letter and risk management plans                     |
| Communication                  | • Enhance communication processes for management of target group            |
|                                | • Develop and implement communication strategy between key stakeholders   |
| Education, training and research | • Deliver education regarding clinical and non-clinical processes to all key stakeholders |
|                                | • Identify other options for further research                              |
| Partnership                    | • Develop a shared clinical governance framework across tertiary and primary care providers |
|                                | • Document and evaluate the partnership process                             |
| Context                        | • Skills development of staff across sectors                                |
|                                | • Seamless transition of care for patients                                  |
|                                | • Transferability of the model                                            |
Evaluation methods

1. Document review
   Designed to assess the relevance and/or responsiveness of documents in relation to the evaluation objectives.

2. Recorded interviews
   Based on qualitative questionnaires with mental health clinicians in the hospital, Allied Health Professionals, Project Officers and other key stakeholders.

3. Audit
   Designed to ascertain the validity and reliability of information relating to the project objectives.
Significant findings

- **Timeliness of referrals** is a key factor for building clinicians’ confidence in the referral process.
- **Dedicated positions within Acute Care Teams and Medicare Local** contributed significantly to improved communication and shared referral protocols.
- **More joint training and education** across the tertiary and primary mental health sectors is required to build shared language and tools including the development of shared care arrangements for identified at risk patients.
- There were very **low re-presentations** to EDs
Project outcomes

- Increased Awareness
- Increased number of referrals
- Increased confidence and capacity
- Closer communication
- Increased opportunities for training and networking
- Implementation of follow up service
- Documentation of issues and recommendations
Key requirements for collaborative patient management

Collaborative patient management

- Medicare Locals
- Acute mental health sector
- Existing mechanisms
- Shared language
- GPs and psychiatrists
- Shared care
- Higher level support
- Suicide prevention clinicians
Issues to consider

• Involving NGOs in networking events and seeking their input
• Identifying mechanisms for consumer feedback.
• Involving GPs and psychiatrist in networking events and training
• Involving Consultants and registrars in the ATAPS suicide prevention service referral process
• Follow up of clients to ensure engagement with AHP
• Clear mechanisms for clients re-presenting to ED MH
• Closer collaboration and linkage across other programs
• Closer collaboration with the Queensland Aboriginal and Torres Strait Islander Hub for Mental Health (The Hub)
• Closer collaboration with the Queensland Transcultural Mental Health Centre
Access the report

To access a copy of the full evaluation report, please visit the CheckUP website at [www.checkup.org.au](http://www.checkup.org.au) and click on the “Knowledge Hub” button in the main menu bar.
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