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Assertive case management to prevent repeat suicide attempts among patients admitted to emergency departments for suicidal behavior

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The HOPE program standards: Assertive case management to prevent repeat suicide attempts among patients admitted to emergency departments for suicidal behavior

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1. Introduction

Suicide is an important global health issue (World Health Organization, 2014). In England, 220,000 patients per year are admitted to hospitals for self-harm behaviors (Hawton et al., 2007). In the United States, 538,000 patients per year are admitted to emergency departments (EDs) for attempted suicide and self-inflicted injury (Ting et al., 2012). The number of ambulance transfers to EDs for self-harm behaviors in Japan has also increased in the past 20 years (Japanese Ministry of Health, Labour and Welfare, 2019), and most of these suicidal patients have mental health problems (Kawashima et al., 2014). However, suicidal patients receive inadequate mental health-care management in their communities after ED discharge (Gairin et al., 2003; Olfson et al., 2012). Therefore, ED admittance provides an important opportunity to conduct effective interventions for suicide attempters.

It is widely recognized that patients admitted to emergency medical facilities for suicidal behavior have a high risk of repeated suicide attempts and completed suicide (Cooper, 2005; Fedyszyn et al, 2016; Nordentoft et al., 2011). The risk is extremely high immediately after the suicide attempt. Indeed, about 75% of repeated suicidal behaviors occur within 6 months (Kapur et al., 2006). Therefore, it is important to develop an effective intervention to prevent repeat suicide attempts during this high-risk 6-month period. Our previous systematic review and meta-analysis of trials recommended active contact and follow-up interventions to reduce the risk of repeat suicide attempts at 12 months in patients admitted to EDs for a suicide attempt (Inagaki, et al., 2015). On the other hand, a large scale (n = 914), multicenter randomized controlled trial, the ACTION-J study, demonstrated that assertive case management (i.e., an active contact and follow-up intervention) was effective at reducing the incidence of recurrent suicidal behavior in the 6 months following discharge among patients admitted to ED after a suicide attempt (Hirayasu et al, 2009; Kawanishi et al, 2014). Subsequently, the effectiveness of this type of intervention for the 6-month post-discharge period was confirmed by our recent systematic review and meta-analysis (Inagaki, et al., 2019).

In response to the clinical findings described above, the assertive case management intervention for suicide attempters was adopted by the Japanese Ministry of Health, Labour and Welfare's medical payment scheme when medical fees covered by the National Health Insurance System were revised in 2016. As lack of fidelity to the standards contributes to poor results, we have developed an official educational program

to train medical professionals in assertive case management (Kawashima et al., 2020). This training course is evidence-based and originated from the training developed for the ACTION-J study (Hirayasu et al, 2009; Kawanishi et al, 2014), which we refined for dissemination and implementation purposes. We named the assertive case management model the Hospital Oriented suicide Prevention after Emergency care (HOPE) program, because this program is patient-centered but is also based on a hospital-oriented care/service delivery model.

The training courses were initially funded and carefully monitored by the Japanese Ministry of Health, Labour and Welfare, and are currently run by the Japanese Association for Suicide Prevention. This training course is the only educational program that is officially approved by the Ministry of Health, Labour and Welfare, Japan (Kawashima et al., 2020). To claim medical costs under the National Health Insurance System, participating psychiatrists and case managers must be officially trained and have certification for the training course. These activities by the Japanese Association for Suicide Prevention are good examples of the dissemination and implementation of the findings of suicide prevention research to real world clinical practice.

Here, we publish the HOPE program standards, which guide the HOPE program start-up, practical implementation, and program monitoring by clearly defining the minimum requirements. Successful HOPE model implementation and demonstrated improvements in patient outcomes are best accomplished by close adherence to the HOPE program standards.

2. The HOPE program

The HOPE program provides assertive case management to patients admitted to emergency medical facilities in a critical medical condition after a suicide attempt. As mentioned above, repeated suicide attempts tend to occur quickly and it is difficult to engage patients in treatment (Lizardi and Stanley, 2010). Therefore, it is important to introduce hospital-oriented care promptly at ED admission and to continue care after ED discharge for the high-risk period of 6 months. It is crucial to establish high-quality supportive relationships with suicidal patients, who are poor at seeking help.

2-1 Requirements of participating hospitals

Hospitals satisfying the following preconditions can participate in the program

under the Japanese National Health Insurance System (Table 1). First, the hospital should have both emergency medicine and psychiatry departments, so that the hospital can effectively provide patients with psychiatric assessments in the ED. Second, the hospital should have a psychiatric consultation liaison team, which had been specified in the National Health Insurance System in 2012 to facilitate clinical care in general hospitals for physically ill patients with psychological symptoms and psychosocial distress (Grassi et al, 2015). In addition, the hospital should have officially trained case managers to claim medical costs. The case managers must have certification for the training course, which will be officially filed at the local office for the National Health Insurance System in Japan.

Table 1. Requirements of participating hospitals

Should have both emergency medicine and psychiatry departments
Should have a psychiatric consultation liaison team
*Should have an officially trained case manager**

**Case managers must have certification for the HOPE program.*

2-2 Requirements of case managers

The HOPE program is based on a multidisciplinary collaborative model and requires adequate numbers of staff members with sufficient individual competence to provide care and services and to establish high quality supportive relationships with patients.

Social workers, registered nurses, occupational therapists, or clinical psychologists are eligible to be case managers (Table 2). Case managers must have specialized knowledge and experience in social work, and should complete an official training course designed for the HOPE program.

A strong supportive relationship with a case manager is very important for suicidal patients, who are poor at seeking help, to improve their adherence to health services. Therefore, in the HOPE program, the case manager, who was the first person to help the patient at ED admittance, provides assertive case management to patients consistently even after discharge from the ED.

Table 2. Specialties eligible for the role of case manager*

1. *Medical doctor*
2. *Medical social worker*
3. *Psychiatric social worker*
4. *Registered nurse*
5. *Occupational therapist*
6. *Clinical psychologist*

**Case managers must complete an official training course designed for the HOPE program.*

2-3 Patients

Most suicidal patients have mental health problems (Kawashima et al., 2014). However, suicidal patients often receive inadequate mental health-care management in their communities after ED discharge (Gairin et al., 2003; Olfson et al., 2012). Assertive case management is provided to patients who are severely and physically impaired following a suicide attempt and who are admitted to emergency medical facilities to receive physical care. Under the HOPE program, the emergency doctor consults a psychiatrist while the patient is receiving critical care. The psychiatrist carefully evaluates the patient, confirms that they have made a suicide attempt, and confirms any psychiatric diagnoses.

2-4 Procedures

2-4-1 Psychosocial assessment

As mentioned throughout this document, a positive relationship between the patient and a dedicated case manager is crucial for suicidal patients, who are poor at seeking help. Therefore, the first interview session is an important opportunity to improve future adherence to the program. The case manager is expected to have good communication skills with the patient.

After suicide attempters have been physically stabilized and alert consciousness has been confirmed, patients will receive a thorough, patient-centered, individualized psychosocial assessment. This includes medical history; familial history; and the social, psychological, and motivational factors specific to the suicidal event (Table 3). Psychiatrists diagnose any mental health problems. Before meeting the patient, case managers are encouraged to collect information from medical records, emergency staff,

and the ambulance crew. If necessary, the case manager will contact the primary care physician, the family members, or persons with close relationships with the patient during hospitalization.

Table 3. Psychosocial assessment

*1. Medical history**
2. Familial history
3. Social factors specific to the suicidal event
4. Psychological and motivational factors specific to the suicidal event

**A psychiatrist confirms the clinical diagnosis of mental health problems.*

2-4-2 Medical treatment

Appropriate treatment for patients with a psychiatric diagnosis is provided by psychiatrists. Possible physical complications are treated by the emergency doctor, the patient's primary care physician, or other specialists.

2-4-3 Psychoeducation

Psychiatrists or other trained medical personnel will administer semi-structured psychoeducation, which involves a discussion of psychological changes leading to suicide, risk factors for suicide, and the relationship to psychiatric disorders; introduce stress management; demonstrate the usefulness of psychological and social support; and make patients aware of social resources. The psychoeducation materials were based on those developed for the ACTION-J study (Kawanishi et al, 2014).

Psychoeducation is also provided to the patient's family during the hospitalization, when possible. After the psychoeducation session, patients will be provided with an information pamphlet that lists social resources (e.g., healthcare sector and consultation services provided by local governments).

2-4-4 Assertive case management

After the crisis intervention, the trained case manager offers assertive case management to patients. Assertive case management is provided not only during the patient's hospital stay, but also periodically after discharge for 6 months. Specifically, assertive case management consists of a first intervention in the ED and follow-up

intervention during hospitalization or after discharge. Follow-up case management during hospitalization is provided as needed after the first interview session. After discharge, case management is provided at least once a month for 6 months. The hospital can claim back costs for the follow-up case management once a month. The case manager calls the patient to remind them of the appointment before the follow-up intervention.

Seven components of assertive case management are shown in Table 4. Case management consists of assessment, planning, encouragement, and coordination. The assessment includes evaluation of treatment status and adherence, suicidal ideation, relationship with family and other caregivers, social problems that could affect mental and treatment status, and use of various social resources. On the basis of the results of the patient-centered individualized assessment, the case manager develops a practical care/service plan for the patient and shares it with the patient and other team members.

Table 4. Seven components of assertive case management

1.	*Periodic interviews with patients*
2.	*Collection of information about each patient's background and treatment status*
3.	*Encouragement of psychiatric treatment for patients*
4.	*Coordination of appointments with psychiatrists and primary care physicians*
5.	*Encouragement of psychiatric treatment for patients who have stopped receiving treatment*
6.	*Referrals to social resources and private support organizations, and coordination of the utilization of these resources*
7.	*Provision of psychoeducation content*

Four domains constitute this assessment and planning framework (Table 5). The case manager then encourages the patient to adhere to psychiatric treatment and other community-based medical or social care, and if necessary, coordinates the use of these resources to meet individual demands. Patient empowerment and involvement are fundamental to the principles and operation of individualized and effective case management.

Table 5. Four domains that constitute the assessment and planning framework

1. Risk of suicide as it relates to:
Present suicidal ideation
Other signs of suicide
2. Adherence to medical treatment as it relates to:
Physical problems
Psychiatric complications
3. Psychosocial factors as they relate to:
Risk factors for suicide re-attempt
Protective factors for suicide re-attempt
4. Utilization of resources for help as they relate to:
Social support resources
Private advisers

In principle, assertive case management should be accomplished through direct dialogue or face-to-face interviews at participating hospitals; a telephone conversation is the next best option. If case managers cannot reach patients, they will approach the family members who have given their consent to be contacted in advance. However, the hospital cannot claim back costs in these cases. Psychiatrists continuously supervise the case manager and conduct periodic case conferences with other staff.

A smooth transition from hospital to outpatient clinic or community services is crucial after discharge for these patients. However, the social background of suicidal patients is very varied and their subjective needs are multidimensional. Indeed, in addition to medical issues, psychosocial problems in daily life often underlie suicidal risks (Kroll et al., 2018). Therefore, the participating case managers must have good relationships with outpatient clinics, community social resources, local service providers (e.g., healthcare sectors, consultation services provided by central or local governments), and non-governmental organizations. Some examples of the available services and social resources in Japan are shown in Table 6.

Table 6. Examples of available services and social resources in Japan

1. *Community mental health services*
    1) *Healthcare Center/Public Health Centers*
    2) *Mental Health and Welfare Centers*
2. *System for medical expenses*
    1) *Public Health Insurance Systems*
        ① *Health Insurance System (for employees)*
        ② *National Health Insurance System*
        ③ *Medical Care System for Elderly People (75 years and over)*
        ④ *Medical and Welfare Cost System*
    2) *Medical Payment for Services and Supports for Persons with Disabilities*
    3) *High-Cost Medical Expense Benefit*
3. *Social resources for legal issues (e.g., multiple debts/compensation for damages for railway accidents)*
    1) *Japan Legal Support Centers*
    2) *Services and Supports for Persons with Disabilities*
    3) *Adult guardianship system/Voluntary guardians*
    4) *Japan Federation of Bar Associations*
    5) *Japan Federation of Shiho-shoshi's (Solicitor's) Associations*
    6) *Japan Financial Services Association*
    7) *Japan Credit Counseling Organization*
4. *Social resources for persons with disabilities*
    1) *System of Physical Disability Certificate*
    2) *System of Rehabilitation Certificate*
    3) *System of Mental Disability Certificate*
    4) *Health Care and Welfare Measures for People with Physical Disabilities*
5. *Health and welfare services for parenting*
    1) *Child Consultation Centers*
    2) *Child Development Support Centers*
    3) *School Nurse Office/School Psychologist*

4) *Childcare Leave, Caregiver Leave, and other measures for the Welfare of Workers Caring for Children or Other Family Members*
5) *Children's Medical Support program*
6) *Medical Expense Subsidy for Single-Parent Families*
7) *Single-Parent Home Support Subsidy*
8) *Child-rearing Allowance/Special Child-rearing Allowance*
9) *Lump-sum Childbirth Allowance*

6. *Health and welfare services for elderly people*
   1) *Long-Term Care Insurance (in-home/community-based/facility services)*
   2) *Community-based Integrated Care System*
   3) *Adult guardianship system/Voluntary guardians*
   4) *Pension for Elderly People*
7. *Social resources for domestic violence*
   1) *Spousal Violence Counseling and Support Centers*
   2) *Guidance Centers for Women/Women's Centers*
   3) *Women's Shelters/Domestic Violence Shelters*
   4) *Maternal and Child Living Support Facility*
8. *Social resources for gender issues*
   1) *Local Self-help Groups/Non-profit Organizations*
   2) *Change of Gender Designation*
9. *Social resources for daily living/pensions/housing*
   1) *Public Assistance Services*
   2) *Living and Welfare Fund Loan Program*
   3) *Special Disability Allowance*
   4) *Pension Security Services/Public Housing Services*
10. *Social resources for workplace problems/employment support*
    1) *Child Care and Family Care Leave*
    2) *Employment Insurance Benefits*
    3) *Injury and Disease Allowance*
    4) *Industrial Accident Compensation Insurance*
    5) *Public Employment Service*

3. The HOPE program training course

The HOPE program training course run by the Japanese Association for Suicide Prevention is the only training program that is officially approved by the Ministry of Health, Labour and Welfare, Japan (Kawashima et al., 2020). The goal of this training course is to offer a formal certification program to medical professionals who are to provide the HOPE program to patients admitted to EDs. The Japanese Association for Suicide Prevention will sanction this certification program for eligible medical professionals under the auspices of the Ministry of Health, Labour and Welfare, Japan. Through role playing and group exercises using various patient simulations, trainees learn how to use an assessment and planning form to effectively conduct assertive case management, and how to respond to incidents during follow-up interventions. There is evidence that the training program improves attitudes, self-efficacy, and skills for suicide prevention among participating medical professionals (Kawashima et al., 2020).

As lack of fidelity to the standards contributes to poor results, the training course not only provides minimum standards for program operation, but also provides a brief explanation of the rationale for many of the requirements that have been difficult for providers and administrators to implement.

3-1 Who should attend

This course has been developed for individuals who wish to gain the necessary knowledge and skills to provide assertive case management to patients admitted to emergency medical facilities. Medical professionals with the above-mentioned specialties are eligible for this course and also eligible to become case managers (Table 2). It is highly recommended that professionals attend the course at the same time with the medical doctor working together in the psychiatric consultation liaison team.

Participating psychiatrists and case managers should complete the HOPE program training course and must have certification to claim back medical costs.

3-2 Course duration

Two days (16 hours). The training course timetable and contents have been published elsewhere (Kawashima et al., 2020).

3-3 Location

Tokyo, Osaka, Fukuoka, and other cities in Japan.

3-4 Certification

There is no formal assessment for this course but delegates must complete all sections of the course. On completion of the training course, delegates will receive certification for the HOPE program training course.

4. Monitoring of the program

The HOPE program provides assertive case management to patients admitted to ED after a suicide attempt. This program is evidence-based and has been developed for dissemination and implementation purposes. Successful implementation and demonstrated improvements in patient outcomes are best accomplished by close adherence to the program standards; a lack of strong fidelity to the standards leads to poorer results. Therefore, it is important to determine whether real-world implementation adheres to the HOPE program standards. These program standards are also used for program monitoring and compliance purposes.

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