European Psychiatry 51 (2018) 20–24

Contents lists available at ScienceDirect

European Psychiatry

journal homepage: http://www.europsy-journal.com

Original article

Immediate and brief intervention after suicide attempts on patients without major psychiatric morbidity—A pilot study in northern Israel

Limor Givon[a,*], Avi Levi[a], Boaz Bloch[b], Eyal Fruchter[a]

[a] Rambam Health Center, Technion, Haifa, Israel
[b] Emek Medical Center, Technion, Afula, Israel

ARTICLE INFO

Article history:
Received 11 November 2017
Received in revised form 5 January 2018
Accepted 8 January 2018
Available online xxx

Keywords:
Suicide
Suicide attempt
Suicide prevention
Crisis intervention
Emergency psychiatry
Public health

ABSTRACT

Background: Suicide Prevention is an ongoing task for mental health services. This article describes a pilot program for suicide prevention that took place in two districts in Israel from 2009 to 2012. The program targeted specific population, patients in high-risk for suicide, without major mental illness or previous association with the mental health system. In that group many suicide attempts were due to stressful life events.
Methods: Patients who performed a suicide attempt or were considered high-risk for suicide were referred to the project. The first contact took place up to 24 h after the referral and included a phone call with suggestion for further intervention. If he was willing, the patient was invited to a serious of 8–12 meetings with a therapist that focused on "crisis intervention" techniques.
Results: 212 subjects were referred to the project. Three quarters of the referrals were females. Most of them were of Jewish nationality, however, the percentage of Druze in the program's population was higher than their percentage of general population. Only 137 continued participation after the initial phone call, people of Jewish nationality were more willing to continue the intervention. During the intervention there was a decline in suicide rates in the participating districts.
Conclusions: The pilot program exhibits promising preliminary results, it is interesting to examine the difference in participation between different ethnic groups. Since the sample size is small, there is a need to continue the program on a larger scale.

1. Introduction

Suicides and suicide attempts are a universal problem, which affects people of all ages, religions and nationalities. There are about 900,000 complete suicides, and between 9 and 36 million suicide attempts reported worldwide each year [1], and yet this data represent an underestimation, mainly due to the low report rate.

The definition of "complete suicide" is straightforward, meaning a death caused by self-directed injurious behaviour with an intent to die as a result of the behaviour [2]. When examining cases of complete suicide there are many important differences between them, such as age and gender of the victim, whether or not he suffered from major mental illness, the method and others [3].

It is more complex to define a suicide attempt. According to the CDC, a suicide attempt is defined as A "non-fatal, self-directed, potentially injurious behaviour with an intent to die as a result of the behaviour; might not result in injury" [2]. Suicide attempts represent a spectrum of acts that differ in many aspects. Such differences include the method used, the seriousness of the intention to die, the chances of "failure" and others.

There are many risk factors for suicide and suicide attempts: demographic, medical, psychological and situational [4]. A previous suicide attempt is serious risk factors for repeated attempts. The suicide risk for males and females who have previously attempted suicide is reported to be as high as 55 and 77 times greater than that of the general male and female population, respectively [5]. A research from Israel showed that as many as 50% of people who reattempted suicide did so in the three months following the first attempt [6]. Therefore, early intervention after suicide attempts can potentially prevent subsequent attempts and it needs to be as early as possible.

However, it is unclear what the best form of intervention is, after a suicide attempt, which, as noted before, is not a uniform "disease", but includes many different situations and behaviours with various levels of risk. Some suicide attempters suffer from major mental illness and will need hospitalization and intense

* Corresponding author at: 8 Eder street, Haifa, 3475227, Israel.
E-mail address: l_givon@rambam.health.gov.il (L. Givon).

http://dx.doi.org/10.1016/j.eurpsy.2018.01.006
0924-9338/

psychiatric treatment, while others performed suicide attempts as an impulsive reaction to a stressful life event, but are otherwise mentally stable [7]. It is clear that there cannot be a "one size fits all" treatment program. An example for this complexity, could be found dealing with the question of hospitalizing the suicidal patient. Psychiatric hospitalization may reduce the risk in the short-term, since the patient will be in a controlled environment. However, hospitalization does not completely prevent suicide and a recent meta-analysis found the rates of inpatient suicides per patient-years to be higher in more recent studies, despite a shorter average length of hospital stay [3]. This finding can be explained by the understanding that hospitalization removes the patient from his natural support system and reduces his faith in his internal coping mechanism. The situation is even more complex if the hospitalization is involuntary. Such commitment can cause anger and resentment and shatter the trust between the patient and his therapist. There are many studies that demonstrated an increase in suicides after discharge from psychiatric hospitals [8–13], and until now, there is no evidence based data about the effectiveness of hospitalization in preventing long-term suicidal behaviour [14–16].

There have been many studies examining interventions developed to prevent subsequent suicide attempts. In a study performed by Fleishman et al., a brief intervention contact (BIC) that included follow up and patient education, lead to significant reduction in death from suicide [17]. A recent study from the United States showed that multifaceted intervention (that included brief intervention and a series of telephone calls after discharge) produced a meaningful reduction in the proportion of participants who attempted suicide over the 12 month observation period and a 30% reduction in the overall number of suicide attempts [18]. Another brief intervention program that included three therapy session and a follow up with a personalized letter, led to a decrease of 80% in repeated suicide attempts [19]. All those studied demonstrate that a brief and focused intervention can reduce the risk for repeated suicide attempts.

1.1. Suicidality in Israel

The suicide prevalence in Israel is 6:100,000 which add up to about four hundred suicides each year. This is lower than most western countries but higher than traditional Islamic countries, probably due to the higher percentage of traditional and religious population [20]. Three Quarters of all suicide victims are males. The suicide rate increases with age, with higher suicide rate in the elderly (over 75 years), although in that age groups suicide causes only 0.1% of the deaths. The prevalence of reported suicide attempts is estimated to be around 100:10,000 [21]. Among females, the prevalence is between 1.3–1.5 times higher than among males. The highest rates of suicide attempts are in the 18–21 age group. In Israel, most young adults in that age group are in mandatory military service. The suicide attempts at this age are mostly in mild and are probably due to the stress of military service as well as potential secondary gain [22]. Although there were some small scale prevention programs, such as in the Israeli Defense Force (IDF) there was never an organized national effort for suicide prevention [23,24].

The first encounter of patients who attempted suicide with the health care system usually takes place in the emergency rooms (ERs) of the general hospitals. Most suicide attempters will not be hospitalized in a psychiatric department and will be discharged after a brief intervention in the ER or a short hospitalization in the medical or surgical departments, and without any follow-up program. The paper will describe a pilot effort for a brief intervention program led by a national effort of suicide prevention and its results.

2. Method

The pilot program continued from January 2009 until December 2012. It took place in two districts within northern Israel: The Northern district and Haifa district. In both districts the population is ethnically diverse and includes Jewish and Arab populations (the Arab population includes Muslims, Christians and Druze). The project involved cooperation between the Ministry of Health, the Ministry of Social Services, the National Insurance Institute, Israel Trauma Coalition and "path to life", a non-profit organization devoted to suicide prevention. Unfortunately, we had access only to the data from the Haifa district.

2.1. Goals of the program

The project had therapeutic and organizational goals. The short-term goal was to provide an immediate and accessible therapeutic connection to people who attempted suicide, in order to reduce the rate of recurrent attempts and prevent suicides. A long-term goal was to create better communication and interface between different mental-health services; especially between the general hospitals, the psychiatric departments, and the community mental health services.

2.2. Target population

The project targeted a specific subgroup of population: people who attempted suicide or were at high risk of suicidal behaviour, did not exhibit a major mental illness (other than adjustment disorder) and were not treated by the mental health system. The rational for choosing this target population was based on the assumption, that in many cases, for this group, the suicide attempt was a reaction to stressful life events and therefore required an urgent crises intervention but not necessarily a long one. Those patients were often reluctant to turn to the public mental health system, and even when they decided to do so, the burden on the system caused long waiting period for treatment, thus making it impossible for them to receive prompt intervention, within the critical 3 months. As a result, many high-risk patients "fell through the cracks" and had to cope on their own, were hospitalized in psychiatric departments that were the only place where acute treatment was available or even ended up re- attempting suicide. Exclusion criteria were: 1) long history of major mental illness, 2) psychoactive substance abuse or dependence, 3) age under 18 years, 4) patient who were already treated in the Israeli mental health system, 5) IDF soldiers.

2.3. The intervention processes

In the Haifa district, the majority of the subjects were referred from the general hospitals in Haifa. Most of them were referred after a suicide attempt, but some were referred after a psychiatric examination that detected high risk for suicide. Before discharge from the hospital, the patients were informed about the program. Those who expressed interest signed a waiver of medical confidentiality. The project's main coordinator referred them to therapy according to their area of residence and cultural background. The first contact with each patient was a telephone call in the first 24 h after the suicide attempt. At this call if the patient agreed, the first intervention meeting was set up to three days after the attempt. The intervention consisted a series of about 12–15 sessions that focused on crisis intervention. After completion of the program, patients who needed additional therapy were referred appropriately. All the therapists that participated in the pilot program were licensed therapists with work experience in the mental health services with suicidal patients. The therapy was based on the principles of crisis intervention, specifically: identification and revealing of the trigger,