Improving Continuity of Care for Suicidal Persons Through Collaboration Between Hospitals and Community-Based Services

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ABSTRACT

Improving the continuity of care for suicidal persons is an important challenge in suicide prevention. However, partnerships between hospitals and community-based services are difficult to create and sustain. The aim of this study was to explore the point of view of health care professionals from a range of disciplines and organizations concerning the factors that facilitate or hinder interagency collaboration in enhancing continuity of care for suicidal persons. Structured interviews were created from a purposive sample of 40 professionals recruited from 15 partner organizations in mental health services. Results indicated that interagency trust is essential to improved continuity of care, and that building trust requires time and sustained contacts. Regular meetings allowed partners to discuss and collectively solve problems. Barriers included staff turnover, difficulty in evaluating the severity of suicidal crisis, and the time required to exchange information.

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Suicidal behaviour is a major public health concern and a leading reason for visits to general hospital emergency departments. As individuals who end up in an emergency department following a suicide attempt are at high risk for repeated suicide attempts and for completed suicide (Owens, Horrocks, & House, 2002), it is essential that they begin follow-up care shortly after discharge (American Psychiatric Association, 2003; National Institute for Clinical Excellence, 2004; Royal Australian and New Zealand College of Psychiatrists, 2004). Despite the availability of effective treatments (Brown et al., 2005; Guthrie et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Salkovskis, Atha, & Storer, 1990; Wood, Trainor, Rothwell, Moore, & Harrington, 2001), less than 40% of suicide attempters receive post-discharge psychotherapeutic care (Bronisch & Hecht, 1990; Motto & Bostrom, 2001). There are three main reasons for this situation. First, hospital-emergency professionals do not systematically recommend follow-up care (Douglas et al., 2004; Suominen, Isometsä, Martunnen, Ostamo, & Lönnqvist, 2004). Second, the referral process in hospital emergency departments is not always optimal: The suicidal patient is sometimes given no more than the name and number of a resource person and expected to make an appointment himself, even though this strategy has been shown to be ineffective (Poulin, Houle, & Van Nieuwenhuyse, 2006). Instead, setting up an appointment before discharge and direct contact between the patient and the professional who will provide follow-up care are procedures associated with a higher probability of obtaining post-discharge support (Granboulan, Roudot-Thoraval, Lemerle, & Alvin, 2001; Spooren, Van Heeringen, & Jannes, 1998). Third, poor collaboration between hospitals and community mental health resources constitutes a major obstacle to continuity of post-attempt care for suicidal persons (Dlugacz et al., 2003; Lesage, 2005; Yung et al., 2005).

In order to provide suicidal patients with comprehensive post-discharge follow-up, it is necessary to establish collaborative relationships between hospitals and community-based services, which is a challenging, lengthy, and complex process (Van Eyk & Baum, 2002). Successful interagency collaboration is difficult to develop because of professional-level and agency-level barriers, such as differing aims, roles, and responsibilities; lack of commitment; and poor communication and information sharing (Sloper, 2004). Respecting the role and the workers of the other agency and viewing them positively are fundamental components of an effective collaborative relationship (Darlington, Feeney, & Rixon, 2005; Gask, 2005). It may be more difficult to achieve effective collaboration between hospitals and community-based services because of their significant cultural differences, reciprocal misjudgment, and unequal power relationships (Durbin, Goering, Streiner, & Pink, 2006; Poland et al., 2005). The care of suicidal patients could also be particularly challenging for interagency collaboration because of health care professionals' negative attitudes toward this clientele (Herron, Ticehurst, & Appleby, 2001; McCann, Clark, McConnachie, & Harvey, 2006) and their fear of being sued if a patient ends up committing suicide (Packman, Pennuto, Bongar, & Orthwein, 2004). Despite a growing body of work on interagency collaboration, empirical analysis of collaboration between hospitals and community-based services is almost completely lacking in the literature (Poland et al., 2005). Furthermore, the particular case of enhancing interagency collaboration in the care of suicidal patients has not been examined previously.

The current paper reports on the first phase of a pilot project to establish interagency collaboration between hospitals and community-based services in order to enhance continuity of care for suicidal patients. The purpose of this article is to explore the point of view of professionals from different disciplines and organizations concerning the factors that facilitate and hinder interagency collaboration. This qualitative

study will provide a better understanding of the potential barriers to continuity of care of patients who visit an emergency department following a suicide attempt, which could help us to plan more effective post-discharge follow-up.

METHOD

Pilot Project

In the context of developing its strategic plan for 1998–2000, the suicide prevention centre for the Montreal region, Suicide Action Montréal (SAM), realized that it was not reaching all suicidal persons through its crisis telephone line and that it needed to work with other organizations that came into contact with such persons as a result of their mission and regular activities. SAM therefore launched a major initiative to mobilize and coordinate the efforts of the main organizations that intervene with suicidal persons in the Montreal area, namely, the psychiatric emergency departments of area hospitals, the crisis centre, the local community service centres (CLSC), and the drug addiction treatment centre. The managers of these organizations met and agreed that there was a serious problem with continuity of service for suicidal persons. They recognized that they very rarely referred suicidal patients to each other; as a result, these patients had to take the initiative to obtain the services they needed from another organization or else risk "falling through the cracks," getting lost in the maze of the health-care system, or becoming discouraged about long wait times. To better coordinate interventions for suicidal persons, to improve continuity of care, and to work toward common goals, a pilot project for interagency collaboration was designed and implemented in 15 organizations in three different settings.

Collaboration was developed using an innovative referral protocol that comprises five steps (see Table 1) and rests on the following assumption: The more personalized and structured a referral, the better the chances of a suicidal person accepting help and obtaining follow-up care. Suicidal patients did not have to meet precise eligibility criteria to be referred through the protocol; the protocol targeted the people most at risk of committing suicide, that is, those who have attempted suicide. It could also be used for people grappling with serious suicidal thoughts and who presented with several risk factors, although they may not yet have attempted or planned suicide.

Table 1
Steps in Referral Protocol

For agencies making a referral

1. Obtain consent of suicidal person for data exchange transfer;
2. Personally contact partner agency where suicidal person is being referred;
3. Forward completed referral form to receiver agency.

For agencies receiving a referral

4. Contact person referred within 48 hours (or 72 hours on weekends) to offer services;
5. Report results of referral to referring agency.

Partner Agencies

The pilot project involved the psychiatric emergency departments of three general hospitals in the metropolitan area of Montreal, Quebec. These hospitals are linked through formal agreements to at least four organizations in the health-care network in their catchment areas: a crisis centre, a CLSC, a drug addiction treatment centre, and a suicide prevention centre. These hospitals and agencies offer different services to suicidal persons; the summary description in Table 2 demonstrates not only the differences between their services but also the many complementary aspects of their work. However, at the time they signed the formal agreement for interagency collaboration, each of the partners had to share certain values:

1. They had to believe in the importance of combining their efforts with those of their partner organizations to attain a common goal: improving the continuity of care for suicidal persons.
2. They had to engage in a real partnership in which they would invest their own resources and benefit from those of their partners in a spirit of mutual assistance and sharing.
3. They had to recognize the unique contributions of each of the partners and to respect their competencies.
4. They had to be willing to revisit their own practices in order to learn to better work together.

Each organization had to designate a protocol director who would be responsible for implementing the protocol. The suicide prevention centre acted as the principal coordinator and organized regular meetings to ensure cohesion between the organizations' protocol directors. During these regular meetings to coordinate

Table 2
Mandate of Each Agency With Respect to Suicidal Persons

Organization	Mandate
Psychiatric emergency department	Internal: evaluation by a psychiatrist, physical care, short stay for suicidal persons who present an imminent danger to themselves or others
Crisis centre	Internal: short-term shelter for suicidal persons in crisis but who are not in imminent danger of committing suicide External: follow-up in the community
Local community service centre (CLSC)	External: orientation, referral service, and brief psychotherapy service (with a long waiting list) for suicidal persons whether they are in crisis or not, but who are not in imminent danger of committing suicide
Drug addiction treatment centre	Internal: detoxification unit External: support services designed to reduce or eliminate the consumption of alcohol or drugs and the practice of gambling by suicidal persons whether they are in crisis or not, but who are not in imminent danger of committing suicide
Suicide prevention centre	External: telephone service available to all suicidal persons and their loved ones, training in the community for clinicians, and services for bereaved people

the implementation of the protocol, the various organizations were able to interact with each other and debate the problems that they encountered as they applied the protocol. They discussed any problems between professionals or between organizations that arose during the application of the protocol and arrived at solutions collectively. The professionals (clinicians) in each organization who on a daily basis intervened on behalf of clients in distress used the referral protocol, with the support and supervision of their organization's protocol director.

Sample

Each of the 15 partner organizations that implemented the protocol participated in the study: three general hospitals, three crisis centres, seven CLSCs, one drug addiction treatment centre, and one suicide prevention centre. A purposive sample of stakeholders was recruited in each of the partner organizations. Participants were recruited as a function of their role in implementing the protocol. Each organization's protocol director submitted a list of potential participants to the researchers, who then contacted each person on the list by telephone to invite them to participate in the study. As they covered a range of professions (psychiatrists, nurses, mental health workers) and had different responsibilities for applying the protocol (regular user, manager, caseworker), a multitude of opinions and perspectives was assured. The researchers and study participants did not know each other before the data were collected, with the exception of the participants from the suicide prevention centre, who had worked with the principal investigator (JH) over the course of earlier studies.

Data Collection

One group interview was organized in each of the 15 partner organizations from June to September 2005. Each session averaged 1.5 hours in duration. A semistructured discussion guide was used to explore the following dimensions: protocol implementation context, strategies used to promote the protocol, referral procedure and pathway, and implementation barriers and facilitators.

Data Analysis

Exchanges were tape-recorded and transcribed verbatim. One researcher read all of the transcripts and devised a preliminary coding scheme. The emerging themes were then discussed by two researchers, and the scheme was finalized by consensus. One researcher then coded all the transcripts using NVivo software in order to facilitate the systematic inspection of the coded text in each category. The analysis sought to identify key concepts and describe variations in opinions and attitudes. Anonymous excerpts from the transcripts were used to illustrate the topics raised by the participants.

Ethical Considerations

The study was approved by the respective ethics committees of the Montreal Public Health Board, the drug addiction treatment centre, and four of the seven CLSCs. The other organizations authorized the research on the basis of previously obtained ethics approval. Before the start of each group interview, the researcher carefully explained the objectives of the study, the type of participation that was expected, the

confidentiality of the data collected, and the fact that participation was voluntary and participants had the right to withdraw from the study. Two copies of a consent form containing this information were then given to each participant. The participants were asked to read and sign both copies; one was returned to the researcher and the other was retained by the participants.

RESULTS

All the professionals approached to participate in the interviews agreed to take part; the group interviews averaged 4 participants each. In all, 40 professionals—3 psychiatrists, 10 nurses, 20 mental health workers, and 7 managers—took part in the interviews.

Implementation Facilitators

Trust. The establishment of a relationship of trust and mutual respect among the partner organizations was considered by participants to be the key to success. Before implementation of the protocol, the organizations were poorly acquainted with each other and had biased opinions about each other's work, which undermined collaboration; consequently, referrals were rare. Protocol implementation generated opportunities for interaction and, in time, led professionals with different outlooks and allegiances to better understand and respect one another and to work together in pursuit of a common objective. The hospitals gained awareness of the quality and complementarity of services delivered by the community-based organizations, and the latter had the chance to acquire a better understanding of how psychiatric emergency departments function, along with their constraints and responsibilities. The interactions that occurred as required from time to time for referrals, as well as the more formal meetings held for the purpose of coordination, enabled this relationship of trust to develop. In this regard, representatives from all the partner organizations in a given catchment area met three times a year in order to review the referral process, point out problems, and find solutions collectively. These occasions for interaction were greatly appreciated by the participants and deemed vital to the success of the protocol, as evidenced by the following comment made during a focus group:

> We gained respect for the other guy and his competencies. A mutual trust set in between us and the partner we refer patients to. We developed a good chemistry and we now enjoy working together and seeing each other at meetings.

Coordination. The sustainability of the protocol depends on the quality of the coordination of the collaborative enterprise. The work of the coordinator serves to stoke motivation and interest, strengthen cohesion among the agencies, and ensure the quality and productivity of their interactions. The coordinator's duties include inviting organizations individually to participate in the protocol, identifying and resolving problems, planning and hosting meetings, and developing and disseminating promotional tools. All the partners recognized the invaluable contribution of the suicide prevention centre, which acted as coordinator, in this regard.

> The project needed constant boosting and the suicide prevention centre was the one to do it, and a good thing, too, because if we had just let things go, I think the thing would have died in the first 3 months.

Leadership. Each participating organization also had to designate an in-house protocol director. Respondents pointed to this person's leadership as another decisive factor in successful implementation. This person truly had a heavy mandate to fulfill. Duties included training staff in how to follow the protocol,

ensuring compliance with referral procedures, offering support as needed, and representing the agency at partners' meetings. This person also had to enjoy the trust of his or her managers and demonstrate a dynamic approach and initiative in order to anchor the protocol in the practices of the service providers.

> A good director must embrace the protocol's philosophy. He must participate in every stage of the process, he must be personally committed to it, and he must make sure that his organization is on board. He must demonstrate enthusiasm and be close to the service providers who will use the protocol.

> When there are professionals for whom using the protocol when they make referrals is the least of their worries and who are very resistant to change, the in-house protocol had to be very convincing!

Common objective. Lastly, the professionals in the partner agencies had to be engaged in the pursuit of a common objective: to ensure better continuity of care for suicidal persons. They had to believe in the protocol, its relevance, and the value it added to their organization's work. In hospital emergency departments, participation in the protocol by psychiatrists proved to be particularly important. Nurses and social workers were more highly motivated to use the protocol when encouraged to do so by psychiatrists, who led by example.

Implementation Barriers

Staff turnover. Frequent changes in staff, particularly in the hospital emergency departments, made it difficult to apply the protocol in a continuous and uniform manner 24 hours a day, 7 days a week. For example, among psychiatric emergency staff, liaison nurses were the ones who best mastered the procedures inherent in the protocol's application. However, as they were present only on weekdays and during regular work hours (8:00 a.m. to 4:00 p.m.), the protocol was rarely used during evenings, nights, and weekends. Inadequate promotion of the tool and the absence of mandatory training for new employees were other factors that contributed to its underutilization.

> The reason we don't use the protocol automatically is because we're not familiar with it enough. That's why it doesn't always spring to mind. I think we need regular refresher training to remind professionals what it is and what the procedures are.

Absence of protocol eligibility criteria. There was no common understanding of eligibility between the hospitals and their community-based partners, or among the hospitals, or even among the professionals within a given hospital. This proved to be a major obstacle to the smooth operation of the referral mechanism and a recurring source of misunderstanding between agencies. Certain partner organizations reserved the protocol for persons who had just attempted suicide or who were in a severe suicidal crisis, while others applied it to the entire suicidal clientele, regardless of crisis severity. The use of overly inclusive criteria raised ethical issues relative to wait lists for follow-up psychological care. In this regard, though the protocol required that priority be given to referred patients, this privilege was hardly justified if these persons did not present a higher suicide risk than did those already awaiting services. These ethical dilemmas caused dissatisfaction among the partner organizations and undermined the trust of certain professionals in the protocol's benefits.

> If I received a referral for someone who had only mentioned having suicidal thoughts without acting on these or presenting significant risk factors, it placed me in an awkward position with respect to the other people on my waiting list.

The absence of a clear definition of the clientele eligible for the protocol also led the psychiatric emergency departments to question the pertinence of certain referrals. In some cases, the suicide crisis was not deemed sufficiently severe to warrant an emergency stay or a psychiatric evaluation, an assessment contested by the referring partner and judged to run counter to the spirit of the protocol.

> The pertinence of a referral is sometimes questioned and some people are made to blame. Yet, we had agreed not to bear judgment on the evaluations made by other organizations.

> Sometimes, the professionals in emergency find that we exaggerate and amplify the suicide risk. They always see themselves as the experts.

Time required to transmit written information. The exchange of written information between partner organizations was an essential component of the protocol. The obligation to fill out a referral form, particularly within the context of a crisis intervention, was deemed to be a nuisance by many respondents.

> I had a suicidal client once, but I didn't use the protocol because the interview lasted a long time and I had other clients waiting. I just didn't have the time to do the paperwork.

DISCUSSION

The interagency referral protocol evaluated in this study falls within the current trend toward collaborative mental health care (Craven & Bland, 2006). The success of a collaborative process such as the one evaluated in this study requires considerable time and energy, as the organizations need to get to know one another better and to develop relationships of trust. In this regard, interagency trust has been recognized as an essential condition to the establishment of fruitful partnerships in numerous studies (Van Eyk & Baum, 2002; Walker, Bisset, & Adam, 2007). Trust has been defined as "the expectation that an actor (1) can be relied on to fulfill obligations, (2) will behave in a predictable manner, and (3) will act and negotiate fairly when the possibility for opportunism is present" (Zaheer, McEvily, & Perrone, 1998, p. 143). In order to ensure proper continuity of care to suicidal patients, hospitals must work more closely with community-based resources, respect the competencies of community agencies, and recognize the complementarity of the services they offer (Holst & Severinsson, 2003). The presence of a clear and constantly renewed determination to work collaboratively is essential to ensuring the sustainability of such an initiative.

The development of interagency trust also depends on regular exchanges between partner organizations, as communication is one of the key ingredients in developing fruitful partnerships (Gerardi & Fontaine, 2007; Walker, 2001). Periodic meetings between partner organizations are critical in supporting the continued and successful application of the protocol. Our results converge with those of several other studies that have shown that the quality of interagency collaboration improves when partner organizations meet regularly and discuss their collaboration face to face (Van Eyk & Baum, 2002; Holst & Severinsson, 2003). In this regard, in his many works on the subject, Walker (2001; Walker, Bisset, & Adam, 2007) has demonstrated that interagency trust was primarily the fruit of positive interactions at the individual level, rather than merely the product of formal agreements among managers.

Another study of interagency collaboration has shown that persons mandated to set up the process must have the requisite authority and legitimacy within their organization to be successful in getting their colleagues to adopt the protocol (Van Eyk & Baum, 2002). Poland and colleagues (2005) mentioned in

this respect that for every person willing to invest time and energy on this important mission, there are many more whose values, philosophy, or culture do not favour interagency collaboration. These persons must therefore be won over patiently, trained properly, and supervised. The comments we gathered over the course of our study are consistent with this view. Among other things, the leadership manifested by the in-house protocol director was identified as a key to success by the focus group participants. However, it is important that this director not be the only one with an in-depth understanding of the procedures inherent in the protocol's application, as observed in some of the partner organizations. All the professionals in the partner organizations must be able to use it independently, which is why it is important to offer continuous training and supervision to service providers.

The protocol evaluated in this study is perfectly in keeping with current practice guidelines for evaluating and treating suicidal persons, which recommend active referral of these persons for follow-up care after hospital discharge (American Psychiatric Association, 2003; National Institute for Clinical Excellence, 2004; Royal Australian and New Zealand College of Psychiatrists, 2004). Moreover, it employs a strategy recognized to boost treatment compliance by suicidal persons, namely, securing a first follow-up appointment prior to discharge (Granboulan et al., 2001; Poulin et al., 2006; Spooren et al., 1998). Though the protocol alone is not a guarantee of the quality of care provided by community-based resources, it does serve to ensure that the referred person is granted priority and quickly contacted by a partner organization. However, given the privileges that it confers, the protocol should be reserved for the clienteles most at risk for suicide in order to avoid becoming a source of inequity. Organizations with wait lists for their services are wary of granting priority to a suicidal clientele presenting a low to moderate suicide risk. Persons in comparable or more serious situations could already be on the list and, consequently, it would be contrary to the principle of equity that prevails in health care not to provide equivalent access to care to those with similar needs (Whitehead, 2000).

The absence of a uniform suicide risk assessment tool is another of the main sources of conflict among partner organizations. This is no small obstacle, because at present there is no instrument capable of predicting sufficiently well whether someone will actually attempt suicide (Cochrane-Brink, Lofchy, & Sakinofsky, 2000). Furthermore, risk varies over time and thus can fluctuate considerably between the time of referral and the beginning of treatment. Clinical judgment, together with a good knowledge of risk and protective factors, still remains the best guide (Haynes & O'Brien, 2000; Motto, 1991). However, not all community-based mental health workers have the training and expertise to formulate a clinical judgment regarding suicide risk.

The primary limitations of this study reside in its exploratory nature and its small sample size. However, the criteria used to select participants allowed us to sample a wide variety of viewpoints and experiences and to ensure that all the agencies involved in the protocol were represented. In addition, the last of the group interviews contributed no major new element, suggesting data saturation had been reached. Our results are nevertheless subject to the limitations inherent to group interviews, in which opinions can end up being explored only superficially on account of the number of participants. Group interviews are also sensitive to group dynamics, which can lead certain persons to bite their tongue and others to hog the floor. We sought to avoid this phenomenon by regularly doing the rounds and asking each participant for his or her opinion. Furthermore, it is crucial in qualitative research to ensure that the link between data and findings is explicit, credible, and plausible (Thorne, 2000). In our study, we supported each result with quotes reported in the

text. Finally, given that the aim of the protocol was to transform the organizational practices of agencies rather than to improve patient care, our study focused on the professionals involved in implementing the new practices. It would have been interesting, though, to obtain the viewpoint of the suicidal persons referred under the protocol.

CONCLUSION

This evaluation of a referral protocol aimed at improving continuity of care for suicidal persons demonstrates that reaching this objective hinges in large part on the quality of the ties forged among the partner organizations. It is through the development of a relationship of trust, based on mutual respect of competencies and adherence to common values, that such a liaison mechanism can be implemented successfully. We showed that stronger collaboration between emergency departments and community-based resources is imperative to establishing genuine continuity of care for suicidal persons. This constitutes one of the major challenges facing the organization of mental health services.

RÉSUMÉ

Améliorer la continuité des soins pour les personnes suicidaires est un défi important en prévention du suicide. Cependant, les partenariats entre les hôpitaux et les ressources de la communauté sont difficiles à établir et à maintenir. Le but de cette étude était d'explorer le point de vue des professionnels et professionnelles de la santé provenant de diverses disciplines et organismes à l'égard des facteurs qui facilitent ou entravent l'établissement de collaborations inter-organisationnelles visant à améliorer la continuité de services pour les personnes suicidaires. Des entrevues structurées ont été effectuées auprès d'un échantillon intentionnel de 40 professionnelles et professionnels recrutés au sein des 15 établissements partenaires. Les résultats ont indiqué que la confiance inter-organisationnelle est essentielle afin d'améliorer la continuité de soins. Cette confiance requiert du temps, des contacts soutenus et la possibilité de discuter et résoudre les problèmes en collaboration. Parmi les barrières on a trouvé le roulement de personnel, la difficulté à évaluer la sévérité de la crise suicidaire et le temps requis pour l'échange d'informations.

REFERENCES

American Psychiatric Association. (2003). Practice guideline for the assessment and treatment of patients with suicidal behaviors. *American Journal of Psychiatry, 160*, 1-60.

Bronisch, T., & Hecht, H. (1990). Prospective long-term follow-up of depressed patients with and without suicide attempts. In G. Ferrari, M. Bellini, & P. Crepet (Eds.), *Suicidal behavior and risk factors.* Bologna: Monduzzi.

Brown, G.K., Ten Have, T., Henriques, G.R., Xie, S.X., Hollander, J.E., & Beck, A.T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *JAMA, 294*(5), 563-570.

Cochrane-Brink, K.A., Lofchy, J.S., & Sakinofsky, I. (2000). Clinical rating scales in suicide risk assessment. *General Hospital Psychiatry, 22*, 445-451.

Craven, M.A., & Bland, R. (2006). Better practices in collaborative mental health care: An analysis of the evidence base. *Canadian Journal of Psychiatry, 51*, 1S-72S.

Darlington, Y., Feeney, J.A., & Rixon, K. (2005). Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers. *Child Abuse and Neglect, 29*, 1085-1098.

Dlugacz, Y.D., Restifo, A., Scanlon, K.A., Nelson, K., Fried, A.M., Hirsch, B., . . . Greenwood, A. (2003). Safety strategies to prevent suicide in multiple health care environments. *Joint Commission on Accreditation of Healthcare Organizations, 29*(6), 267-278.

Douglas, J., Cooper, J., Amos, T., Webb, R., Guthrie, E., & Appleby, L. (2004). "Near-fatal" deliberate self-harm: Characteristics, prevention and implications for the prevention of suicide. *Journal of Affective Disorders, 79*, 263-268.

Durbin, J., Goering, P., Streiner, D.L., & Pink, G. (2006). Does systems integration affect continuity of mental health care? *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 705-717.

Gask, L. (2005). Overt and covert barriers to the integration of primary and specialist mental health care. *Social Science and Medicine, 61*, 1785-1794.

Gerardi, D., & Fontaine, D.K. (2007). True collaboration: Envisioning new ways of working together. *AACN Advanced Critical Care, 18*, 10-14.

Granboulan, V., Roudot-Thoraval, F., Lemerle, S., & Alvin, P. (2001). Predictive factors of post-discharge follow-up care among adolescent suicide attempters. *Acta Psychiatrica Scandinavica, 104*(1), 31-36.

Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., . . . Tomenson, B. (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning. *British Medical Journal, 323*(7305), 135-138.

Haynes, S.M., & O'Brien, W.H. (2000). Introduction of psychological assessment. In S.M. Haynes & W.H. O'Brien (Eds.), *Principles and practice of behavioral assessment* (pp. 3-24). New York: Plenum.

Herron, J., Ticehurst, H., & Appleby, L. (2001). Attitudes toward suicide prevention in front-line health staff. *Suicide and Life-Threatening Behavior, 31*, 342-347.

Holst, A., & Severinsson, E. (2003). A study of collaboration inpatient treatment between the community psychiatric health services and a psychiatric hospital in Norway. *Journal of Psychiatric Mental Health Nursing, 10*, 650-658.

Lesage, A. (2005). Can psychiatrists prevent suicide? Yes, in collaboration. *Canadian Journal of Psychiatry, 50*(9), 507-508.

Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D., & Heard, H.L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1064.

McCann, T., Clark, E., McConnachie, S., & Harvey, I. (2006). Accident and emergency nurse's attitudes towards patients who self-harm. *Accident and Emergency Nursing, 14*(1), 4-10.

Motto, J.A. (1991). An integrated approach to estimating suicide risk. *Suicide and Life-Threatening Behavior, 21*(1), 74-89.

Motto, J.A., & Bostrom, A.G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services, 52*(6), 828-833.

National Institute for Clinical Excellence. (2004). *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.* London: National Institute for Clinical Excellence.

Owens, D., Horrocks, J., & House, A. (2002). Fatal and non-fatal repetition of self-harm: A systematic review. *British Journal of Psychiatry, 181*, 193-199.

Packman, W.L., Pennuto, T.O., Bongar, B., & Orthwein, J. (2004). Legal issues of professional negligence in suicide cases. *Behavior Science and Law, 22*(5), 697-713.

Poland, B., Graham, H., Walsh, E., Williams, P., Fell, L., Lum, J.M., . . . Yardy, G. (2005). "Working at the margins" or "leading from behind"? A Canadian study of hospital-community collaboration. *Health and Social Care in the Community, 13*(2), 125-135.

Poulin, C., Houle, J., & Van Nieuwenhuyse, H. (2006). Follow-up of individuals admitted to emergency following a suicide attempt. *Psychiatrica Danubina, 18*, 144.

Royal Australian and New Zealand College of Psychiatrists. (2004). Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm. *Australian and New Zealand Journal of Psychiatry, 38*, 868-884.

Salkovskis, P.M., Atha, C., & Storer, D. (1990). Cognitive-behavioural problem solving in the treatment of patients who repeatedly attempt suicide: A controlled trial. *British Journal of Psychiatry, 157*, 871-876.

Sloper, P. (2004). Facilitators and barriers for co-ordinated multi-agency services. *Child: Care, Health and Development, 30*(6), 571-580.

Spooren, D., Van Heeringen, C., & Jannes, C. (1998). Strategies to increase compliance with out-patient aftercare among patients referred to a psychiatric emergency department: A multi-centre controlled intervention study. *Psychological Medicine, 28*, 949-956.

Suominen, K., Isometsä, E., Martunnen, M., Ostamo, A., & Lönnqvist, J. (2004). Health care contacts before and after attempted suicide among adolescent and young adult versus older suicide attempters. *Psychological Medicine, 34*, 313-321.

Thorne, S. (2000). Data analysis in qualitative research. *Evidence-Based Nursing, 3*, 68-70.

Van Eyk, H., & Baum, F. (2002). Learning about interagency collaboration: Trialling collaborative projects between hospitals and community health services. *Health and Social Care in the Community, 10*, 262-269.

Walker, R. (2001). Trust between primary health care organisations. *Health Promotion Journal of Australia, 11*, 43-47.

Walker, R., Bisset, P., & Adam, J. (2007). Managing risk: Risk perception, trust and control in a primary care partnership. *Social Science and Medicine, 64*, 911-923.

Whitehead, M. (2000). *The concepts and principles of equity and health*. Copenhagen: World Health Organization.

Wood, A., Trainor, G., Rothwell, J., Moore, J., & Harrington, R. (2001). Randomized trial of group therapy for repeated deliberate self-harm in adolescents. *Child and Adolescent Psychiatry, 40*, 1246-1253.

Yung, A., Gill, L., Sommerville, E., Dowling, B., Simon, K., Pirkis, J., . . . Burgess, P. (2005). Public and private psychiatry: Can they work together and is it worth the effort? *Australian and New Zealand Journal of Psychiatry, 39*(1-2), 67-73.

Zaheer, A., McEvily, B., & Perrone, V. (1998). Does trust matter? Exploring the effects of interorganizational and interpersonal trust on performance. *Organizational Science, 9*, 141-159.