CHARACTERISTICS AND OUTCOMES OF INDIVIDUALS WHO ENGAGE IN UFITT AFTERCARE FOLLOWING A MENTAL HEALTH CRISIS PRESENTATION

Julie Ward PA-S, BSc, BA

7670235

umward28@myumanitoba.ca

Supervisor: Dr. James M. Bolton, MD

A capstone project submitted to the Faculty of Graduate Studies of The University of Manitoba
in partial fulfillment of the requirements for the degree of
MASTER OF PHYSICIAN ASSISTANT STUDIES

Masters of Physician Assistant Studies
University of Manitoba

May 15, 2023

TABLE OF CONTENTS

ABSTRACT **3**

INTRODUCTION **4**

METHODS **6**

Study Period and Cohort Generation *6*

Data Sources, Variables, and Outcomes *6*

RESULTS **7**

Clinical and sociodemographic characteristics of the cohorts *7*

Health outcomes between cohorts *9*

DISCUSSION **10**

Clinical and sociodemographic characteristics of the cohorts *10*

Health outcomes between cohorts *12*

Conclusions, limitations & considerations for future studies *14*

REFERENCES **17**

APPENDIX **19**

Table 1. Sociodemographic and clinical characteristics of patients referred to and accepted by UFITT (N=122). *19*

Figure 1. Representations to CRC, UC, or ED within 60-day follow-up period from initial presentation *21*

Figure 2. Time relationship between initial presentations, UFITT engagement, and representation in 60-day follow-up period. *22*

ABSTRACT

Introduction: The Urgent Follow-up Integrated Treatment Team (UFITT) program is the primary mental health follow-up program for individuals attending the Crisis Response Centre (CRC) and Health Sciences Centre emergency department. Although approximately 130 individuals are referred to the UFITT program each month, there is a high rate of no-shows. No research has been done on these individuals referred to UFITT regarding their demographics, characteristics, or what happens after their referral. This study aimed to better understand if there are common clinical and demographic characteristics that can be identified within the individuals that attend aftercare following their UFITT referral, compared to those that do not. Furthermore, it was hypothesized that individuals who do not engage in any part of the UFITT program represent with a mental health crisis faster and more often compared to those who do attend follow-up care through the program.

Methods: The study period was from August 1 to November 30, 2022 and included all individuals who presented to either the Crisis Response Centre, emergency department, urgent care, or Crisis Stabilization Unit between August 1 and September 30, 2022 with a mental health crisis who were referred to and accepted by UFITT. These individuals were then divided into two cohorts, those that attended at least one visit to the UFITT program: “UFITT engagement”, and those that did not: “No UFITT engagement”. Using the CRC electronic health record program (Momentum), descriptive statistics were used to compare the two groups on clinical and sociodemographic characteristics at time of referral. Descriptive statistics were also used to compare the groups on the outcome of health service use within their 60-day follow-up period.

Results: Of the 122 individuals, 73 (59.8%) did not engage in any UFITT services, while 49 (40.2%) of the remaining individuals engaged in one or more services offered by the UFITT program. The group that did not engage in UFITT follow-up were younger, more often unhoused, and had higher rates of personality disorders, previous hospitalizations, and almost half misused substances. Suicidal behavior did not distinguish the two groups. Twelve (16.4%) patients that had no UFITT engagement and 11 (22.4%) patients that engaged with UFITT services represented within 60 days of their initial presentation. There were more individuals who represented in the first 20 days in the No UFITT engagement group compared to the UFITT engaging group.

Discussion: The first hypothesis is partially supported by the dissimilarities observed between cohorts as those in No UFITT were younger, had more previous hospitalizations, and higher rate of substance misuse. The results do not support the hypothesis that individuals who do not engage in UFITT aftercare return to the CRC more often. Although results provide support for the hypothesis that those not engaging with UFITT aftercare represent sooner, it is unknown if this is statistically significant. The No UFITT cohort was additionally observed to have marginally worse health outcomes. More research is needed to determine the significance of these dissimilarities.

INTRODUCTION

Approximately 1 in 3 Canadians will be affected by a mental illness during their lifetime.[1] Between the years 2016 and 2017, 1 in 7 Canadians used health services for a mental illness (57% female and 43% male).[2] Furthermore, according to a Maru Public Opinion poll, 32% of Canadians aged 18-34 believed they needed mental health care but could not access any services.[3]

The Urgent Follow-up Integrated Treatment Team (UFITT) program is the primary mental health follow-up program for individuals attending the Crisis Response Centre (CRC) and Health Sciences Centre emergency department (ED). It accepts referrals from the CRC, the Crisis Stabilization Unit (CSU), all Winnipeg EDs, and all urgent care (UC) centres in Winnipeg. UFITT's aim was to develop a program that is low barrier and high inclusion, creating favourable accessibility for the mental health resources and support that is greatly needed.

In sum, the UFITT program has three treatment arms. The first involves an assessment by a psychiatrist, the main objective of this usually being diagnostic clarification and medication management. The second arm is large psychotherapy classes, all comprising of evidenced-based psychotherapies that are tailored to common mental health presentations. The first class is based on cognitive behavioral therapy and mindfulness (CBTm; typically for mood and anxiety disorders), the second is the Managing Difficult Emotions (MDE) class, based on skills from dialectical behavior therapy (typically for cluster B personality disorders but can apply to emotional struggles across disorders), and lastly is Living With Hope, a blend of CBT, DBT, and other suicide prevention-specific skills (for people who have attempted suicide). The last arm is a brief treatment service with 1-on-1 counselling, thus it is slightly less accessible than the group classes in regard to wait-times, as it is more resource intensive.

What gives UFITT its feature of high accessibility is that the sessions of the CBTm and MDE classes are all independent of each other. Therefore, a newly referred individual could start right away, despite the program being mid-cycle into their classes. These two classes take the highest number of UFITT patients, and since individuals do not have to wait until the first class to begin, UFITT can support a high volume of patients and give access to care with a minimum waitlist.

Although approximately 130 individuals are referred to the UFITT program each month, there is a high rate of no-shows. No research has been done on these individuals' demographics, characteristics, or what happens after their referral. Likewise, no research to date has been done regarding the qualities of the individuals that do attend at least one session of aftercare via the UFITT program, and if doing so leads to better health outcomes. This is important since the UFITT program services people with acute and urgent mental health issues, often with severe symptoms and safety issues. As such, when people do not attend follow-up, there is concern about their wellbeing.

The purpose of this study was a quality improvement project. This study aimed to better understand if there are common clinical and demographic characteristics that can be identified within the individuals that attend aftercare following their UFITT referral, compared to those that do not. Identifying these correlates within the latter cohort would be especially beneficial, as this could help health care providers at point of referral understand if adjustments in approach regarding certain populations are necessary to increase the likelihood for aftercare. Additionally, recognizing populations that are most likely to benefit from UFITT is key to allocate and maximize resources where appropriate. The first hypothesis was that individuals who are more unwell and have barriers accessing help, more specifically, those who are younger, male, and

presenting with more severe clinical presentations are less likely to engage in UFITT follow-up.

A secondary objective of this study was to better understand the outcomes of individuals that attend UFITT aftercare, compared to those who do not attend any UFITT services. It was predicted that individuals who do not show-up for any services come back to the CRC, CSU, ED, or UC not only faster, but more often as well.

METHODS

Study Period and Cohort Generation

The study period was from August 1 to November 30, 2022. The study included all individuals who presented to either the CRC, ED, UC, or CSU between August 1 and September 30, 2022 with a mental health crisis who were referred to and accepted by UFITT. These individuals were then divided into two cohorts, those that attended at least one visit to the UFITT program: “UFITT engagement”, and those that did not: “No UFITT engagement”.

Those who were considered as “UFITT engagement” were defined as individuals who attended one or more services provided by the UFITT program. Before attending UFITT classes, individuals are invited to attend an Information Class (IC) that serves as an orientation for the program. Individuals who attended an IC class but ultimately did not participate in any other classes or services, were still included in the UFITT engagement cohort.

Data Sources, Variables, and Outcomes

Using the CRC electronic health record program (Momentum), descriptive statistics were used to compare the two groups on clinical and sociodemographic characteristics at time of referral. These variables included age, gender, marital status, housing accommodations,

employment, previous psychiatric diagnoses, primary psychiatric diagnosis at presentation, previous psych admissions, pre-existing chronic medical illness, history of self-harming behaviours, history of attempts, substance misuse, current primary substance, substance use in the last 30 days, self-harm within a week of presentation, suicidal ideation (SI) at presentation, suicide attempt or preparatory acts toward suicide within a week of presentation, and psychosis at presentation.

Descriptive statistics were also used to compare the groups on the outcome of health service use within their 60-day follow-up period. Descriptors such as the number of representations to CRC, ED, or UC within 60 days of initial presentation, days between initial presentation and first representation, self-harm at representation, SI at representation, suicide attempt or preparatory acts at representation, substance use since initial presentation and type of primary substance, psychosis at representation, psychiatric admission at representation, and admission to CSU at representation were used to compare health outcomes between groups.

RESULTS

Clinical and sociodemographic characteristics of the cohorts

Out of the total 126 participants in the study sample who were referred to UFITT after a mental health crisis, four were deemed ineligible for the UFITT program, leaving 122 total participants. Of these 122 individuals, 73 (59.8%) did not engage in any UFITT services, while 49 (40.2%) of the remaining individuals engaged in one or more services offered by the UFITT program. The sociodemographic and clinical characteristics of the UFITT engagement and No UFITT engagement cohorts are described in Table 1.

When compared to the UFITT engagement cohort, people that did not engage with follow-up were more often younger and unhoused. Forty-five percent of the No UFITT engagement group were under the age of 25, whereas only 35% of the UFITT engaged group were under 25. The prevalence rates of gender, marital status, and employment appeared similar. Regarding clinical correlates, rates were higher in the No UFITT engagement group for previous psychiatric hospitalization (16.4% vs 2%), personality disorder (24.7% vs 8.2%) and substance misuse at presentation (43.8% vs 34.7%). Conversely, the UFITT engagement cohort had higher rates of anxiety disorders (34.7% vs 17.7%) and a previous psychiatric diagnosis (81.6% vs 71.2%). Patients referred from sites other than the CRC had lower rates of UFITT engagement. There was no clear trend among the variables assessing suicidal behavior.

Substance misuse was explored further in terms of types and recency of use. Among the No UFITT engagement group, alcohol was the most reported primary substance, with 15 individuals (46.9%) reporting current use. Other reported primary substances used were marijuana (n=9, 28.1%), cocaine (n=5, 15.6%), opiates (n=2, 6.3%), and meth (n=1, 3.1%) Furthermore, 28 (87.5%) of these individuals used their primary substance in the last 30 days before their initial presentation. There were two patients whose primary substance was reported as cocaine that did not indicate use in the last 30 days. Two patients who had alcohol reported as their primary substance had an unknown history of use in the last 30 days from their initial presentation.

Conversely, 17 (34.7%) of the cohort who did engage with UFITT were categorized as having substance misuse. Additionally, unlike its counterpart, alcohol and marijuana both had 8 (47.1%) individuals who were documented to have either as their primary substance. One patient was considered to have cocaine as their primary substance. All 17 individuals in this cohort

deemed to have substance misuse reported use of their primary substance within the last 30 days of their initial presentation.

Health outcomes between cohorts

The second aim of this study was to compare health outcomes between patients that engaged in UFITT's aftercare services versus those who did not. As demonstrated in Figure 1, 12 (16.4%) patients that had no UFITT engagement and 11 (22.4%) patients that engaged with UFITT services represented within 60 days of their initial presentation.

Of the 12 individuals with no engagement, one (8.3%) individual represented twice within the 60 days, two (16.7%) endorsed self-harm at representation, 10 (83.3%) endorsed SI at representation, and three (25%) had a suicide attempt or made preparatory acts at representation. None had symptoms of psychosis at representation. Four (33.3%) reported substance use since initial presentation, with two deeming alcohol and two deeming cocaine as their current primary substance. For two (16.7%) individuals, their representations resulted in a psychiatric admission, and another three (25%) with admissions to CSU. The time between initial and representation was most commonly in the first 20 days (n=8, 66.7%), and even more so in the first 10 days (n=5, 41.7%), as shown in Figure 2. Three (25%) patients represented 31-40 days after their initial presentation and only one (8.3%) in the last 51-60 days.

Alternatively, with the 11 individuals who engaged with UFITT aftercare services, two individuals represented twice within their 60-day follow-up period. One of these individuals both engaged with UFITT and first represented in less than 10 days. The other, first represented in 11-20 days but did not engage with UFITT until 51-60 days after their initial presentation. Figure 2 further describes the time relationship of days between initial presentation and first UFITT

engagement within the cohort, as well as time between initial presentation and representation. Two (18.2%) endorsed self-harm at representation, seven (63.6%) endorsed SI at representation, and three (27.3%) had a suicide attempt or made preparatory acts at representation. None had symptoms of psychosis at representation. Two (18.2%) reported substance use since initial presentation, both deeming alcohol as their current primary substance. One (9.1%) patient's representation resulted in a psychiatric admission, and another three (27.3%) with admissions to CSU.

Of the total 122 patients, 18 (14.8%) individuals' initial presentations involved a suicide attempt and/or preparatory acts within a week of presenting. Furthermore, two of these 18 both represented within 21-30 days from their original presentation, endorsed SI, and a suicide attempt or preparatory acts were involved at the time of their representation.

There did not appear to be differences between cohorts regarding sites patients chose to represent at, with the CRC significantly being the most common for both (no UFITT = 8, 66.7% and UFITT = 8, 72.7%). ER and UC centres were second and third respectively for both cohorts.

DISCUSSION

Clinical and sociodemographic characteristics of the cohorts

Our results confirm that despite the many referrals UFITT receives and accepts, the majority of patients are lost to follow-up and do not engage in the program's services.

This study aimed to better understand if there are common clinical and demographic characteristics that can be identified within the individuals that attend aftercare following their UFITT referral, compared to those that do not. The group that did not engage in UFITT follow up were younger, more often unhoused, and had higher rates of personality disorders. Individuals

who did not engage in UFITT were more unwell insofar as they had more previous hospitalizations and almost half misused substances. However, suicidal behavior did not distinguish the two groups. Thus, the first hypothesis was only partially correct.

However, a trend to note is the discrepancy we continue to observe between males and females regarding mental health diagnoses and therapy-seeking. Although there is continued improvement and awareness in today's society regarding barriers to men seeking help for their mental health, traditional gender roles and cultural expectations of men have created the long-lasting stigma that to be male and struggle with mental health, or to seek help for mental health, is considered to be weak or "unmasculine"[4]. This stigma is a contributing factor as to why males are not only less likely than females to disclose a mental health problem, but they are also far less likely than females to seek professional support[5]. Table 1 exhibits that in both cohorts, there is an almost equal gender discrepancy between individuals who identified as cis male compared to cis female. Furthermore, in both cohorts, there was approximately twice the number of cis females with a previous psychiatric diagnosis than cis males with a previous psychiatric diagnosis. While gender was not a correlate that distinguished likelihood of engagement in follow-up care, it is important to note the much higher rate of women who seek emergency mental health.

As previously stated, identifying commonalities in individuals who do not engage with after-care services could help indicate if adjustments in approach regarding certain populations are necessary to increase the likelihood for aftercare through referral. A 2010 study investigating gender and self-reported mental health problems and predictors of help-seeking from a general practitioner suggested that a "'gender sensitive approach' should be applied to mental health policies, mental health promotion, and prevention programmes"[6]. This suggests that additional

interventions need to be made well before aftercare in order to be more effective in providing mental health support for this population.

There are almost 17% more individuals presenting with personality disorder as their primary diagnosis who did not engage with UFITT compared to those that did with the same primary diagnosis. On the other hand, people with an anxiety disorder as their primary diagnosis at presentation had 17% more who did attend UFITT aftercare than their counterpart. It is difficult to interpret whether there is a true difference in these psychiatric disorders and if one is more or less likely to seek UFITT aid, or if it is simply due to the complexity of mental disorders in that usually, with both of these disorders, multiple mental health diagnoses exist concurrently[7,8]. In other words, it is difficult to know which mental health diagnosis contributes to or hinders the likelihood of engaging in aftercare.

A 2022 study found that two of the key motivations for use of psychosocial aftercare services for people with mental health disorders was "feeling understood" and having a space of safety[9]. These interventions can be integrated into how we approach individuals presenting with a mental health crisis in order to provide benefit, regardless of population.

Health outcomes between cohorts

This study also aimed to better understand the health outcomes of individuals that attended UFITT aftercare, compared to those who did not engage in any UFITT services. The hypotheses predicted that individuals not attending any part of the UFITT program were expected to both come back to the CRC, UC, ED, or CSU faster and more often compared to their counterparts. The results did not support the latter hypothesis. While there was a low number of representations within the 60-day follow-up period for both cohorts (81.1%

combined), there were 6% more represents in those that engaged with any part of UFITT, compared to those that did not. One explanation for this could be that treatment contacts represent a person's willingness to connect with the health system, rather than their clinical need. Therefore, the people that engaged with UFITT may have been more likely to represent not because they are doing worse clinically, but instead are patients who are keen on seeking care in the first place.

Alternatively, 66.7% of patients who did not engage with UFITT after-care and represented within 60 days, did so in the first 20 days. Whereas 45.5% represented in the first 20 days in those who participated in UFITT and represented in the follow-up period. Furthermore, there was a slightly higher percentage of a representation resulting in a psychiatric or CSU admission in the No UFITT engagement group versus UFITT engaged. Otherwise, the descriptors used to quantify health outcomes were relatively indifferent between cohorts. Although these results provide support for the hypothesis that those not engaging with UFITT aftercare represent sooner, and perhaps have marginally worse health outcomes, it is unknown if this is statistically significant.

These results showing rapid representation underscore the acuity of these groups and highlight the importance of rapid follow-up care after initial presentation. Time between UFITT referral and UFITT engagement is not always patient-dependent. As described previously, there are some arms of UFITT that are less accessible and have longer wait-times which can affect patient outcomes. For example, one patient in this study did not receive the UFITT services they required until >60 days after their referral. Unfortunately, they represented 51-60 days after their initial presentation and at this representation they endorsed SI, self-harm, and ultimately was admitted to the CSU. While it is impossible to determine if this representation could have been

avoided had they received UFITT follow-up care sooner, the importance of rapid aftercare remains significant. A study conducted in 2015 investigated the effect of initiating a transitional psychiatry clinic (TPC), which provided a bridge after discharge for patients who presented to the ED with a psychiatric crisis. If a TPC appointment was achieved in 3 days after ED discharge, it was associated with significantly longer periods in community without ED presentation. Furthermore, increased wait-times for TPC were strongly associated with non-attendance[10].

Conclusions, limitations & considerations for future studies

In conclusion, while this study created a foundation by which we can better understand the effects of this program and the individuals that do and do not engage in it, more research is needed to provide long-term insight and recommendations to improve the quality of care in those that present with a mental health crisis.

This study was not without its limitations. Some descriptive and clinical information was subjective, as the data collected was taken from documentation from a mental health professional who interviewed the patients during their mental health crisis presentation and/or representation. Therefore, characteristics such as primary psychiatric diagnosis at presentation and primary substance used were sometimes open to interpretation by both the interviewer and researchers of this study.

Furthermore, substance misuse was not systematically assessed and very much dependent on clinical opinion. This was difficult to assess appropriately as frequent alcohol and/or marijuana use as well as other occasional recreational drug use does not always equivalate to a substance use disorder. Additionally, substance use in the last 30 days referred to only use of

their acknowledged primary substance, and any other additional substance use was not included.

Race/ethnicity was originally included as part of demographical characteristics in hopes that we could identify any discrepancies between populations, perhaps indicating that adjustments in approach regarding certain populations are necessary to increase the likelihood for aftercare through referral. However, race and ethnic background were rarely self-reported, and only done so if patients included its relevance to their current presentation. Therefore, frequently the only time it was provided was in the mental status examination. This was not done often, and if so, was once again subjective to the interviewer. Out of the 122 patients, 82% of individuals' race and ethnicity were unknown and therefore this was omitted from the study.

Other limitations to consider involve the follow-up period. Due to time constraints of the study, only a 60-day follow-up period could be considered for representations. It is unknown if either cohort had more representations at a later time, and perhaps a longer follow-up period would provide more substantial evidence regarding health outcomes. Comparative statistical tests were not used to determine if the crude rate differences were statistically significant; this should be an approach of further work in this area.

Should this study be repeated, it is important to consider other factors, especially regarding those who did not engage with UFITT. This study did not consider reasons for why patients did not engage with UFITT. Scheduling conflicts, transportation, and other socioeconomic factors are all reasons to consider non-attendance. This could be ascertained using qualitative interviews of patients agreeable to participating in focus groups. Furthermore, several patients are lost to follow-up and are unreachable after discharge from initial presentation. Their status or reasons for non-attendance remain unknown. Similarly, although the majority of patients in this study did not represent, this does not confirm that they are clinically

well or had better health outcomes.

Finally, this study did not consider a UFITT attender's extent of participation. A subsequent study that investigates if there are differences in both characteristics and health outcomes between individuals who attended only the UFITT IC, versus those with partial UFITT program completion, versus those who completed the entire UFITT program, could provide further insight to help allocate and maximize mental health resources where appropriate.

REFERENCES

1. Pearson C, Janz T, Ali J. Mental and substance use disorders in Canada [Internet]. Ottawa: Stats Canada; 2013 Sept [cited 2022 Oct 30]. 8 p. Cat. No.: 82-624-X. Available from: https://www150.statcan.gc.ca/n1/en/pub/82-624-x/2013001/article/11855-eng.pdf?st=8MJZvswI

2. Canadian Chronic Disease Surveillance System. Mental Illness in Canada, 2015 [Internet]. Ottawa: Public Health Agency of Canada; 2015 May [cited 2022 Oct 30]. 40 p. Cat. No.: HP35-56/2015E-PDF. Available from: https://www.canada.ca/content/dam/canada/health-canada/migration/healthy-canadians/publications/diseases-conditions-maladies-affections/mental-illness-2015-maladies-mentales/alt/mental-illness-2015-maladies-mentales-eng.pdf

3. Maru Public Opinion. Canada's mental health crisis [Internet]. Canada: Maru Public Opinion; 2022 Mar 14 [cited 2022 Oct 30]. Available from: https://static1.squarespace.com/static/5a17333eb0786935ac112523/t/624b0209e95d5424602a610d/1649082891112/CDN+mental+health+22+F.pdf

4. Mental Health Foundation. Men and mental health [Internet]. London: Mental Health Foundation; 2021 Oct 1 [cited 2023 Mar 23]. Available from: https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/men-and-mental-health

5. Doward J. Men much less likely to see mental health help than women. The Guardian [Internet]. Date of publication 2016 Nov 5 [2023 Mar 23];Society:[1 pg.]. Available from: https://www.theguardian.com/society/2016/nov/05/men-less-likely-to-get-help--mental-health

6. Tedstone Doherty D, Kartalova-O'Doherty Y. Gender and self-reported mental health problems: predictors of help seeking from a general practitioner. Br J Health Psychol [Internet]. 2010 Feb [cited 2023 Mar 23];15(1):213-28. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC28^{4}5878/
doi: 10.1348/135910709X457423

7. Pollack MH. Comorbid anxiety and depression. J Clin Psychiatry [Internet]. 2005 [cited 2023 Mar 11];66(8):22–29. Available from: https://www.psychiatrist.com/wp-content/uploads/2021/02/11964_comorbid-anxiety-depression.pdf

8. SOL Mental Health. Why personality disorders are so hard to treat [Internet]. United States: SOL Mental Health; 2021 Oct 12 [cited 2023 Mar 13]. Available from: https://www.collectivebh.com/2021/10/12/why-personality-disorders-are-so-hard-to-treat/

9. Böhm M, Stiglbauer B. Motives for the use of psychosocial aftercare services. Neuropsychiatry [Internet]. 2022 Sept [cited 2023 Mar 11];36(3):97-103. Available from: https://pubmed.ncbi.nlm.nih.gov/34383252/
doi: 10.1007/s40211-021-00397-7

10. McCullumsmith C, Clark B, Blair C, Cropsey K, Shelton R. Rapid follow-up for patients after psychiatric crisis. Community Ment Health J [Internet]. 2015 Feb [cited 2023 Mar 11];51(2):139-44. Available from: https://pubmed.ncbi.nlm.nih.gov/25398419/
doi: 10.1007/s10597-014-9782-z

APPENDIX

Table 1. Sociodemographic and clinical characteristics of patients referred to and accepted by UFITT (N=122).

Characteristics	No UFITT engagement N=73 (59.8%)	UFITT engagement N=49 (40.2%)
Age	18-24 = 33 (45.2%) 25-29 = 17 (23.3%) 30-39 = 11 (15.1%) 40-49 = 7 (9.6%) 50-64 = 3 (4.1%) 65+ = 2 (2.7%)	18-24 = 17 (34.7%) 25-29 = 12 (24.5%) 30-39 = 5 (10.2%) 40-49 = 9 (18.4%) 50-64 = 6 (12.2%) 65+ = 0
Gender	Cis Male = 26 (35.6%) Cis Female = 44 (60.3%) Non-Binary = 2 (2.7%) Trans Male = 0 Trans Female = 1 (1.4%) Two-spirit = 0 Other = 0 Unknown = 0	Cis Male = 17 (34.7%) Cis Female = 29 (59.2%) Non-Binary = 1 (2.0%) Trans Male = 1 (2.0%) Trans Female = 1 (2.0%) Two-spirit = 0 Other = 0 Unknown = 0
Marital status	Single = 33 (45.2%) Relationship = 15 (20.5%) Married/Common-law = 18 (24.7%) Separated/Divorced = 5 (6.8%) Unknown = 2 (2.7%)	Single = 23 (46.9%) Relationship = 10 (20.4%) Married/Common-law = 14 (28.6%) Separated/Divorced = 1 (2.0%) Unknown = 1 (2.0%)
Housing accommodations	Permanent = 67 (91.8%) Transitional = 0 Unhoused = 5 (6.8%) Unknown = 1 (1.4%)	Permanent = 47 (95.9%) Transitional = 0 Unhoused = 0 Unknown = 2 (4.1%)
Employment	No = 28 (38.4%) Yes = 36 (49.3%) Student = 6 (8.2%) Retired = 2 (2.7%) Unknown = 1 (1.4%)	No = 18 (36.7%) Yes = 27 (55.1%) Student = 3 (6.1%) Retired = 1 (2.0%) Unknown = 0
Pre-existing chronic medical illness	Y = 21 (28.8%)	Y = 16 (32.7%)
Previous psychiatric diagnosis	Y = 52 (71.2%)	Y = 40 (81.6%)
Primary psychiatric diagnosis at presentation	Anxiety Disorder = 13 (17.8%) Mood Disorder = 27 (37.0%) Personality Disorder = 18 (24.7%) Psychotic Disorder = 0 Substance Use Disorder = 6 (8.2%) Eating Disorder = 0 PTSD = 3 (4.1%) Adjustment Disorder = 5 (6.8%) N/A = 1 (1.4%)	Anxiety Disorder = 17 (34.7%) Mood Disorder = 20 (40.8%) Personality Disorder = 4 (8.2%) Psychotic Disorder = 0 Substance Use Disorder = 2 (4.1%) Eating Disorder = 0 PTSD = 3 (6.1%) Adjustment Disorder = 2 (4.1%) N/A = 1 (2.0%)
Previous psychiatric admission	Y = 12 (16.4%)	Y = 1 (2.0%)
History of self-harm	Y = 39 (53.4%)	Y = 29 (59.2%)

History of suicide attempts	Y = 33 (45.2%)	Y = 21 (42.9%)
Substance Misuse	Y = 32 (43.8%)	Y = 17 (34.7%)
Self-harm within week of presentation	Y = 12 (16.4%)	Y = 12 (24.5%)
Site of presentation	CRC = 52 (71.2%) UC = 9 (12.3%) ED = 12 (16.4%) CSU = 0	CRC = 39 (79.6%) UC = 3 (6.1%) ED = 7 (14.3%) CSU = 0
SI at presentation	Y = 55 (75.3%)	Y = 34 (69.4%)
Suicide attempt or preparatory acts within week of presentation	Y = 10 (13.7%)	Y = 8 (16.3%)
Psychosis at presentation	Y = 1 (1.4%)	Y = 2 (2.0%)

Note: Percentages reflect column percentages within each cohort.

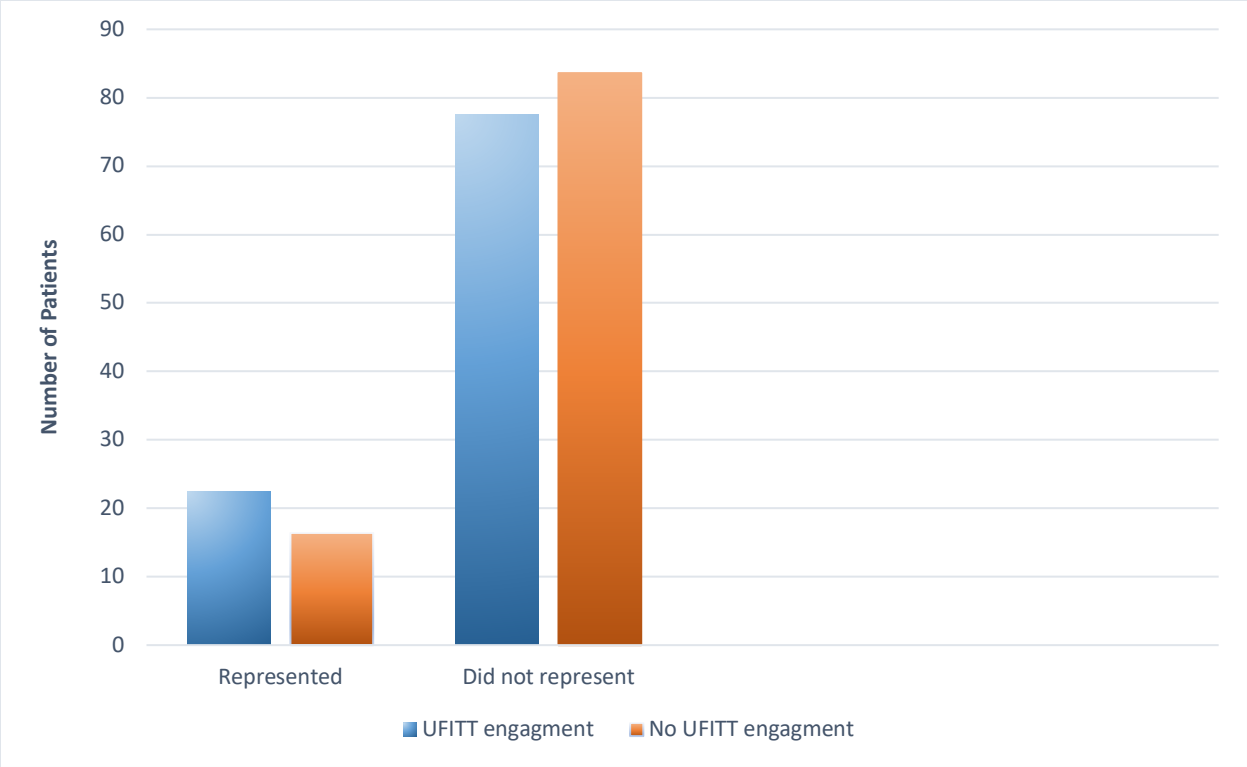

Figure 1. Representations to CRC, UC, or ED within 60-day follow-up period from initial presentation

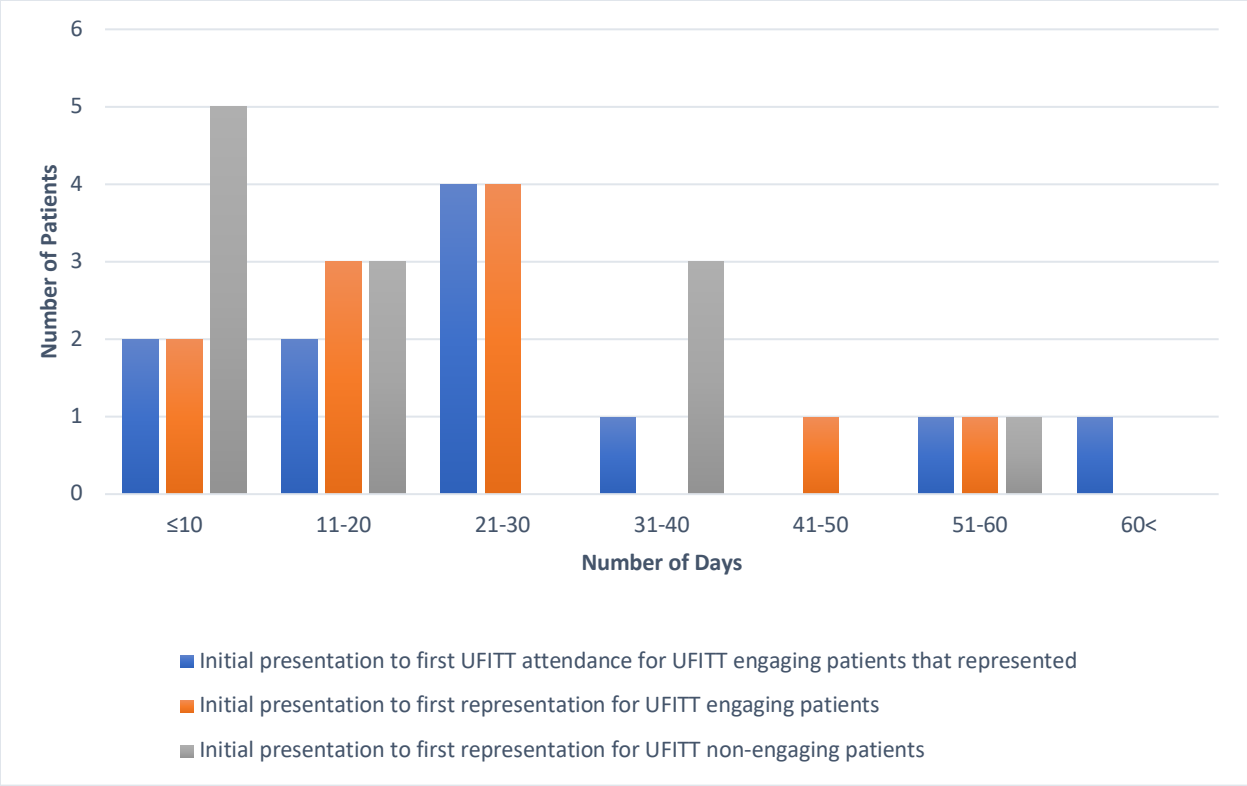

Figure 2. Time relationship between initial presentations, UFITT engagement, and representation in 60-day follow-up period.