TRANSITION

ZEROSuicide | INSTITUTE
IN HEALTH AND BEHAVIORAL HEALTH CARE

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> ## Follow patients through every transition in care.
> Put policies into action that ensure safe hand-offs between caregivers and upon discharge.

Overview: Care Transitions are High-Risk Times for Patients

Zero Suicide outlines specific action steps to provide excellent support to transition patients at risk to the next level of treatment. The burden lies on providers, rather than on patients and their family, to develop systems to ensure that patients make and keep appointments.

Caregivers and clinicians must bridge patient transitions from inpatient care, emergency department, or primary care to outpatient behavioral health care. It is equally important to address suicide risk at every visit within an organization, from one behavioral health clinician to another, and between primary care and behavioral health staff in integrated care settings.

Consider these findings from the National Survey of Drug Use and Health during 2008 to 2012.[1] Of the adults who reported that they had attempted suicide in the past 12 months:

- 46 percent received no mental health treatment even though 60 percent of those who attempted suicide had received medical attention for the suicide attempt and 43 percent had stayed overnight in a hospital
- 60 percent did not participate in any outpatient mental health visit
- 48 percent of those receiving mental health treatment received only prescription medication for a mental health disorder

This is insufficient care for someone with suicidal thoughts, let alone someone who has attempted suicide. But when organizations use effective clinical bridging strategies they can triple the odds that a patient will link to outpatient care.[2]

Research has also demonstrated that some of the highest risk periods are immediately after discharge from an inpatient psychiatric unit and that suicide rates among this group "remain high for many years after discharge."[2]

Recommendation: Provide Follow-up & Supportive Contacts

It is essential to emphasize proactive and personal provider involvement in follow-up care and care transitions.[3] The Zero Suicide approach for care transitions stipulates that:

- Organizational policies provide guidance for successful care transitions and specify the contacts and support needed throughout the process to manage any care transition
- Follow-up and supportive contacts for individuals on a suicide care management plan, also called a pathway to care, are tracked and managed using an electronic health record or paper record
- Patients are engaged in an individualized, culturally sensitive manner that takes into account their needs and preferences
- Staff are trained how to provide supportive caring contacts and follow-up care using techniques such as motivational interviewing, safety planning, and lethal means assessment and counseling

With isolation as a strong risk factor for suicide, successful care transitions are especially important for patients.

Timely supportive contacts (e.g., calls, texts, letters, visits) should be standard at critical times including after acute care visits, once a patient begins treatment, when a patient is in a higher risk period, or when services are interrupted (e.g., a scheduled appointment is missed). Research has demonstrated that caring, handwritten letters sent quarterly to monthly throughout the year for up to 5 years after inpatient hospitalization significantly reduced the number of suicide deaths among patients who received them compared to similar patients who did not.[4] This intervention has specifically targeted those who refused long-term care or to engage in the health care system. The effect of the caring letters was significant even in the group who declined or refused treatment.[4] Additionally, a recent study found that patients with screening plus intervention, consisting of secondary suicide risk screening, discharge resources, and post-discharge telephone calls focused on reducing suicide risk, showed a 5 percent absolute reduction in suicide attempt risk and a 20 percent relative risk reduction.[5]

Conclusion: Continuous Innovation for Engaged and Rapid Care Transitions

The emerging standard in suicide care requires innovative approaches to creating smooth and uninterrupted care transitions from one setting to another with support and contact provided throughout by the behavioral health provider, physician, or other designated staff from the organization. Follow-up "caring contacts" with high-risk individuals, such as postcards or letters expressing support, phone calls, and in-person visits, have been shown in randomized control trials to reduce suicide mortality. [6,7,8,9]

Citations

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