R2. Documentation of Clinical Care

4. Adequate clinical documentation of the care provided to suicidal patients is required for optimizing continuity of care. Providers must consider ethical, clinical, and legal issues when documenting their assessment, management and treatment of suicidal patients.

DISCUSSION

A common factor identified by research in civilian population and in the military is the failure or breakdown in the continuity of care for mental health problems (**Schoenbaum et al., 2009**). The report by the Center for Military Health Policy Research of the RAND Corporation summarized the problem:

> *"Having a "chain of care" and "warm transfers" would prevent individuals from "falling through the cracks of the care system" and is seen as particularly important for individuals suffering from a mental health problem or experiencing suicidal ideation or intent. In the military context, it would mean ensuring smooth transitions between providers during transition times (e.g., moves, deployments, redeployment) so that there is always care available."(Ramchand et al.,, 2011. P. 47)*

Adequately addressing continuity and coordination of care is a challenge in any health care system. This is a particular problem for suicidal individuals and most detrimental example is suicidal patients who are treated in emergency departments. In this setting, patients generally don't receive adequate treatment to address underlying mental illnesses or substance use problems; nor do they leave connected with the kind of follow-up outpatient care that could expedite their recovery.

Increased occurrences of suicidal ideation or behavior appear to be associated with disruptions in patient medication access and continuity**. Moscicki (2010)** collected survey data in 3 cross-sectional cycles in 2006 (as part of the National Study of Medicaid and Medicare Psychopharmacologic Treatment Access and Continuity). The data showed that patients who experienced medication switches, discontinuations, and other access problems had 3 times the rate of suicidal ideation or behavior compared with patients with no access problems (22.0% vs 7.4%, P < .0001).

S. Monitoring after Recovery

BACKGROUND

With effective treatment, illnesses and perpetuating factors can be alleviated, protective factors and coping strategies can be fortified, and the patient's suicidality can resolve to a state of clinical recovery whereby the acute risk has resolved. Nevertheless, the risk of relapse remains. Maintenance treatment with suicidality ("disease") surveillance is warranted to provide early detection of recurrence.

Routine screening of adults in a primary care population for suicidal ideation has not been proven to be of benefit. The US Preventive Services Task Force (USPSTF) concluded that there is insufficient evidence to recommend for or against routine screening. However, in the patient who has a history of suicidal intent or behavior, and especially in the patient who has a diagnosis of a mental disorder, future monitoring and periodically re-assessing the risk for suicide may be justified.

RECOMMENDATIONS

1. Patients with a history of suicide attempt or behavior should continue to be evaluated for risk of relapse on a regular base.

APPENDIX F:
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