

Module D: Follow-up and Monitoring of Patient at Risk for Suicide

Among patients with high suicide risk, particularly those who have attempted suicide, immediate follow-up and continuity of care are crucial to promoting positive outcomes. Patients leaving the ED or hospital inpatient unit after a suicide attempt, or otherwise at a high acute risk for suicide, require rapid, proactive follow-up. This Module focuses on the critical steps that should be followed in the immediate and long-term follow-up of patients at high acute risk for suicide. A previous suicide attempt is one of the most important risk factors for later death by suicide. This risk is particularly high in the weeks and months following the attempt, including the period after discharge from acute care settings such as EDs and inpatient psychiatric units.

A few studies support continued contact or outreach following a crisis, as recommended in this module. Studied programs proven successful sent caring letters following hospital discharge, provided patients an emergency card to facilitate easy access, or a suicide prevention counselor coordinated care following hospital discharge. However, a review of other studies found insufficient evidence to establish clinical effectiveness for psychosocial interventions as: case management, intensive inpatient and community care, or assertive approaches. Thus, most recommendations are based on consensus of practicing clinicians informed by the results of these studies. There is still a need for further research to identify specific aspects of these interventions, in particular the populations served by the military healthcare system and the VHA.

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O. Follow-up and Monitoring

Follow patients at risk of suicide regularly and reassess risk frequently, particularly when the patient's situation changes. Follow-up should commence in the immediate period after discharge from acute care settings. The frequency of contact should be determined on an individual basis, and increased when there are increases in risk factors or indicators of suicide risk. Support should include reinforcement of the safety plan at regular intervals, including practice and, if needed, revisions. Contact and support can be helpful even when telephone, letters, or brief intervention provides it.

BACKGROUND

Suicidal behavior is a final common pathway for a wide variety of static (e.g. personality, chronic illness) and dynamic (e.g. financial or marital stress) factors. Most people who die from suicide have had contact with a healthcare professional in the weeks or months before their deaths. Many others have reached out for help but were unable to obtain it. These findings demonstrate the importance of recognizing people at risk and implementing interventions as soon as possible. However, the potential for death from suicide remains elevated long after the immediate situation. The nature of suicide risk as fluid, dynamic, and changing over time calls for an emphasis on pro-active follow up after acute interventions as part of any suicide prevention program. One cannot assume that because someone has been discharged from an inpatient unit or an emergency department that they are no longer at risk. Suicide risk often continues or is easily rekindled.

The first week, month and year following discharge from psychiatric inpatient settings is a period of increased vulnerability. The first 30 days after discharge from an inpatient psychiatric unit is considered to be the highest risk period in which someone is likely to attempt or re-attempt suicide. The risk for suicide should be reassessed frequently, particularly if the patient's situation changes. Within ambulatory care settings, patients at clinically significant risk for suicide require regular contact to provide support and to monitor them for times when they are at increased risk.

Providing ongoing follow-up and ensuring future access to care are critical elements in reducing the likelihood of suicide in any individual at risk. Patients discharged from inpatient setting or emergency department; need a prompt outpatient follow-up appointment, preferably within one week of discharge, as more suicides occur in the first week then at any other time.

Patients should be followed up by behavioral health or primary care providers who know the patient and are knowledgeable about suicide prevention. Following acute management, the care team should assure that previously suicidal patients are actively engaged in ongoing care for any mental disorders and regular health care maintenance. Patients with co-occurring conditions should continue to receive treatment for prevention of relapse or recurrence of depression, bipolar disorder, anxiety disorders, psychosis, or other conditions. For those with a history of alcohol or substance abuse, corresponding treatment can be critical to prevent relapse.

The timing of follow-up appointments should be determined on a case-by-case basis depending upon the patient's clinical state and preferences. Follow-up can be conducted in a clinical setting, the patient's home, or the community. It can be face-to-face, by telemedicine, by telephone, or by other modalities. Caring for patients at risk within structured programs that provide elements of care management can facilitate effective treatment. Feasibility, acceptability and outcome of different tele-health modalities (e.g. phone versus web-based chat versus email or messaging) have not been evaluated and should be a focus of future research.

RECOMMENDATIONS

Follow-Up

1. Establish timely and ongoing follow-up care for those who attempt suicide and others at high acute risk in the immediate period after discharge from acute care settings and identify the responsible provider during this period.
2. Patient should be re-evaluated following an inpatient or Emergency Department discharge, as soon as possible, but not later than 7 days.
3. High acute risk patient should be actively managed to assure adherence and coordinated care.
4. Patients at high acute risk should be followed closely (e.g., weekly for the first month) after they are identified or after inpatient or ED discharge.
5. Consider contacting the patient before initial follow-up appointment to monitor transition to the outpatient care plan and to reinforce adherence to the discharge plan.
6. The frequency of outpatient follow-up should be determined on a case-by-case basis. It should be greatest after attempts and related behaviors, after change in treatment, or after transitions to a less restrictive setting of care. Once the patient stabilizes and is engaged in care the frequency of follow-up can be decreased based on:
 - a. The current level of risk
 - b. The requirement of the treatment modality
 - c. The patient's preference

Duration of Care Focused on Suicide Prevention

7. Patients who survived a suicide attempt or identified as high acute risk for suicide should be monitored for at least **one year**. Patients identified as intermediate acute risk for suicide (who have never engaged in suicidal behaviors) should be followed for at least **six months** after suicidal ideation has resolved. Patients who have been identified as low acute risk may be followed by their primary care provider and periodically re-assessed for suicide risk.

DISCUSSION

The importance of providing follow up services promptly after emergency department or hospital discharge is highlighted by findings of a study by the Department of Veterans Affairs which showed the period after inpatient discharge to be the time of greatest risk for suicide for depressed veterans (Valenstein et al., 2009). The decrease in care following discharge has been considered as contributing to the excessive suicide rate in this population; however, an alternative explanation may be that the increase is related to the reason for admission. Death by suicide in the period after discharge from inpatient psychiatric units is more frequent than at any other time during treatment (Valenstein et al., 2009), similarly, the period after discharge from Emergency Departments has been found to be a time of high suicide mortality (Weis et al., 2006). There is also reason for substantial concern in the period following discharge from residential addiction treatment (TIP50 DHHS, 2009).

Patients with suicidal behavior have been characterized as difficult to engage in after-treatment. Lizardi et al., (2010) suggests that a critical intervention point before discharge and the start of treatment is almost always unaddressed. In a review of intervention studies, van Heeringen found that compliance in routine

after-care seldom exceeds 40% [van Heeringen et al., 1995]. Intervention at this critical time period can help patients move from the assessment stages to being motivated to engage in and complete a successful course of treatment. Various trials of interventions offering help after discharge from hospital care or emergency department have focused on treatment accessibility and adherence to after-treatment. Incorporating different forms of contact across time as well as strategies that reach out to patients may improve treatment engagement among suicide attempters (Lizardi et al., 2010).

The clinical and epidemiological literature demonstrates that the probability of suicide and suicide-related behaviors can be elevated for extended periods of time after people are identified as being at risk. In this context, Fleischmann's finding that continuity of care with frequent, though brief, encounters can decrease suicide rates is an important demonstration that follow-up can be effective.

Fleischmann et al. (2008) studied the effect of brief educational intervention and periodic follow-up contacts (BIC) for suicide attempters in five culturally different sites (Campinas, Brazil; Chennai, India; Colombo, Sri Lanka; Karaj, Islamic Republic of Iran; and Yuncheng, People's Republic of China) as part of the WHO Multisite Intervention Study on Suicidal Behaviors (SUPRE-MISS). Among the 1,867 suicide attempters enrolled in the emergency departments of the participating sites, 922 (49.4%) were randomly assigned to a brief intervention and contact (BIC) group and 945 (50.6%) to a treatment as usual (TAU) group. The experimental intervention provided a one-hour educational intervention in the emergency department or as soon as possible after discharge followed by nine in-person or telephonic contacts over an 18 month period. Referrals to other agencies and services were arranged as appropriate. Although the overall number of deaths was small, the risk of death by any cause was cut in half in the treatment group compared with those who received treatment as usual. The proportion of individuals who died by suicide was also lower in the intervention group (0.2% v. 2.2%, $w_2 = 13.8$, $P < 0.001$).

A secondary outcome measured in this study evaluated repeated suicide attempts over the 18 months following the index attempt was reported in a second publication (Bertolote et al., 2010). The repeated attempts were identified by follow-up calls or visits. Overall, the proportion of subjects with repeated suicide attempts was similar in the BIC and TAU groups (7.6% vs. 7.5%, $\chi^2 = 0.013$; $p = .909$), but there were differences in rates across the five sites. The secondary outcome in the study from the five low- and middle-income countries does not confirm the effectiveness of brief educational intervention and follow-up contacts for suicide attempters in reducing subsequent repetition of suicide attempts up to 18 months after discharge from emergency departments.

The conclusion of this study should be interpreted in caution since they were based on informant report rather than official data sources and data were not available for those lost to follow-up. The fact that the population included in this study was from low-income countries (Brazil, China, India, Iran, and Sri Lanka) calls into question whether the results are generalizable to the DoD and VA population.

Neither this study, nor the rest of the literature can address the key questions about how continuity can be achieved. Specifically, research has not yet provided clear answers to questions about:

- When should care and follow-up begin?
- How long should it continue?
- What is the appropriate frequency of follow-up?
- What is the appropriate duration of an encounter?
- What should be accomplished at each follow-up encounter?
- What information should be obtained from follow-up to decide when treatment plans need to be modified?

In the absence of specific evidence to answer these questions, recommendations about follow-up must be based on a consensus that is informed by the evidence.

However, when a meta-analysis of the results of trials evaluating the effect of follow-up interventions on repetition of deliberate self-harm was conducted, there was no convincing evidence of greater effectiveness compared with routine care (Hawton et al. 2000; NICE, 2011).

Finally, it is useful to consider a residual category of older studies that were conducted to evaluate counseling or psychosocial interventions that do not constitute clinical trials of manual-based psychotherapies. Whether or not the specific interventions that were tested proved to be replicable or effective, they should be considered for what they can say about the outcomes of follow-up care.

P. Reassessment and Monitoring

1. Follow-up appointments should include:
 - a. Reassessment of: interim events, changes in suicide risk; symptoms of mental disorder; and medical conditions
 - b. Provision of specific treatment targeting suicidality
 - c. Continuation of treatment of co-occurring underlying conditions
 - d. Monitoring the symptoms of co-occurring conditions
 - e. Assessment of adherence and adverse effects
 - f. Modification of treatment, as indicated
 - g. Support, reinforcement, and update of the safety plan
 - h. Addressing patient/family concerns
 - i. Determination of the frequency of future follow-up

Q. Adherence to Treatment and Follow-up care Strategies

BACKGROUND

Barriers to care

Patients with severe and persistent mental illness, few skills, minimal resources, and socioeconomic distress are difficult to engage in outpatient treatment. Access-to-care obstacles may become barriers to follow-up and prove overwhelming for many patients at risk for suicide. Efforts to improve follow-up, continuity of care, and prevent repetition of self-harm should target higher-risk patients prone to disengagement and non-adherence.

Table D-1. Barriers to Mental Healthcare in the General Population and Among Formerly Deployed Military Personnel (Rand 2010 p49)

General Population (Kessler, Berglund, et al., 2001)	Formerly Deployed Military Personnel (Schell and Marshall, 2008)
Lack of perceived need	Negative career repercussions
Unsure about where to go for help	Inability to receive a security clearance
Cost (too expensive)	Concerns about confidentiality
Perceived lack of effectiveness	Concerns about side effects of medications
Reliance on self (desire to solve problem on one’s own or thoughts that the problem will get better)	Preferred reliance on family and friends
	Perceived lack of effectiveness

There is limited evidence that adherence to treatment will lower suicide attempt and death rates. “Outreach” generally refers to various methods of contacting the patient. Planning the outpatient program before discharge avoids unnecessary service gaps and insures continuity of care. Various forms of motivational counseling prior to discharge, next-day appointments, intensive follow-up treatment, reminders, or home visits may improve previously low adherence rates for following the recommended treatment plan. Facilitating adherence begins with the initial establishment of the physician-patient

relationship and the collaborative development of a plan of care that is attentive to the needs and preferences of the individual patient. For example, rates of keeping a first appointment may improve if prior to the appointment the patient has had personal or telephone contact with a new clinician.

When family members or other supportive individuals are involved (e.g., military command personnel or supportive roommates), they can also benefit from education and can be encouraged to play a helpful role in improving adherence.

RECOMMENDATIONS

1. A follow-up care plan should be developed with input from the patient and, where appropriate, available support system (e.g., family, unit, friends), to address the treatment of conditions that may have contributed to the risk of suicide.
2. Follow-up care should be coordinated by an interdisciplinary team and communicated with the patient through a single identified point of contact.
3. Barriers to adherence to the care plan after discharge may be addressed by follow-up programs that include the use of:
 - a. Telecommunications (phone, web based, v-tel) [I]
 - b. Mailing multiple “caring letters” [I]
 - c. Community workers reaching out to those at high acute risk
 - d. Methods to enhance and facilitate access to care (“Green cards”) [I]
 - e. Home visits to support engagement [I]
 - f. A facility-based registry of all high acute risk patients [I]

Patient Who Refuse Care

4. Patients who continue to be at risk for suicide and do not arrive to their follow-up appointment require a reassessment of risk, since not showing may demonstrate a risk behavior. The assessment should include: locating the patient and establishing contact, reassessment of level of risk, reinforcement of the safety plan, and directing the patient to the appropriate level of care.
5. If patient contact cannot be established, available data should be used to reassess the level of risk and corresponding effort should be made to locate the patient through direct contacts (e.g., next of kin), other points of available contacts (friends, peers, command), or, in cases of high acute risk, local emergency response (mobile crisis team, law enforcement).
6. Consider the use of caring letters for suicide attempters who refuse treatment. [I]
7. Home visit may be considered to support re-engagement of patients at high acute risk who discontinue outpatient care. [C]

DISCUSSION

Reports from randomized clinical trials and other studies on the continuity of care and follow-up for patients at risk for suicide were divided into those that address several areas or types of interventions that include:

- Care management and related strategies
- Facilitating access to care
- Communication of Caring Messages (Mailing letters/postcards)
- Telephone contacts

- Outreach in the patient’s home
- Intensive care

Q1. Case- or Care- Management Strategy

Several studies evaluated care management and related strategies provided in mental health care settings specifically to address the risk for suicide. According to the definition provided in Clarke, 2002, case management includes a needs assessment, treatment planning, arranging access to planned services, monitoring the use and quality of the services received, and long-term flexible support

Clarke et al., (2002) made the comparison between case management and treatment as usual. Adults (20+ years) presenting to Accident and Emergency Department following Deliberate Self Harm (DSH) were randomized to intervention group that involved case management combined with routine management, including medical and psychiatric assessment. The usual care group received a triage, medical and psychosocial assessment and treatment as required. There was insufficient evidence to determine if there was a clinically significant difference between nurse-led case management and standard aftercare on reducing the likelihood of people who self-harm being readmitted to hospital (RR = 0.85, 95% CI, 0.48 to 1.51). However, investigators reported that multiple re-admissions were much more common in the experimental group than the control (9 out of 220 versus 2 out of 247). At 36 months’ follow-up, one suicide had occurred in each treatment group.

De Leo et al., (2007) evaluated the impact of an intensive case management follow-up of high-risk people for one year. Sixty males with a history of suicide attempts and psychiatric illness were randomly assigned to one of two conditions: Intensive Case Management (ICM) or Treatment As Usual (TAU). ICM featured weekly face-to-face contact with a community case manager and outreach telephone calls from experienced telephone counselors. TAU participants were discharged under existing hospital practices.. At the end of the twelve-month treatment phase, only 22 patients completed the final evaluation, leaving a final sample of 22 (ICM=14, TAU=8). People in the ICM condition had significant improvements in depression scores, suicide ideation, and quality of life. ICM participants reported more contacts with mental and allied health services, had better relationships with therapists, and were more satisfied with the services that they did receive. No suicides were recorded in the twelve-month follow-up period. A few participants engaged in self-harming behaviors, though there were no differences between the treatment group and control. The author conclusion was that despite the high attrition rate and subsequent low sample size, initial indications are that intensive case management may be beneficial in assisting the post-discharge phase of high-risk psychiatric patients.

EVIDENCE TABLE

	Evidence	Source	LE	QE	NB	SR
1	Case management following discharge of high risk patients	Clarke et al., 2002 De Leo et al., 2007	I	Low	None- Small	I

LE=Level of Evidence; QE=Quality of Evidence; NB=Net Benefit; SR=Strength of Recommendation (See Appendix A)

Q2. Facilitating Access to Care After Discharge

There has been interest in the UK in providing patients immediate access to help at times of acute crisis. Two studies evaluated the effect of an emergency care ‘Green Card’ - a card of the size of a credit card with a telephone number that allows patients direct access to psychiatric care and/or hospitalization at the time of their suicidal crisis. A third study evaluated a similar strategy consisting of a mailed letter inviting high-risk patients to make an appointment with their family physician.

Morgan et al. (1993) offered patients (n=212) easy access to a therapist or re-admission on demand in the case of a crisis. The result after follow-up of one year was a reduction of repetition of deliberate self-harm (DSH) in the ‘green card’ group. There were 7 repeats in the experimental group and 15 in the control

group, however this difference was statistically non-significant. This reduction was independent of the actual use of the green card. A trend was noted towards greater use of services in the control group. The findings suggest that an offer of help which emphasis the opportunity to contact a therapist by phone or face-to-face any time needed may reduce repetition of self-harm.

[Evans et al. \(1999b\)](#) conducted a large ‘green card’ study, offering 827 patients who self harmed 24 hours telephone access for a 6-month period after the index DSH. No direct offer of face-to-face consultation was made. The study did not provide support for the initial findings by Morgan (1993), there being no difference in the rate of repetition of deliberate self-harm between the two treatment groups. A follow-up publication ([Evans et al., 2005](#)) evaluating the results of the intervention after one year showed similar results. There was no effect on the number of repeat episodes at 12 months and no difference between those with and without a previous history of self-harm. Time to repeat was not different between the experimental group and the control. The authors’ conclusion of the follow-up study was that there was no benefit in issuing a crisis card allowing telephone consultation to all those presenting to hospital after self-harm.

A different strategy to improve access to care was evaluated by [Bennewith et al. \(2002\)](#). The practices of general practitioners (GP) (n=49) were randomly allocated to the intervention group and 49 practices to the control group. If a patient’s GP was in the intervention group, their GP got written information about the DSH and a letter to forward to the patient, inviting him/her to make an appointment with the GP. The GP received guidelines for the management of DSH. The practice-based intervention did primarily focus on the assessment of risk factors following a traditional bio-medical illness model and there was neither emphasis on putting the suicide attempt into a personal life context nor on establishing a therapeutic alliance. No difference between the intervention and the control group was found.

EVIDENCE TABLE

	Evidence	Source	LE	QE	NB	SR
1	Providing contact information and facilitate access to care	Evans et al., 1999, 2006 Morgan et al., 1993	I	Mod	Small-None	I
2	Reaching out to patients through their primary care	Bennewith et al., 2002	I	Mod	None	I

LE=Level of Evidence; QE=Quality of Evidence; NB=Net Benefit; SR=Strength of Recommendation (See Appendix A)

Q3. Communication of Caring Messages (Mailing letters/postcards)

Sending caring messages to suicidal patients may reduce their suicidal behaviors. Providers can consider strategies for conveying a supportive and caring message to their suicidal patients. There is indication, based on some literature, that post-cards used in the appropriate patient population (e.g., high risk, refusal for ongoing treatment) may reduce repeat suicide rates. Coordinated mailings by the patient care team should be considered as part of a repeat mailing program. Depending on circumstances, setup, and provider comfort level, options such as sending a caring email, letter, card, and/or text message can be considered.

Historically, the evidence has supported the use of caring communication in reducing mortality rates. New evidence is currently emerging regarding the efficacy of cards to reduce lethality and increase engagement in care following discharge.

There is limited evidence supporting the use of post-cards for all patients post-discharge for suicidal ideation or attempts. In a large-scale study [Moto & Bostrom \(2001\)](#) demonstrated a significant reduction in suicide rates among high-risk persons who refused ongoing treatment. The participants in the study group received repeated contacts over the next 5 years. The contacts were aimed to show concern for the patients and their wellbeing and not to motivate attendance to treatment. However, in a similar study by [Carter et al. \(2007\)](#), a post-card intervention program demonstrated no significant reduction in the

proportion of people repeating suicide attempt. Yet, there was a significant reduction in the rate of repetition.

The large RCT that was carried out in the 1970's in San Francisco by [Motto & Bostrom \(2001\)](#) recruited people who had been admitted to a psychiatric hospital because of depressive symptoms or suicidal ideas. Patients who either refused follow-up care or had discontinued treatment following discharge were randomized to a group that received caring letters or a usual care (no-contact) condition (N = 843). Those in the caring letters condition received brief, typed, caring letters that included personal information gathered during the patient's stay or from follow-up responses. Motto emphasized the importance of not using the caring letters to gather test data or information of any kind, and to instead write letters that let patients know the staff remembered them and had positive feelings about them. Speculating that one note would not have much impact, but that the cumulative effect of repeated caring contacts would have the potential for the greatest influence (Motto, 1976), the letters were sent every month for 4 months, then every 2 months for 8 months, and finally every 3 months for 4 years. The findings indicated that number of suicides in the no-contact group was greater than twice that of the contact group for the first 2 years. Although the suicide rate curves were not significantly different when evaluated over the full 5 years, the significant differences during the first 2 years occurred when the letters were most frequent and during the time period when the highest suicide rates would be expected.

A similar strategy was used in a more recent trial in Australia ([Carter 2005-07](#)). Participants (772 adults) discharged from hospital after deliberate self-poisoning were randomized to receive either a series of postcards over 12 months (in addition to usual treatment) or to usual treatment alone. The postcards included a simple message of concern. The mailing of the postcards reduced the cumulative number of repeat episodes of deliberate self-poisoning both at 12 months (Incident Risk Ratio [IRR] 0.55; 95% CI, 0.35 to 0.87) and at 24 months (IRR 0.49; 95% CI, 0.33 to 0.73), but did not reduce the proportion of patients with repeat deliberate self-poisoning at either time point: intervention 15% (95% CI 11.5–18.7) v. control 17% (95% CI 13.5–21.0). At both 12 months and 24 months, subgroup analyses found that the between-group differences in cumulative number of repeat episodes of deliberate self-poisoning were largely accounted for by a small number of women in the control group with a past history of self-harm (n = 18, less than 3% of the sample).

[Beautrais and colleagues \(2010\)](#) report findings from a randomized controlled trial of a postcard intervention in New Zealand. The study randomized individuals aged 16 and older who were discharged from hospital following self-harm of attempted suicide into two groups. The treatment group received six postcards mailed during the 12 months following an index emergency department attendance for self-harm. The control received no mailing. Due to ongoing difficulties with recruitment procedures, with clinical staff reluctant to recruit participants to the trial, the trial was stopped after 8 months with a sample size of 327. After adjustment for prior self-harm, there were no significant differences between the control and intervention groups in the total number of self-harm re-presentations (IRR 1.07; 95% CI, 0.80 to 1.43) or total proportion of patients who re-presented for self-harm (OR 0.97; 95% CI, 0.58 to 1.62). The investigators' concluded that the postcard intervention did not reduce further self-harm. Postcard intervention may be effective only for selected subgroups.

A recent large study (n=2300) published by [Hassanian et al., 2011](#) tested the efficacy of a postcard intervention plus treatment as usual (TAU) versus TAU in an RCT in the large referral hospital for poisoned individuals in Tehran, Iran. The primary outcomes were suicidal ideation, suicide attempts and self-cutting (or self-mutilation). Similar to the study by Carter (2005-7), the treatment group received 8 postcards during 12 months after discharge from the hospital. Each postcard had a different message and were mailed each month for the first 4 month and every 2 month in following 8 months. A ninth postcard was sent for each participant's birthday. There was a significant reduction in suicidal ideation (RRR = 0.31, 95% CI 0.22–0.38; NNT= 7.9, 95% CI 6.10–11.5), suicide attempt (RRR = 0.42, 95% CI 0.11–0.63; NNT= 46.1, 95% CI 26.0–203.7) and number of suicide attempt events per person (IRR = 0.64, 95% CI 0.42–0.97). The investigator concluded that postcard intervention can reduce suicidal ideation and suicide attempts in a non-Western population. Sustained, brief contact by mail may reduce suicidal ideation and suicide attempts in individuals who self-poison.

EVIDENCE TABLE

	Evidence	Source	LE	QE	NB	SR
1	Mailing postcards in the immediate period after discharge in addition to usual care	Carter et al., 2005, 2007	I	Low	Small	I
2	Mailing caring letters for suicide attempters who refuse treatment	Motto & Bostrom, 2001	I	Low	Sub	I
3	Follow-up mailing for patients with high risk for suicide for extended period (> one year) can reduce suicidal and suicide attempts	Carter et al., 2005, 2007 Beautrais et al., 2010 Hassanian et al., 2011 Moto & Bostrom, 2001	I	Low	Mod	I

LE=Level of Evidence; QE=Quality of Evidence; NB=Net Benefit; SR=Strength of Recommendation (See Appendix A)

Q4. Telephone Contact

Phone follow-up interventions have been used to enhance the effectiveness of post-discharge treatment (via efforts to motivate for, and engage in treatment) and to provide brief assessment, crisis intervention, or referral as needed at the time of contact.

Telephone contact of patients in the period after discharge from acute care after attempted suicide may reduce the number of those who re-attempt suicide. Better results may be achieved if the call is done early after discharge by a trained clinician.

In the tele-help project for an elderly Italian population, regular telephone contact and access to further telephone care decreased the number of suicides significantly compared with an age-adjusted general population group (De Leo et al., 2002). Service users in the study group received an alarm device to remotely trigger a pre-established response network (TeleHelp). Users also received welfare monitoring and emotional support from trained and paid staff, via short and informal twice-weekly telephone interviews; users were also able to initiate calls at any time (TeleCheck). Active outreach, continuity of care and increased level of emotional support were key elements in providing protection against suicide, at least in females. The studied group was compared with the general population and not a control group of people sharing the same characteristics as the clients of the service.

In Sweden, Cedereke et al. (2002) investigated the impact of a randomly allocated telephone intervention with the aim of improving motivation for professional treatment. The study showed that telephone contact to patients at 4 and 8 months following hospitalization for a suicide attempt improved treatment adherence and some psychological symptoms compared to a control group. The controlled study that assessed the usefulness of telephone contact at four and eight months after suicide attempts, in addition to usual treatment, found no significant difference between the intervention and control groups in number of further suicide attempts at one year. The researchers concluded that the method was nevertheless useful because it offered patients who had never received psychiatric care before their index suicide attempt the chance of contact with health professionals.

Another study conducted in France (Vaiva et al., 2006) of individuals who had poisoned themselves used a telephone-based intervention in a randomized three-armed design. Participants received either telephone contact at 1 month, telephone contact at 3 months, or no telephone contact. Experienced psychiatrists made the calls. The psychiatrists reviewed existing treatments or suggested new ones, made urgent appointments at the emergency department if necessary, and provided 'psychological support'. The number of participants contacted at one month who reattempted suicide was significantly lower than that of controls (12% (13/107) v 22% (62/280) P = 0.03). This difference was seen over the first six months after telephone contact. No deaths from suicide occurred in this group. For participants contacted at

three months, the number who attempted further suicide was not significantly lower than that of controls (17% (16/95) v 22%; P = 0.27)

The author noted that telephone contact also enables the detection of people at high risk of further suicide attempts and the timely referral for emergency care. Out of 107 patients who were contacted at one month 13 were determined via the phone call by the psychiatrist to be at high risk and sent to the emergency department; 10 off them were considered being at risk and eight of these were admitted to hospital. Only one of these 13 patients reattempted suicide six months later.

EVIDENCE TABLE

	Evidence	Source	LE	QE	NB	SR
1	Contact phone follow-up for patient at high risk	Cedereke et al., 2002 De Leo et al., 2002 Vaiva et al., 2006	I II-a I	Mod	Small-None	I

LE=Level of Evidence; QE=Quality of Evidence; NB=Net Benefit; SR=Strength of Recommendation (See Appendix A)

Q5. Outreach in the Patient’s Home

Five studies evaluated the impact of home visits, either by providing treatment in the home or by conducting home visits to facilitate engagement

Hawton et al. (1981) compared the delivery of brief problem-orientated counseling in flexibly timed home-based therapy (including access via telephone services to the general hospital psychiatric service) versus treatment in weekly outpatient clinics. There was no significant difference in repetition that occurred in 5 out of 48 participants in the domiciliary treatment group as compared with 7 out of 48 in the outpatient group (RR 0.71, 95% CI, 0.24 to 2.09).

One study (**Van Heeringen et al., 1995**), evaluated the impact of a single home visit by a nurse for patients who failed to attend their initial outpatient appointment, with the aim of increasing motivation to attend. Home visits in case of noncompliance after DSH resulted in a significant increase in compliance (51.2%) compared with that of patients who were not visited if they did not attend the first treatment session (39.8%). There was also a decrease in the occurrence of repetition of DSH in the experimental treatment group (10.7% versus 17.4%), which failed to reach statistical significance after adjustment for age, marital status, and history of previous deliberate self-harm.

The **Guthrie et al. (2001)** study evaluated the use of brief psychodynamic interpersonal therapy delivered by nurses in the patient’s home. Clinician furnished four 50-minute psychodynamic-interpersonal therapy sessions to suicide attempters in their home during the first four weeks after ED discharge. It was compared with routine care. The intervention resulted in a significant decrease of DSH in the intervention group. The main outcome was repetition of deliberate self-harm, this outcome being based on self-reported episodes of any type of self-harm. There was a significantly lower repetition rate at the 6 months follow-up in the psychotherapy condition (9%) compared with that in the control group (28%; difference in proportions = 19%, 95% CI 9-30%).

Welu et al. (1977) evaluated a 4-month outreach program with an initial home visit to establish a relationship followed by weekly or biweekly contacts. The program resulted in a higher treatment attendance in the intervention group than in the control group. At 4 months there was a significant reduction of DSH in the treatment group. The treatment modalities in the intervention group were not well defined and the follow-up period was only 4 months.

Gibbons et al. (1978) evaluated the efficacy of crisis-oriented, explicitly time-limited services provided by social worker in the patient’s home rather than the hospital. The method used task-centered casework, which both social worker and client agree to undertake during a defined time-period (up to a maximum of three months). The intervention addressed range of problems such as personal relationships, social transitions due to losses, changes which required finding new roles, emotional distress interfering with

coping ability, problems with officials and organizations, and of inadequate resources. The trial was not comparing a treated with an untreated group. There was no significant difference in repetition of self-poisoning in the 12 months following the index attempt between experimental and control cases (13.5 per cent vs. 14.5 per cent). However, the patients in the experimental intervention by social worker at home rated the program as more satisfactory and helpful. In a third group of patients, excluded from the trial because of high severity of mental illness or immediate risk of suicide, 50 patients (36 per cent) repeated self-poisoning, in a significantly greater number ($P < .001$). After four months, patients in the experimental group also showed more improvement in social problems than did the control group. The investigators' conclusions was that although the method to reduce repetition of self harm is unknown, planned social work service using a task-centered approach in patients' home was more acceptable to patients and can reduce some of their most pressing difficulties in a relatively economical way.

EVIDENCE TABLE

	Evidence	Source	LE	QE	NB	SR
1	Conducting home visit to provide outpatient care	Hawton et al., 1981 Van Heeringen et al., 1995 Guthrie et al., 2001 Welu et al., 1977 Gibbons et al., 1978	I	Low	Small	I
2	Conducting home visits to facilitate re-engagement	Van heeringen et al., 1995	I	Mod	Small	C

LE=Level of Evidence; QE=Quality of Evidence; NB=Net Benefit; SR=Strength of Recommendation (See Appendix A)

Q6. Assertive Outreach

Killaspy et al., 2006 conducted a randomized controlled trial to test high-fidelity assertive community treatment (ACT) in the UK, Randomized Evaluation of Assertive Community Treatment (REACT) study. Patients with severe and enduring mental health problems who are high users of inpatient care were randomized to receive either ACT or continue with their usual care. Comparing outcome data at 36 months follow-up was available for 120 ACT and 117 CMHT. Participants showed no advantage over usual care from community mental health teams in reducing the need for inpatient care and in other clinical outcomes. There were no statistically significant differences between the ACT and CMHT participants in total in-patient days over the 36 months (median difference 0 (95% CI -50 to 56). Self-harm (including suicide) in the ACT group was 15/120 and 19/117 in the control group.

Hvid et al.,(2011) randomized 133 consenting patient to a treatment program that included six to eight assertive and motivational consultations, while a similar control group received standard care from a general practitioner. The consultations included problem solving therapy and other elements focused on outreach, adherence and continuation of care. The outcomes measured after 6 month of treatment and 6 month of follow-up included repetition of attempted suicide or suicide, and the total number of suicidal acts. The results showed a significantly lower proportion who repeated a suicide attempt in the intervention group (proportion 8.7%) than in the control group (proportion 21.9%). The number of repetitive acts was also significant lower (8 repetitions in the intervention - vs. 22 in the control group). The author concluded that there was a protective effect of the treatment program on repetition of suicide attempt and on total number of repetitions during the follow-up.

Van der Sande et al. (1997) was a randomized clinical trial comparing the efficacy an intensive psychosocial intervention with treatment as usual. Participants presenting for medical treatment after attempting suicide were randomly assigned to either intensive psychosocial treatment or 'care as usual'. The intensive psychosocial treatment consisted of brief admission to a special crisis-intervention unit and problem-solving aftercare. The results showed no differences in outcome. The probability of repeat suicide attempts in the 12-month follow-up was 0.17 for patients in the experimental group and 0.15 for

the control group. The study concluded that general implementation of an intensive in-patient and community intervention program for suicide attempters does not seem justified.

Morthorst et al. (2012) reported an RCT that assessed whether an assertive outreach intervention after suicide attempt could reduce the frequency of subsequent suicidal acts, compared with standard treatment. Participants were 243 patients admitted to regional hospitals in Copenhagen with a suicide attempt that were randomized to either Case management through assertive outreach that provided crisis intervention and flexible problem solving or treatment as usual. This approach incorporated motivational support and actively assisted patients to scheduled appointments to improve adherence with after-treatment as an add-on to standard treatment. During 12 months of follow-up, 20/123 (16%) patients in the intervention group had a subsequent suicide attempt, compared with 13/120 (11%) in the control group (odds ratio 1.60, 95% confidence interval 0.76 to 3.38; P=0.22). By contrast, self-reported data on new events showed 11/95 (12%) in the intervention group versus 13/74 (18%) in the control group (0.61, 0.26 to 1.46; P=0.27). The author concluded that assertive outreach showed no significant effect on subsequent suicide attempt. The difference in rates of events between register data and self-reported data could indicate detection bias.

EVIDENCE TABLE

	Evidence	Source	LE	QE	NB	SR
1	Assertive Community Treatment (ACT)	Killaspy et al., 2006	I	Mod	None	I
2	Assertive and motivational consultations (Brief crisis-intervention, and brief follow-up problem-solving)	Van der Sande et al., 1997 Morthorst et al., 2012 Hvid et al., 2011	I	Mod	None	I

LE=Level of Evidence; QE=Quality of Evidence; NB=Net Benefit; SR=Strength of Recommendation (See Appendix A)

Q7. Counseling and Psychosocial Interventions Other than Manual-driven Psychotherapies

Hawton et al. (1987) compared in a randomized prospective treatment study, 80 overdose patients (not requiring intensive psychiatric intervention) who received either brief out-patient counseling or were returned to the care of their general practitioners with advice on management. There was little difference in outcome between the two groups. At 12 months the proportion of repetition in the experimental group was 7.35 compared to 15.4% in the control group. However, two sub-groups of patients benefited more from out-patient counseling than from general practitioner care, these were: (a) women, and (b) patients with dyadic problems. The author concluded that counseling following overdoses should be focused on groups of patients such as these who are most likely to benefit from it.

In a Canadian study **Allard et al. (1992)** the key elements of the intervention were one home visit followed by one month of weekly office visits and eight monthly office visits thereafter. The group that received this “experimental” treatment had a 35 percent reattempt rate, which was higher than the 30 percent rate in the control group. The published report mentions that over 55 percent of the patients were unemployed, about 26 percent had fewer than 9 years of education, and 70 percent were unmarried. Only 21 out of 63 experimental subjects completed the treatment.

Mobile Treatment Outreach

Another study by **Currier et al., 2010** evaluated the impact of a **mobile treatment outreach** for following up on emergency department visits in patients at high risk for suicide. The goal of the study was to determine whether a Mobile Crisis Team (MCT) intervention would be more effective than standard referral to a hospital-based clinic as a means of improving engagement. Participants who were assessed for risk of suicide were subsequently discharged from the ED and randomized to follow-up either in the community via a MCT or at an outpatient mental health clinic. Both groups were offered the same structured array of clinical services and referral options. Successful clinical contact (attending the first

appointment) occurred in 39 of 56 (69.6%) of the MCT group compared to 19 of 64 (29.6%) of the control group. (RR = 2.35, 95% CI = 1.55–3.56, $p < 0.001$). However, there was no significant difference between groups in symptom or functional outcome measures, at 2 weeks or 3 months after enrollment (using intention-to-treat analyses). No data was reported on the Spectrum of Suicidal Behavior scale for suicide that was used to rate increasing risk severity from non-suicidal to serious attempt. The authors' conclusion was that Community-based mobile outreach was a highly effective method of contacting suicidal patients after discharge. However, the location of the post-discharge contact had no effect on outcome.

R. Continuity of Care

BACKGROUND

Continuity of care should be maintained when patients who are, or have been at risk for suicide, transition between care facilities, as to and from DoD and VA care facilities or between other health systems or provider organizations. Care for patients at risk for suicide must pay attention to several potential contexts where there are risks for discontinuities during transitions between care settings. These may include transitions from:

- Primary Care to Behavioral Health Specialty care;
- Emergency Departments to ambulatory services;
- Inpatient units to other setting (e.g., ambulatory services, nursing homes, rehabilitation in the community including domiciliary or other residential treatment settings as for PTSD);
- Nursing homes and residential care units to ambulatory services.

A multidisciplinary team approach to the treatment of suicidal patients maximizes providers' ability to provide optimal management and services to their patients.

Mechanisms for bridging across transitions and for providing information to new providers must be developed on a system-by-system basis. Sustaining the treatment and safety plans is enhanced during transitions of care when provider-to-provider contact and a follow-on appointment with the receiving provider are established. Transition support services (as telephone contact with contracted behavioral health providers) may further enhance transition safety should there be a delay in follow-on services.

RECOMMENDATIONS

R1. Coordination and Collaboration of Care

1. When patients are identified in primary care with intermediate or high acute risk for suicide they should be evaluated by behavioral health providers. Warm handoffs are helpful in ensuring that patients receive the evaluations they require without interruption.
2. All providers involved in the patient's care must actively attempt to connect with others in the suicidal patients' chain of healthcare (e.g., primary care) and with the patient's consent, helping services network (e.g., chaplains) to ensure timely communication, coordination of care, and aftercare.
3. As patients are recovering from crisis and reduce their risk for suicide they may also be transitioning to less restrictive care settings, as to routine care by primary clinicians. It is the responsibility of the healthcare team to update the patient's written Safety Plan over time.

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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