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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Annotation 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.

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.

Annotation 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

Annotation Q. Adherence to Treatment and Follow-up care Strategies

Assess and address 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.

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 though 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]

Annotation 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

Annotation 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.