Preventing suicide after discharge and in outpatient care

Vizient Patient Safety Organization Safety Alert

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Background

Globally, almost 800,000 people—one person every 40 seconds—lose their lives to suicide each year, and 10–20 times more made a suicide attempt.[1] In the United States, suicide has been the 10th leading cause of death for all ages since 2008; however, it is the second for those aged 10–34 and the fourth for those aged 35–54. Suicide rates in the U.S. have steadily increased by 30% from 2000 to 2016 for both males and females.[2] In 2017, the number of Americans who completed suicide rose again to 47,173 with an overall national rate of 14 deaths per 100,000 residents.[3,4] Suicide rates are highest among males, Caucasians, adults 45 to 54 years of age, and 85 years or older.[4] Montana, Alaska and Wyoming have the highest suicide rates which are twice as high as the national rate (26.72 – 28.89 deaths per 100,000 residents).[4] In about 50% of suicides, firearms continue to be the means most commonly used.[4]

Suicide is rarely caused by a single factor. Suicidal behavior is complex, resulting from various combinations of genetic, developmental, environmental, physiological, psychological, social, and cultural factors.[5] Although mental health conditions are often seen as the cause of suicide, over half of the people who died by suicide did not have an identified mental health problem.[6-8] Risk factors for suicide include a history of mental health illness, substance abuse or a previous suicide attempt; hallucinations urging suicide, hopelessness, anxiety, anger or agitation; a recent loss or stressful life event such as financial, relationship, health or legal issues; exposure to violence and isolation; and inadequate support or connectedness.[5] Protective factors which promote strength, resilience and connectedness to others during periods of vulnerability can help prevent suicide. Protective factors include effective coping and problem-solving skills; supportive relationships; connectedness to school, community and other social institutions; access to quality health care; reasons for living; and restricted access to lethal means.[5]

Suicide is preventable but remains among the top five most common sentinel events reported to The Joint Commission (TJC).[9] Health care providers play a critical role in the recognition, prevention and treatment of suicide, because many people who die by suicide are seen in a medical or psychiatric setting shortly before completing the act.[7,8,10-12]

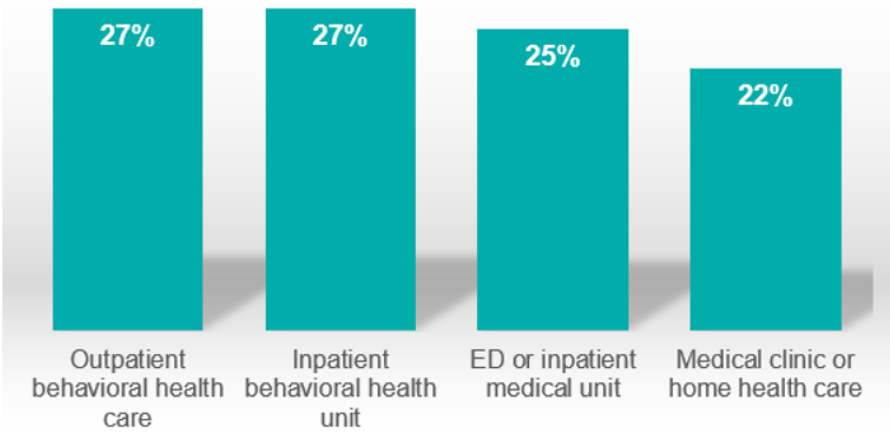
Assessment

The Vizient Patient Safety Organization (PSO) conducted a retrospective analysis of suicides submitted to the Vizient PSO between January 2016 and December 2019. The objective of this analysis was to review event reports on suicide-related behavior to highlight common characteristics and patient risk factors and opportunities for prevention. Data included suicides that occurred after discharge from the hospital or emergency department (ED) or after outpatient medical or mental health encounters. Suicides that occurred in the ED, hospital or another 24-hour care facility were excluded.

Suicides post health care visit

Sixty reports of suicides were found for the 4-year period of analysis. Patients who died of suicide were last seen in different health care settings (Figure 1). More were outpatients (65%) who were last seen for a medical or behavioral health visit or in the ED; whereas, 35% were inpatients who were last seen in a behavioral health or medical unit. Fifty-four percent of patients were last seen for behavioral health reasons, either as an outpatient or inpatient. Almost 40% of patients were last seen for medical reasons in a medical clinic, ED or hospital, or home health care.

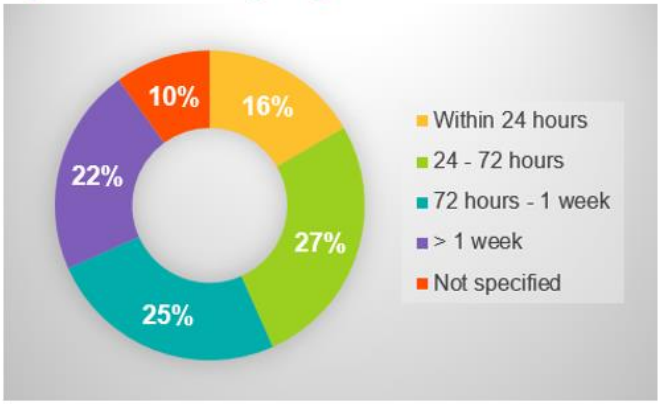
Figure 1. Suicides by the healthcare setting that the patient was last seen



Data source: Vizient Patient Safety Organization.
Period of data: January 2016-December 2019; Number of events: 60

Sixty-eight percent of patients died by suicide within 1 week of their last health care visit—16% within 24 hours of their last visit or hospitalization, 27% within 24-72 hours, 25% within 72 hours to one week, and the remaining were greater than one week or it was unknown (Figure 2). Suicides within one week of the patient's last visit may have been reported more often due to regulatory requirements or health care providers were notified because it was in close proximity to the visit. Patients, who died by suicide within three days, were last seen across all health care settings.

Figure 2. Suicides by length of time since last visit

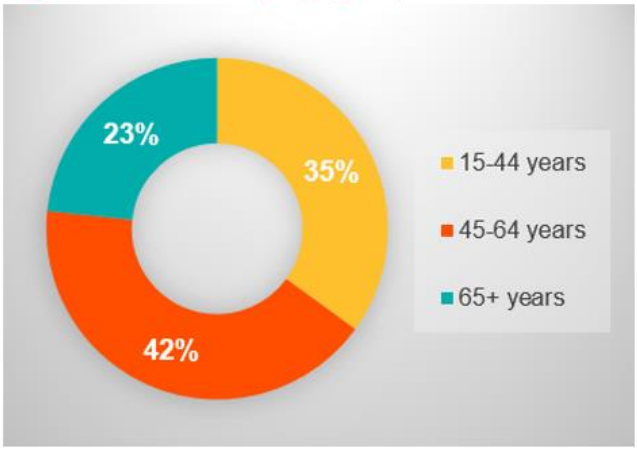


Data source: Vizient Patient Safety Organization.
Period of data: January 2016–December 2019
Number of events: 60

Demographics and causes

Males died of suicide (63%) more often than females. Sixty-five percent of reported suicides were in those over 44 years of age, with the highest among those 45-64 years of age (Figure 3). Similar to national data,[4] the most common cause of death was by use of a firearm (25%). Other more common methods involved suffocation (18%), a drug overdose (17%), or jumping from a high height or in front of a moving vehicle (17%). In the remaining cases, information about the method was not available.

Figure 3. Suicides by age group



Data source: Vizient Patient Safety Organization.
Period of data: January 2016–December 2019
Number of events: 60

Suicide screening

At the time of this analysis, almost 70% of organizations reported they were conducting universal screening for suicide (in 11% of organizations this information was unknown); however, universal screening may not have been implemented at the time of the suicide. Of these, almost 80% of organizations screen patients for suicide with an evidence-based tool. Common evidence-based suicide screening tools used by organizations were the Columbia Suicide Severity Rating Scale (C-SSRS) and Patient Health Questionnaire (PHQ-9).

In 38 (63%) of the suicides, information was available about whether screening or assessments had been completed. Of these, 82% had documentation that a suicide screening or assessment was completed during their last outpatient visit or at the time of discharge from the hospital or ED. In 18% of the 38 cases, there was no documentation that suicide screening or assessment, when indicated, had been conducted. Similar to a finding in another analysis of suicides[13], many patients who had suicide screening or an assessment at their last visit or at discharge denied suicidal ideation or were considered at low risk. At their last visit, some patients were described as displaying an improvement in mood and no signs of depression. In addition, there were cases in which the patient denied suicidal ideation to the provider conducting the assessment, but expressed suicide intent to others.

Warning signs and risk factors

Although the circumstances surrounding these suicides varied, a list of the warning signs and risk factors are summarized in Table 1. This summary was based on the information that was available and is not a complete set of data, because the details were not available in all cases. The most common warning signs and risk factors identified in these cases were a history of mental illness; a newly diagnosed, chronic or

terminal medical illness or chronic pain; recent thoughts and verbal expressions about suicide and/or a recent suicide attempt; access to a firearm; increased anxiety, anger or agitation; or relationship problems, a loss or loneliness. Some patients, who had a newly diagnosed medical condition or chronic medical problem, had a co-occurring mental health disorder.

Table 1. Suicides by warning signs and risk factors

Warning signs and risk factors[a,b]	Percentage of events
History of mental illness	48%
New or chronic medical diagnosis or pain or terminal illness	35%
Thoughts or expressions about suicide	32%
Accessible firearm	25%
Anxiety, anger, agitation	22%
Relationship problem, loss, or loneliness	20%
Recent or prior suicide attempt(s)	18%
History of substance use	15%

Data source: Vizient Patient Safety Organization.
Period of data: January 2016–December 2019; number of events: 60
[a]More than one warning sign or risk factor may have been identified in 1 event.
[b]Warning signs and risk factors were not available or were limited in at least 1/3 of events.

Care related factors

Suicide screening was not completed in the outpatient or inpatient medical setting or ED in 18% of cases in which the information was available. In some of the patients, who screened positively for suicidal thoughts or elicited staff concerns, a timely, comprehensive assessment by a trained clinician was not conducted. Suicide prevention interventions or referrals were inadequate, delayed or the level of care did not appear to be appropriate based on the patient's risk factors or their risk was identified as low. Clinicians in medical inpatient and outpatient settings identified that their patients were having difficulty coping with their medical illness or other stressors, and requested a behavioral health consultation or referral; however, the urgency of an assessment was not recognized.

In the majority of cases, the patient was receiving or had been referred to mental health services after an outpatient visit or inpatient stay. However, some patients had not engaged with the provider, did not show for their scheduled appointment or service, or died by suicide prior to their scheduled appointment. There were a number of different factors described in these cases. The patient was resistant to treatment, was in the process of a medication change or relapsed on substances prior to treatment. Patients that were only receiving psychiatric medication management did not express suicidal ideation at their last visit and died by suicide before their next three-month appointment. Access to care may have been delayed because mental health services (e.g., appointments or beds) were not available. Other issues arose because there were gaps in communication between providers (e.g., ED or inpatient and outpatient providers) or patients were discharged without adequately addressing their safety needs during transport.

In about 40% of cases, the patient had access to a firearm or other lethal means such as their previously or newly prescribed medication. In most cases, it was not specified whether these patients were assessed or counseled on restricting access to lethal means. There were instances where despite notifying the family to remove lethal means, they failed to act on the recommendation.

Protective factors

Of the cases in which information on protective factors was available, about 70% of patients were reported to be connected to family, children, relatives or friends or community or social institutions. In some cases, the patient was reported to have an inadequate or limited support system, was living in a non-supportive or abusive or neglected environment, or the caregiver did not follow through with the health care provider's recommendations for maintaining the patient's safety. About 25% of these patients were not receiving mental health services around the time of the suicide. In suicides that occurred within 72 hours of last being seen in a health care setting, almost 50% of these patients had an inadequate support system or were not connected to mental health services.

Recommendations

Risk reduction strategies to prevent suicide post discharge or during outpatient care were compiled from information in the Suicide Prevention Resource Center's Zero Suicide Toolkit[14], current literature and an expert advisory team (Appendix A).

Zero Suicide, a framework to prevent fragmented care and promote a systematic, evidence-based approach to suicide prevention, is a national initiative by the National Action Alliance for Suicide Prevention (Action Alliance). The Zero Suicide approach was inspired by health care systems that had a dramatic reduction in patient suicides after implementing a similar approach.[14,15] The Division of Behavioral Health Services of the Henry Ford Health System was the pioneer of the model to redesign the system of care to eliminate suicide, referred to as "Perfect Depression Care." The division's initiative, which focused on partnering with patients, clinical care, access and information flow, resulted in a 75% decrease in the suicide rate.[16,17] The Substance Abuse and Mental Health Services Administration (SAMHSA) funds this national initiative, and the Education Development Center's Suicide Prevention Resource Center (SPRC) operates and manages the initiative.[15] There are seven essential elements of suicide care—lead, train, identify, engage, treat, transition and improve—developed by the Action Alliance's Clinical Care and Intervention Task Force.[14]

Note to readers

The complete version of this document is only available to organizations that participate in Vizient PSO.

For more information on how to join Vizient PSO, contact Ellen Flynn, Associate Vice President, Safety at (312) 775-4294.

Leadership commitment

Leaders should commit to dramatically reducing suicide for patients across the care continuum by taking the following actions:[14]

- Obtain clinicians buy-in on the goals and suicide reduction strategies.
- Establish a multidisciplinary suicide prevention implementation team that includes representatives from across care settings and patient advisors who have had their own struggles with suicidal thoughts or attempts or are loss survivors to assist in the oversight and planning process.[14]
- Define the tasks and roles of the implementation team such as:[14]
  - Development of policies and procedures that address screening, assessment, care pathways, treatment and transitions in care.
  - Assessment of staff learning needs and staff training based on roles and responsibilities.
  - Integration of suicide screening, assessment and care management into the electronic health record (EHR) and clinical workflow.
  - Development and implementation of continuous quality monitoring, measurement and improvement activities to mitigate patient harm.

Workforce training

Successful suicide screening, assessment and intervention depends on the ability of clinicians and health care workers to recognize the risks and warning signs of suicide and ensure that immediate and appropriate care is initiated. Education and training are important in prevention because clinicians may lack knowledge and experience or feel uncomfortable dealing with suicidality or mental health issues. TJC requires that organizations develop written policies and procedures that address training and competency assessment of staff who care for patients at risk for suicide. Recommendations include:

- Conduct an assessment on staff and clinicians' knowledge, confidence and practices surrounding suicide prevention. Use The Zero Suicide Workforce Survey to conduct a formal assessment. Develop the education and training plan based on the findings from the survey. Repeat the assessment at least every three years,[14] or more often if needed (e.g., increase in clinician turnover or suicides).
- To improve competence and confidence in suicide prevention, provide education and training to staff based on their roles and responsibilities including non-clinical staff, behavioral health and primary and tertiary care staff and clinicians.[14] All staff including non-clinical staff should receive education to improve their awareness of and ability to identify suicidal patients including the risk and protective factors and warning signs, organizational policies and procedures, and their roles and responsibilities (e.g., how to respond, find help, or make a referral). Additional clinical education on screening, assessing, managing, treating, referring and transitioning patients at risk of suicide should be based on the health care provider's role and clinical setting.[14]
- Integrate clinicians trained in assessment and evidence-based treatment of patients with suicidal ideation and mental health disorders into care pathways.
- Access a summary of resources for education and training of clinical and non-clinical staff on the Suicide Prevention Resource Center website.[14]

Screening and assessment

Health care providers play a critical role in identifying patients at risk of suicide, because many people who die by suicide had a recent health care visit. Studies have shown that 20% of individuals who died by suicide had contact with mental health services within a month of their death, and one-third, within one year. Even more common are encounters with primary care providers—up to 45% of those who died by suicide had contact within a month and 75% within one year of their death.[10]

TJC revised its National Patient Safety Goal (NPSG) on suicide prevention which is applicable to all Joint Commission-accredited hospitals and behavioral health care organizations effective July 2019. For all patients being evaluated or treated for behavioral health conditions as their primary reason for care, TJC requires suicide screening using a validated screening tool. In cases where the patient screens positive, the NPSG requires the use of an evidence-based process for suicide assessment. The suicide risk assessment must ask about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Documentation must reflect the level of suicide risk (e.g. high, moderate or low) as well as the plan to mitigate the risk for suicide.[18] However, opportunities for suicide prevention may be missed when suicide screening is limited to patients who present with behavioral health conditions as their primary reason for care, because many patients who die by suicide do not have a mental health condition or are undiagnosed.[6,19,20]

Health care organizations should develop policies and procedures that outline the process and frequency of suicide screening for patients in all care settings and timely assessment by a trained clinician for patients who screen positively. Primary care and other outpatient medical providers should have access to behavioral health experts for evaluation and management of patients at risk for suicide.[14]

Suicide screening

Health care providers should conduct standardized screening on all patients throughout the care continuum at first and subsequent contacts to identify patients who may be at risk for suicide using an evidence-based screening tool.[14,18,21] The use of standardized tools to screen for suicidal ideation universally across health care settings has resulted in increased screening and identification of patients who may be at risk for suicide.[21-23] Examples of evidence-based screening tools including population specific screening tools, many of which are available free-of-charge, include:

- The Columbia Protocol, which includes the Columbia-Suicide Severity Rating Scale (C-SSRS) for Communities and Healthcare, offers many suicide screening toolkit versions for use in different health care settings (e.g., primary care, ED or hospital) and patient populations (e.g., very young children or cognitively impaired) and is available in many languages. Triage steps or clinical care pathways based on risk stratification can be customized by the organization. These toolkits include the protocol for use and the training. The C-SSRS can be embedded into the EHR.[24]

- Patient Health Questionnaire 9 (PHQ-9) is a validated tool used to screen, diagnose, monitor and measure the severity of depression. The PHQ-9 screens for the presence and duration of suicidal ideation and has been effective at identifying patients with an increased risk of suicide. Simon et al found that patients who reported thoughts of death or self-harm more than half the days or nearly everyday in the past two weeks had a tenfold increase in suicide.[23] Access more information on the PHQ-9.[25]
- Most child and adolescent screening tools are designed for those 10-13 years and older. For example Ask Suicide-Screening Questions (ASQ) toolkit is designed for screening youth ages 10-24 in outpatient, ED and hospital settings. Four yes/no response questions ask about the recent suicidal ideation and lifetime suicide attempts. For positive screenings, a brief suicide safety assessment (BSSA) is conducted by a trained clinician to determine if a full suicide risk assessment is needed.[26] The Suicide Behavior Questionnaire-revised (SBQ-R) is a self-report questionnaire for children and adolescents between ages 13 and 18. The four-question test asks about lifetime suicidal ideation and attempts, the frequency of ideation in the past 12 months, suicide threats, and the likelihood of future suicidal behavior.[27]
- Although less studied, children as young as preschool age can display suicidal behavior and thinking. Suicide may be harder to evaluate in younger children who may exhibit fewer or different warning signs or risk factors than older adolescents. Screening and assessment tools are limited for young children and questions should geared to their level of comprehension.[28] C-SSRS has tools that assess very young children and those cognitively impaired for a full history and since the last contact.[24]
- Some screening tools can be administered as a self-reported questionnaire; therefore, the screening can be completed by the patient immediately prior to seeing their provider. Research has shown that suicide prediction models that incorporated both health record data and responses to self-report questionnaires substantially outperformed existing suicide risk prediction tools.[29]

Risk assessment

For those who screen positive for possible suicide risk, policies and procedures should be developed to ensure the patient remains safe and receives a timely, evidence-based risk assessment by a clinically trained staff on the same day.[14,18,21,30] Recommendations for patients who screen positively include:

- Develop policies and procedures that address monitoring of patients who are at high risk for suicide. Implement environmental safety precautions to prevent patient access to potentially harmful objects (e.g., needles, glass or other sharp objects, medications or chemicals, medical equipment with tubing or cords, plastic bags, ligature risks, etc.), address patient monitoring up to line-of-sight supervision, and when applicable, develop procedures for safe patient transport (e.g., ambulance) to a facility for a risk assessment.
- Review the resources on TJC Suicide Prevention Portal on environmental risk assessment.[30]
- Use an evidence-based suicide risk assessment tool such as:[30]
  - Columbia-Suicide Severity Rating Scale (C-SSRS) Lifetime Recent Version[24]

  - SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians which draws upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors[31]
- Assess the patient's past and current medical and psychiatric history and physical findings; recent and current suicidal ideation, intent, behavior, and plans; history of suicide attempts and behavior; means availability; warning signs, activating events, and risk and protective factors (available resources from which the patient can draw in crisis); and foreseeable changes that may exacerbate risk.[32,33]
- Identify the patient's level of risk, which serves as the basis for safety planning, treatment and follow-up care.[14]
- Gather information and input from multiple sources, including other health care clinicians and non-clinical staff, case managers, family, caregivers or individuals involved in the patient's life. Often, patients who deny suicidal thoughts or plans have made contrary comments to family, friends or other health care staff.[14] Denial may be due to ambivalence, avoidance of restrictive care or the desire to die without interference.
- Develop written policies and procedures for reassessment of patients identified at risk for suicide. Conduct reassessments on all at-risk outpatients at every visit and increase the frequency of visits for patients at higher risk.
- Embed suicide screening, assessment and care management into the EHR based on the setting and clinical workflow. Provide alerts for high risk answers or scores during screening or assessment and flag high risk patients to alert other health care staff.[14]

For additional evidence-based screening and assessment tools, review Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01 EP2: Validated/ Evidence-Based Screening Tools and EP 3 & 4: Validated/ Evidence Based Suicide Risk Assessment Tools.[30]

Patient engagement in care management and evidence-based treatment

Once the patient's level of risk of suicide is determined, an appropriate care management plan should be developed. An organization's policies and procedures should address standardized suicide care management plans or pathways to care (based on the patient's identified risk) for each clinical care setting including outpatient care, home health, ED, hospital or behavioral health care. Care plans should be patient-centered, timely, adequate to meet the individual's needs, documented in the EHR and monitored.[14]

Safety planning

Safety plans have been shown to be more effective than safety contracts in preventing suicide attempts, resolving suicide ideation, and reducing inpatient hospitalization.[34-36] A safety plan intervention is an evidence-based brief intervention that has shown to be effective in reducing suicidal behavior and improving

treatment engagement. This intervention with suicidal patients is used in a variety of health care settings including outpatient clinics, EDs, inpatient care, crisis hotlines, and counseling centers. The safety plan is developed by a trained clinician (e.g., nurse, psychologist, primary care physician, psychiatrist or social worker) in collaboration with the patient following a comprehensive suicide risk assessment. The safety plan takes from 20 to 45 minutes to complete. The safety plan provides a prioritized list of coping strategies, sources of support and help-seeking behaviors to be used by the patient before or during a suicidal crisis. The safety plan includes:[34,37]

- recognizing warning signs of an impending suicidal crisis
- employing internal coping strategies
- utilizing social contacts and social settings as a means of distraction from suicidal thoughts
- utilizing family members or friends to help resolve the crisis
- contacting mental health professionals or agencies and crisis centers
- restricting access to lethal means

Access the Patient Safety Plan Template[37] on the Suicide Prevention Resource Center website or more information on the Safety Planning Intervention website.

- Promote patient engagement through a collaborative safety plan intervention. A safety plan intervention should not to be confused with a safety contract or a no-suicide contract which has commonly been used in the past. A safety contract is not based on evidence, therefore, not a recommended practice.[38,39] Be empathetic and understanding of the patient's feelings and desire to reduce their pain. Explore what happened to the patient, discuss reasons to be hopeful and empower them to use services to alleviate their pain.[37]
- Address any substance abuse issues or violence prevention in the patient's safety plan.[37]
- Counsel the patient and family about the importance of restricting access to lethal means, such as safely storing firearms and other weapons, medications and chemicals or distributing gun safety locks, to keep suicidal individuals safe.[37]
- Use teach back to reinforce and evaluate the patient's understanding of the safety plan.
- Use peer support specialists to engage patients at risk for suicide in safety planning, mindfulness and relaxation techniques, and improving support networks to increase connectedness and decrease hopelessness.[40]

Examples of integrated health care models or pathways to care

Evidence-based treatment

The most effective treatments directly target suicidality, focus on the unique problems of suicidal people that prevent them from solving secondary drivers, and reduce the suicidal patient's access to lethal means.[14] Patients should receive treatment specifically targeted to address their suicidality, in addition to other

treatment modalities such as medication management by a psychiatrist.[37] Effective, evidence-based treatments include:

- *Collaborative Assessment and Management of Suicide (CAMS)* is a collaborative assessment and treatment planning process that focuses on the identification and targeted treatment of patient-defined suicidal ‘‘drivers’’ to eliminate suicidal coping patterns. Central to the CAMS approach is the use of a seven-page Suicide Status Form, which is a valid and reliable assessment, treatment planning, tracking, and outcomes tool. It has evolved over 25 years of clinical research and has been adapted for use across care settings.[49,50]
- *Counselling about Access to Lethal Means (CALM)* is an effective training for mental health professionals, health care providers and social service professionals that increases their comfort and knowledge about how to discuss lethal means restriction with clients as well as the frequency of discussion during times of crisis.[51] Access the free course.
- *Cognitive Behavior Therapy for Suicide Prevention (CBT-SP)* is a relapse prevention approach aimed at reducing risk for future suicidal behaviors. CBT-SP is theoretically grounded in principles of cognitive behavior therapy and dialectical behavioral therapy, and focuses on developing cognitive, behavioral, and interactional skills to prevent further suicidal behavior. The client learns effective coping skills for dealing with stressors and problems that lead to suicidal crises. Lasting about six months, CBT-SP consists of acute and continuation phases and includes a chain analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention and relapse prevention.[52,53]
- *Dialectical Behavioral Therapy (DBT)* is a cognitive-behavioral treatment approach that emphasizes balancing behavioral change, problem-solving, and emotional regulation, with validation, mindfulness, and acceptance of patients. The key components of DBT include weekly individual therapy in conjunction with group skills training, phone access to therapists outside the clinical setting, and consultation in therapist team meetings.[54,55]

To address challenges in care provision, schedule case reviews or conferences to increase multidisciplinary collaboration and treatment planning, and to improve communication between inpatient and outpatient providers.

Telehealth services

Health care organizations should evaluate and expand the availability of trained clinicians to conduct assessments of patients with suicidal ideation and provide treatment through telephone, video, and web-based technologies.[5,56] Telepsychiatry has been shown to be comparable to in-person services in terms of the reliability of clinical assessments and treatment effectiveness, patient satisfaction, and cost effectiveness.[56] Telehealth services can be used in a variety of settings, including outpatient clinics, hospitals, emergency departments, nursing homes and correctional facilities, to address patients’ needs for convenient, affordable and readily-accessible mental health services. Telehealth services can improve the

continuity of care and access to timely care, particularly for those with limited access to services, or transportation or work barriers.[56] Visit the American Psychiatric Association website to learn more about clinical, training, and policy considerations for telepsychiatry and access the Telepsychiatry Toolkit.[57]

Transitions in care

Discharged patients are at high risk of suicide, particularly in the first couple of days and weeks after discharge.[58,59] Up to 66% of young patients seen in the ED are discharged to home and do not receive appropriate follow-up care even though suicide is the second leading cause of death among this age group.[60] Additionally, approximately two-thirds of patients fail to comply with scheduled or rescheduled appointments after a hospital discharge,[61] and about half die by suicide before their first follow up appointment.[59] Early engagement of patients in outpatient mental health treatment is critical in preventing suicide.[59] Hospitals should implement effective clinical bridging strategies to prevent gaps in the delivery of mental health services and safer suicide care.[61] To create successful transitions in care:

- Develop and monitor compliance with written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.
- Establish agreements with behavioral health providers, crisis centers, and others to improve access to care, and facilitate rapid referrals and safe transitions between settings.[14,62]
- Facilitate family meetings during the hospital stay and involve family, friends, and other loved ones in the plans for care transition.[61]
- Reassess the patient for suicidal behavior prior to discharge and obtain input from multiple sources including the treatment team, outpatient providers, caregivers, family or others involved in their care. Evaluate the appropriateness of the discharge plan based on this comprehensive assessment.
- Prior to discharge, develop or review and update the Patient Safety Plan. Develop a specific and comprehensive discharge plan that includes safe transport for those at higher risk and timely outpatient care. Schedule the first follow-up appointment before the patient is discharged, preferably within 24 to 48 hours after discharge, because of the heightened risk in the first days and months after discharge.[62,63] Verbally review the plan with the patient, family and outpatient clinician.[14,61] When communication with the outpatient provider does not occur prior to discharge, designate completion of this responsibility to a specific person.
- Conduct a warm hand-off prior to discharge via an in-person or telephone meeting to review the patient's clinical history, progress, and discharge plan and to connect the patient to the new provider to increase the likelihood of compliance with follow up.[14,61] At discharge, ensure the patient's clinical history and treatment plan is transmitted to the next provider.
- Utilize case managers, community health providers and pharmacists to assist in bridging services.
- Consider other bridging strategies to strengthen patient connectedness and engagement in outpatient treatment such as outpatient clinician visits while in the patient is in the hospital, a preadmission visit to

the outpatient program, or direct admission into the outpatient program after discharge.[61]

Continuous contact and support

Health care providers should facilitate continuous contact and support with patients at risk of suicide, especially following acute care admissions such as:

- Provide written contact information for crisis services as part of every safety plan and at discharge from treatment. Explain the purpose and benefits of the services offered by the crisis center to the patient and their family.[14]
- Initiate follow-up or caring contacts within 48 hours of their health care visits. Caring contacts are brief communications with caring expressions and support from a provider that are delivered multimodally—in-person, by phone, letter, email or text. Caring contacts have been shown to be effective in reducing suicidal behavior and readmissions and increasing treatment engagement.[33,64-67]
- Send appointment reminders from both inpatient and outpatient providers.
- Engage the assistance of crisis lines by setting up formal agreements or subcontracts to provide follow-up calls or services for patients. This contract would require obtaining the patient's written consent.[21,68]
- Track patient appointments in the EHR, flag no-shows and contact referral providers to make sure that the person is receiving follow-up care.[14]
- Initiate immediate and persistent follow-up with any individual at risk of or who has missed a scheduled appointment. Contact the patient to ensure their safety and reschedule the appointment or link them to a higher level of care if necessary.[14]
- Develop incentives to engage the patient in treatment post discharge such as meal vouchers.

Additional resources and examples of follow-up communications:

- Safe Care Transitions for Suicide Prevention toolkit developed by The Utah Zero Suicide Learning Collaborative.[68]
- Zero Suicide website on Safe Care Transitions.[14]
- Suicide Prevention Resource Center website: Support Safe Care Transitions and Create Organizational Linkages.[62]

Measuring outcomes

A multidisciplinary suicide prevention implementation team should develop an approach for monitoring the implementation of policies for suicide care and measuring their effectiveness, and take actions as needed to improve performance in the following areas:

- Compliance with established processes including
  - Suicide screening, assessment and management of patients identified at risk
  - Care protocols
  - Plan when access to care issues arise

  - Use of the safety plan
  - Counseling on Access to Lethal Means (CALM)
- Compliance with the post-discharge or follow-up plan, no-show rates for outpatient visits and programs, and compliance with follow-up calls for no-shows
- 30-day readmissions and return ED visits for suicidal patients
- Elopements by suicidal patients from the ED or inpatient units
- Reports of suicide attempts and death: conduct root cause analyses and take corrective actions based on findings. Review this case example by TJC: Suicidal patient slips through the cracks.

Additional resources on suicide prevention

- National Action Alliance for Suicide Prevention: Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe[69] and Suicide Care in Systems Framework
- Western Interstate Commission for Higher Education (WICHE) Mental Health Program and Suicide Prevention Resource Center (SPRC): Suicide prevention toolkit for rural primary care and Suicide prevention toolkit for primary care
- Suicide Attempt Survivors Task Force of the National Action Alliance for Suicide Prevention: Pathways to hope, recovery, and wellness with insights from lived experience

For more information, contact Tammy Williams or Ellen Flynn.

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Appendix A. Expert advisory team

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