

# Continuity of Care for Suicide Prevention: The Role of Emergency Departments

**Continuity of care** is maintained when one care provider links to another care provider, the transition in care is smooth and uninterrupted for the patient, and the essential clinical information is provided.

## Introduction to the Problem

The goal of this paper is to highlight key steps emergency department (ED) providers can take to establish continuity of care for patients at risk for suicide, and thereby, to substantially reduce the number of suicide deaths and suicide attempts that occur after discharge. The risk of suicide attempts and death is highest within the first 30 days after a person is discharged from an ED or inpatient psychiatric unit, yet as many as 70 percent of suicide attempt patients of all ages never attend their first outpatient appointment. Therefore, access to clinical interventions and continuity of care after discharge is critical for preventing suicide.

ED care providers are in a unique position to address this issue and set in motion a new chain of events to facilitate successful engagement with outpatient care. However, they face many challenges in addressing the needs of patients who may be suicidal due to the complexity of the ED environment, lack of resources, and complex nature of suicide risk. This paper is designed with these challenges in mind and presents the recommendations as a menu of options.

The recommendations in this paper are drawn from [\*Continuity of Care for Suicide Prevention and Research\*](#), a report issued in 2011 by the Suicide Prevention Resource Center (SPRC), American Association of Suicidology, and U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), and from a panel of expert reviewers. Following them will help organizations implement national standards and goals relevant to ED care for patients with suicide risk, such as The Joint Commission's [\*National Patient Safety Goal 15.01.01\*](#) (also see for background the [\*Sentinel Event Alert: A follow-up report on preventing suicide\*](#)), and Objective 8.4 in the [\*National Strategy for Suicide Prevention\*](#).



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## The Recommendations

Recommendations from the continuity of care report are summarized in separate sections below. Readers should select the most feasible options to implement depending on their organization's capacity, environment, and resources.

### » Screening

**Prioritize screening for suicide risk in the ED.** Despite a number of challenges involved with screening, the ED, like the primary care clinic, is “available to all and is accessed by so many” (p. 35). However, the report acknowledges barriers to screening, which include a lack of conclusive research evidence on the value of universal screening, inconsistencies in the way providers use the information from screening, and difficulty securing follow-up care for people who screen positive.



#### Where to Start

- Research the types of screening that are appropriate for your ED. Two places you can start are: 1) the expanded discussion of the issue in [the report](#) on pages 29–32, and 2) the article “Screening for Suicidal Ideation and Attempts among Emergency Department Medical Patients: Instrument and Results from the Psychiatric Emergency Research Collaboration.”<sup>1</sup>
- Standardize screening for suicide risk with all patients in a manner similar to screening for domestic violence, fall risk, or alcohol abuse.
- Identify people who may be suicidal and conduct an initial assessment to decide if they need a consult with a specialist (where available) or hospitalization.
- Review The Joint Commission’s *National Patient Safety Goal 15.01.01* and related materials referenced in the introduction of this paper.

#### Research on the Value of Screening

Results of a study funded by the National Institute of Mental Health, Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE), should help illuminate the value of universal screening for suicidal ideation and behavior in EDs. ED-SAFE is being conducted from 2010 to 2015 and is examining ways to improve detection of suicidal patients and suicide prevention in EDs. For more information on ED-SAFE, look at the [description of the study](#).

### » Discussing the Patient’s Condition and Treatment Options

**After an assessment, provide patients who are at risk for suicide with education to help them understand their condition and treatment options.** Due to patients’ poor engagement with outpatient follow-up, the ED visit may be the only opportunity to intervene and therefore the best chance for transmitting important suicide prevention information to the patient and family. This discussion facilitates patient and family adherence to the follow-up plan.

<sup>1</sup> Allen, M. H. et al. (2013). *Suicide and Life-Threatening Behavior*, 43(3), 313-323.

## Where to Start

- Request the patient's permission to include his or her family and/or close friends in a manner similar to what is used with patients with medical emergencies.
- Discuss the [condition, risk and protective factors](#), warning signs of worsening condition, safety planning, treatment options, home care, and follow-up recommendations with the patient.
- Provide additional information on the following topics: limiting access to lethal means, especially firearms (see the online course [Counseling on Access to Lethal Means](#)); crisis stabilization and management; and medication adherence.
- Discuss your expectations of follow-up care with the patient.
- Provide written educational materials, such as the *After an Attempt* guides for [people who have attempted suicide](#) and their [families](#).



## » Discharge Planning

**Develop thorough discharge plans for suicidal patients that include family involvement and making contact with outpatient providers.** This approach to discharge planning can increase access to follow-up care and reduce rates of recidivism. Emergency care providers should consider the patient's individual barriers to accessing services after an ED visit such as concerns about stigma and financial barriers.

## Where to Start

- When possible, schedule the first follow-up appointment before the patient is discharged, preferably within 24 to 72 hours and at least within seven days after discharge.
- Provide crisis cards with contact information to help after discharge. Contact your local crisis center for information or visit the [National Suicide Prevention Lifeline](#) to order free crisis cards and other materials.
- When possible, facilitate a phone call between the patient and the outpatient clinician prior to discharge. This is particularly important if the patient will have a new outpatient clinician.
- Develop a personalized safety plan. Safety planning is developing a written list of coping strategies and sources of support that a person can use during or before suicidal crises. Safety planning should not be confused with Contracts for Safety or No-Suicide Contracts. There is no evidence of the effectiveness of such contracts,<sup>2,3</sup> and they can provide a false sense of security. Safety planning, however, has a growing research base. Designed as a therapeutic technique, it may also be conducted prior to discharge planning as a brief intervention by the emergency care provider. Three useful safety planning resources are:
  - ◇ [Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version](#)
  - ◇ [Safety Planning Guide: A Quick Guide for Clinicians](#)
  - ◇ [Patient Safety Plan template](#)

2 Rudd, M. D., Mandrusiak, M., & Joiner, T. E., Jr. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology: In Session*, 62(2), 243–251.

3 Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19(2), 256–264.

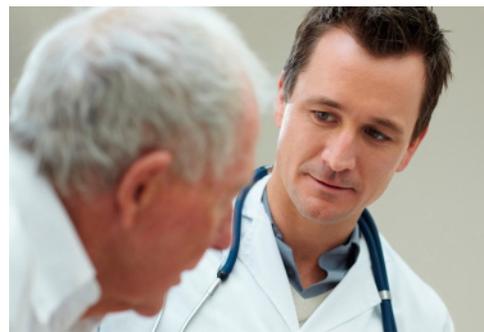
- Review discharge arrangements with patients verbally, rather than only using a written document, and counsel them on adherence to their discharge plan.
- Stress the importance of follow-up care. Ask the patient and his or her family to verbally explain the discharge plan, and check whether they know what to do if symptoms change.

## » Referring ED Patients to Follow-up Services

**Select and make arrangements for appropriate outpatient follow-up care for suicidal patients.** Referring ED patients to follow-up services is a critical piece of developing a thorough discharge plan.

### Where to Start

- Develop a team of care providers at your ED—including social workers, case managers, mental health consultants, or others—to help arrange follow-up for suicidal patients.
- Maintain a list of local outpatient mental health providers to consider for follow-up appointments. Note the clinicians with skills in suicide assessment, management, and treatment.
- Visit the National Suicide Prevention Lifeline [Therapy Finder website](#) to locate outpatient mental health resources in your area, or consult with the local crisis center or 2-1-1 provider, who may be willing to share their list with your ED.
- Consider the patient’s individual needs and possible barriers to accessing outpatient services when selecting the providers for follow-up care.
- With the patient’s consent, transmit relevant clinical information about the patient’s ED visit to the referral provider.
- If the number of days between ED discharge and the follow-up appointment exceeds the recommendations above (within seven days of discharge), consider the following alternatives until an option for longer-term treatment is established:
  - ◇ Transition clinic: short-term outpatient crisis management clinic established to receive patients at risk for suicide on short notice and promptly find them appropriate, longer-term care services
  - ◇ Partial hospitalization or day treatment program: intensive treatment for patients who do not need 24-hour care but require more than conventional outpatient treatment
  - ◇ Crisis residential placement: 24-hour crisis stabilization and intensive treatment
- Refer the patient to a follow-up appointment with a primary care provider (PCP) if none of these options are available or in addition to using one of them. Contact the PCP to discuss the patient’s condition and reason for referral.



## » Follow-up After Discharge

**During the ED visit, activate services or supports that can occur after a suicidal patient is discharged to facilitate his or her ability to access an outpatient follow-up visit.** Patients in crisis are often inattentive to matters unrelated to the crisis, so important treatment decisions and certain actions taken during the ED visit will increase follow-up services and supports.

### Where to Start

- During the ED visit, with the patient’s permission enlist family and/or close friends to be involved with the patient after his or her discharge. Involving them is a key way of helping to ensure follow-up appointments are kept by patients leaving the ED.
- Establish a process for making telephone contacts or sending e-mails, postcards, or text messages as reminders to the patient post-discharge. For example, consider the National Suicide Prevention Lifeline follow-up model described in the “Partnering with Crisis Centers” section below.
- Send postcards, e-mails, texts, or letters expressing concern and support, which can promote a feeling of connect- edness and may decrease suicide risk during the first two years following discharge (see pages 67–68 in the report). Inquire with your information technology (IT) department about the feasibility of generating automated mailings.
- For hospitals with community-based services capacity, employ intensive outreach interventions, such as home visits and frequent home-based therapy sessions, and/or intensive case management to decrease frequency of repeat suicide attempts and hospital readmissions. For hospitals without this capacity, partner with community organizations that provide this service.
- Assess ways to utilize available resources in your hospital to facilitate use of follow-up services, for example, using electronic medical records to “flag” patients at increased risk for suicide and/or using automated appointment reminder systems.
- Establish partnerships with community organizations to facilitate follow-up services.

### Partnering with Crisis Centers

In the National Suicide Prevention Lifeline Crisis Center Follow-Up pilot, at least 30 crisis centers are collaborating with EDs and inpatient psychiatric units to provide follow-up services for discharged patients. In this pilot, with the patient’s consent crisis centers contact via phone, e-mail, or text suicidal patients who were recently discharged from EDs or inpatient psychiatric units. These contacts motivate patients to continue the journey toward recovery after discharge and receive needed behavioral health care. One pilot demonstrated significant decreases in involuntary hospitalizations following implementation of follow-up calls,<sup>4</sup> and a SAMHSA analysis of return on investment demon- strated a decrease in hospital readmissions.

## » Provider Experience and Training

**Provide emergency care staff with the necessary training in suicide assessment, management, treatment, and discharge planning, and/or increase the percentage of clinical staff with these skills.** All aspects of care in the ED and continuity of care after an ED visit are greatly enhanced when emergency care providers have the necessary training and skills to address the individualized symptoms and circumstances of suicidal patients.

4 National Suicide Prevention Lifeline. (2013, March). Examples from crisis center collaborations with emergency departments.

## Where to Start

- Evaluate the capacity of all providers who work in the ED to identify and respond appropriately to suicidal patients. Providers include the intake/triage personnel and the non-mental health and mental health providers (i.e., medical assistants, nurses, mid-level providers, physicians, social workers, case managers, and registration or administrative emergency care staff).
- If there is not sufficient capacity to respond appropriately to suicidal patients, there are a few different options to increase it:
  - ◇ Train emergency care providers in working with patients who are suicidal. Information on available trainings and related materials can be found on the [ED pages](#) of the SPRC website. To enhance follow-up care, include information about local mental health resources in the training.
  - ◇ Allocate time in the ED for designated mental health providers from other departments in the hospital or health care system with the needed skills and experience to assess and treat suicidal patients.
  - ◇ Establish contracts with outside mental health providers to provide services in the ED to suicidal patients as needed.
  - ◇ Use telepsychiatry to close provider gaps if local resources are limited.
  - ◇ Hire additional providers with the necessary clinical skills and experience to work with people who are at risk for suicide.

### Using Telepsychiatry to Provide Specialty Care

For EDs with limited mental health staffing resources, *telepsychiatry* may be an option. Model programs with the [South Carolina Department of Mental Health](#) and at [East Carolina University](#) in North Carolina allow EDs to provide risk assessments and recommendations for initial treatment and follow-up care without having to hire additional staff. Instead, qualified psychiatrists in other locations use teleconferencing and review of electronic medical records to provide the services. Both programs have demonstrated improved quality and timeliness of psychiatric services provided in EDs and reduced costs and length of stay.

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### Suicide Prevention Resource Center

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